



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Melanie Alexander

BORN: 5/10/2012

DIED: 7/26/2012

DATE OF ORAL REPORT: 7/26/2012

FAMILY KNOWN TO:

Beaver County Children and Youth Services

REPORT FINALIZED ON:

6/4/2013

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

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. Beaver County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Melanie Alexander	child	5/10/2012
██████████	mother	██████████ 1984
██████████	father	██████████ 1984

Notification of Child (Near) Fatality:

On 7/25/2012 Beaver County Children and Youth Services received a report ██████████ pertaining to Melanie Alexander. EMS had been called to the family home because the child was not breathing and was blue. The child was brought to ██████████ in ██████████ Her injuries include ██████████ The child was fully ██████████ and not expected to live. The child was certified to be in critical condition. There was no credible explanation for the child's injuries. The child's injuries were consistent with ██████████. Both parents ██████████ since they had both been alone with the child.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. The case files included the child's medical records and autopsy report. The regional office also participated in the County Internal Fatality Review Team meeting on November 30, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

There was no prior agency involvement with the mother or the subject child.

The father had a prior [REDACTED] report on a child of his former paramour, which occurred in November of 2011. A review of the case file pertaining to that report revealed that on 11/10/10 the agency received a report [REDACTED] on the six year old child of the father's then girlfriend. According to the report the child bit him and he bit the child back. The child sustained a 6cm bruise in the center of the right thigh with visible teeth marks. According to the child she and her mother's boyfriend (he was not her father) were playing a game called "good kids-bad kids". The child was a good kid and the boyfriend was the bad kid. She had a dress on at the time of the incident. Child also had a bruise on her head. According to the report received by the agency the reporting source stated that the child was [REDACTED] and had other [REDACTED]. The child was repeating kindergarten. She had been wetting herself since the beginning of the school year. The wetting incidents occurred two to three times a day at school and the child smelled of urine. According to the record, the child was waking up in the middle of the night and would not go back to sleep. Consequently, the child was falling asleep at school. The mother's boyfriend reportedly favored this child over her older sister. Because of these behaviors the reporting source was concerned that the boyfriend was possibly [REDACTED] the child. The mother was leaving the boyfriend to watch the children more often and for longer periods of time.

The reporting source had a number of other concerns about the boyfriend. On 10/23/10 the family cat was in his arms and he dropped the cat and it hit its head on the step. The cat had to be put to sleep because of his injuries. The family's other two cats also died when they were alone with him. The boyfriend reportedly was molested as a child himself. He was reportedly [REDACTED]. In addition, he was reportedly a former [REDACTED] who had [REDACTED].

During the investigation the caseworker reported the home was cluttered with old food on plates throughout the house. Clean and dirty clothes were intermingled throughout the house. The mother was also [REDACTED]. Both children had [REDACTED]. Both children had been in placement in Lawrence County.

The caseworker saw the child at school the day of the report. The worker took pictures of the child's injuries. The child reported that she and her mother's boyfriend tickle one another. She said that he had bit her after she had bit him on the shoulder. She denied that anyone came into her room.

The child's sister was interviewed on the same day. She said that her sister was not allowed in her room and no one else comes into her room. She described the incident as the child bit the mother's boyfriend on his shoulder and he bit the child back. Afterwards her mother and the boyfriend had an argument over the incident with her mother telling him that he couldn't do that.

The boyfriend was interviewed that day, he admitted to biting the child because she bit him on the shoulder. He wanted to teach her a lesson.

The mother was also seen that day and was extremely upset that Children and Youth Services was back in her life. She accused the agency of harassing her. She refused to sign any documents that the agency requested her to sign.

The agency [REDACTED] the report on 11/19/10. The family was opened for services with the agency. The boyfriend subsequently left the home; however the record did not specify when he moved out of this household.

Circumstances of Child Fatality and Related Case Activity:

On 7/24/2012 the subject child of this fatality report was transported by helicopter to [REDACTED] from the [REDACTED]. The child's condition was consistent with [REDACTED] and she was in critical condition and not expected to survive. The report [REDACTED] was filed on 7/25/2012. The agency's assigned caseworker contacted the hospital who told her that the mother was out of the home at the time of the incident and that the father was alone with the child. The father reported to the hospital that he noticed the child's lips were blue and she wasn't breathing. He looked up on the internet how to do CPR and eventually called the mother when the child wasn't responding. The mother told him to call 911. According to the hospital the parents were aware of the hospital's [REDACTED]. They also knew that the child was [REDACTED] and [REDACTED]. The final tests for [REDACTED] were in the process of being completed. Those tests would be completed by the next morning and the child would be removed [REDACTED]. The parents had discussed the incident between themselves. The mother was initially upset with the father but they resolved the issue. The parents were asleep in the child's room.

On 7/25/2012 the caseworker first interviewed the mother by herself. The mother stated that she went to Bingo with her mother about 6:00 pm the evening of 7/24/2012. The father stayed home with the child. About 9:26 pm the father called the mother and told her the baby wasn't responding. He asked her what to do. She told him to call 911. After she hung up with him, she called her sister who was a medic in the army and asked her to go to the home to perform CPR which she did. Her mother called her father to go to the home which he did. The mother and the grandmother were on the way to the family home when they received a call to go to the [REDACTED] which they did. The child was transported by helicopter [REDACTED]. She and her mother came to the hospital.

