pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Shelby Mastrogiovanni

BORN: 05/21/03

DATE OF INCIDENT: 1/05/2013

DATE OF ORAL REPORT: 1/08/2013

FAMILY WAS NOT KNOWN TO:

Monroe County Children and Youth Services

REPORT FINALIZED ON:

6/03/2013

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b)

Office of Children, Youth and Families
Northeast Region 100 Lackawanna Avenue
Scranton, Pa. 18503 570-963-4376 | www.dpw.state.pa.us

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Monroe County was not required to convene a review team in accordance with Act 33 of 2008 because the case was [redacted] within 30 days.

Family Constellation:

Name:	**Relationship:**	**Date of Birth:**
Mastrogiovanni, Shelby	Deceased Victim Child (VC)	05/21/03
[redacted]	Mother/[redacted]	[redacted]/69
	Father/[redacted]	[redacted]/68
	Sibling	[redacted]/01

Notification of Child Near Fatality:

On 1/8/2013 a report was made to ChildLine regarding the VC. The VC died on 1/5/2013. It has been reported that the VC died from an [redacted] The [redacted] reported that the VC did not have any other medical/physical issue. The VC's [redacted] was instructed to take the VC to the [redacted] on 1/4/13 by an urgent care center. The VC's [redacted] allegedly failed to follow the center's [redacted]. Likewise, the VC's [redacted] also allegedly had [redacted]. On 1/4/2013 the VC vomited, however, the VC fell asleep by 3 a.m. The following morning (1/5/13) the VC could not be awakened. Emergency services were notified, however, upon their arrival it was determined the VC was deceased. The VC's body was taken directly to the coroner from the house. The [redacted] was contacted by [redacted] was notified and was actively involved with the investigation.

Summary of DPW Child Near Fatality Review Activities:

The NERO Human Service Program Representative (HSPR) met with the Monroe County Children and Youth Services (MCCYS) Child Protective Services Supervisor, Caseworker, Manager, and Director to discuss this case. The HSPR had obtained and reviewed the entire file regarding this family. The NERO HSPR also participated in the decision to forgo the County Internal Fatality Review Team meeting due to the case being unfounded on day 30.

Summary of Services to the Family:

Children and Youth Involvement Prior to Incident:

The family was not known to the MCCYS in the last 16 months.

Circumstances of Child Fatality and Related Case Activity:

The VC did not have a bowel movement and the VC's stomach became extended. The VC has had a [redacted] was repeatedly told to take the VC to the doctor for this issue. It was reported that VC [redacted] took VC to urgent care center on 1/04/2013 and was told to take VC to the [redacted]. [redacted] did not take the VC to the [redacted] because the VC was scared and did not want to go to the [redacted] asked the Urgent Care Center for a second opinion and was [redacted] was able to retrieve a comparable [redacted] story is consistent with the medical records. [redacted] reported that she was going to take the VC to the [redacted] on 1/05/2013 if her symptoms continued. VC was vomiting on Friday night and then fell asleep about 3 am. When [redacted] tried to wake up VC at 7am, VC would not wake up. Saturday morning 911 was called but the VC was already deceased. The VC died on 1/05/2013 at home. It was reported that the VC [redacted] VC's body was removed and taken to the Lehigh Valley Hospital morgue. An autopsy was scheduled for Monday, January 7, 2013 at 10:00am. Medical records indicate that VC did have a [redacted]. MCCYS investigated the case and conducted relevant interviews from 1/08/2013 through to 2/07/2013.

Current Case Status:

[redacted] report was submitted on 02/07/2013 with an [redacted].

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

Act 33 of 2008 requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. MCCYS did not convene a review team in accordance with Act 33 of 2008 related to this report due to the fact that this case was [redacted] on day 30 and therefore was not required.

Strengths: Not Applicable
Deficiencies: Not Applicable
Recommendations for Change at the Local Level: Not Applicable

Recommendations for Change at the State Level: Not Applicable

Department Review of County Internal Report: Not Applicable

Department of Public Welfare Findings:

NERO agrees with MCCYS findings related to the investigation and the [redacted] in relation to the allegation for medical neglect by the [redacted]. The entire file was received and reviewed (safety assessments, safety plans, risk assessment, dictation, etc...).

County Strengths: The MCCYS conducted a safety assessment (1/08/2013) on the VC's sibling and as a result there were no safety threats identified therefore, a safety plan was not necessary. A thorough investigation was completed and the agency made a determination after collecting all of the information. The [redacted] was submitted within the time frame. MCCYS obtained all medical documentation. MCCYS was supportive of the family throughout the investigative process.

County Weaknesses: There were not any county weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance: There were not any statutory or regulatory areas of non-compliance identified.

Department of Public Welfare Recommendations:

MCCYS should continue to follow the requirements regarding Act 33 of 2008. MCCYS should continue to seek technical assistance through the NERO and the Child Welfare Resource Center as needed.