The mother reported that the story that the father told her was that he did not hear the alarm go off at 7:00 pm for him to start cutting up the meat for dinner. He reported that it was about 7:49 pm that he started cutting up the meat and preparing dinner. Before he started preparing dinner he tried to feed the child a bottle and she would not take it. He put her pacifier back in her mouth and let her sleep on the couch in the living room while he prepared dinner. After he cut up the meat he went to the bathroom to wash the blood off his hands. When he came out of the bathroom he noticed that the child's lips were blue and she was not breathing. He picked up the child and held her by shoulders and shook her to try to wake her up but that didn't work. He then went to the computer and to the site ASK.COM to find out how to perform CPR on an infant. He could not find anything on that site so he went to another site. He then tried to

perform CPR on the child. When that didn't work he then called the mother which was at 9:26 pm.

At that point the mother did not know what to believe. She did not know why her daughter stopped breathing. She said that she had called her doctor earlier in the day on 7/24/2012 because the child had a fever of 99.6 and the doctor's office told her that she did not have to bring the child into the office unless the child's fever went up to 102 degrees. She did receive a text from the father at one point during the evening that the child's temperature was back to normal. The hospital doctors had told her that the baby was shaken but the father said that he just shook her little to wake her. She did not understand why the father did not call 911.

The mother stated that the father had been good with the baby. The only thing that she did not like was that he yelled at the child two times to be quiet. She told him that you cannot yell at an infant because they are crying that is what they do. He was good with her six year old nephew. She did know about the incident where the father had bit a former girlfriend's child. She reported that she told him that you cannot do that. He never gave her a reason that he would hurt her child. She also told the caseworker that she knew he [REDACTED]

The caseworker then met with the father. She described his demeanor as being unemotional. The father told the caseworker that he did not hear the alarm go off at 7:00pm for him to start cutting up the meat for dinner. At 7:20pm he tried to feed the child a bottle and she would not take it. He put her pacifier back in her mouth and let her sleep on the couch in the living room while he prepared dinner. He looked at his watch and it was 7:49pm that he started cutting up the meat and preparing dinner. After he cut up the meat he went to the bathroom walking past the child on the couch to wash the blood off his hands. The child's head was turned to the cushions on the back of the couch so he did not see the child's lips at that time. When he came out of the bathroom he noticed that the child's lips were blue and she was not breathing. When the caseworker asked him why he left the kitchen and went to the bathroom to wash his hands he said that he did not like to use the kitchen soap to wash his hands.

When he realized that the child wasn't breathing he picked up the child and she was completely limp. He then shook her little to wake her up and that didn't work. He tried to do CPR on her and realized that he did not know how to do it. He then logged back onto the computer at the site ASK.COM to find out how to perform CPR on an infant. He could not find anything on that site so he went to another site. He then tried to perform CPR on the child again, that didn't work. Two of the mother's friends stopped by to see the child and he told them it was not a good time. That was when he called the mother. The mother's sister was the first person to arrive at the home and she performed CPR on the child. Then the EMT's arrived and started to work on the child and they took her to the ambulance to work on her. The father stayed in the apartment to shut off the lights and the computer. He called his mother for a ride to the hospital and went outside to wait for her. He realized that he locked his keys in the apartment and asked the landlord to let him back into the apartment so he could get a drink because he was thirsty.

The father reported to the caseworker that the child was fussy the last couple of days and was up almost all night Monday, 7/23/2012. The child would not sleep in her crib and the mother was up most of the night with her. He had the baby on Tuesday, 7/24/2012 so the mother could sleep. He also reported that the mother had called the doctor on 7/24/2012 because the child had a fever of 99.6 the doctor's office told her that she did not have to bring the child into the office unless the child's fever went up to 102 degrees. He had texted the mother on the evening of 7/24/2012 that the child's temperature was normal. According to the father he did not know why the child stopped breathing. The hospital doctors had told him that the child had been shaken but he claimed that he only shook her to make her breath. He added that he should have just called 911. When asked why he didn't call 911 he said that he had to fix the problem because he didn't want the mother to come home and find the baby not breathing. He added that things would never be the same because the mother's family is mad at me.

He acknowledged that he had [REDACTED] report from a couple of years ago when he bit his former girlfriend's daughter. He said that he should have not bitten her back after she bit him. He bit her back to teach her a lesson. The father reported that he [REDACTED] because when he was a teenager he was [REDACTED]. The [REDACTED] was then changed to [REDACTED] which is his current [REDACTED].

[REDACTED]. He reported that most days he plays video games and is on the computer. He liked being a father except when the child cried and he had to stop playing a game or being on a computer. He then repeated his previous statements that he did not know why the child stopped breathing; he only shook her to wake her up. He felt he should have called 911.

The caseworker then interviewed the maternal grandmother who confirmed the information that the mother and the father had told the caseworker. The only fact that the grandmother added was that the father told her that he had just finished a cigarette when he noticed the child's lips were blue. The grandmother stated that she had never seen the father be rough or inappropriate with the child and she never saw signs of domestic violence between the father and the mother. The grandmother stated that she believed that the father shook the baby and then did not help her. She was finding it very difficult to be around the father at the hospital. She found his affect to not be appropriate, he had not shown any emotion concerning what had happened to his daughter.

The caseworker then interviewed the maternal grandfather. He stated that his wife called him and told him to go to the parent's apartment because the child wasn't breathing. When he arrived at the apartment the child's aunt who is his daughter was performing CPR on the child. The father told him the story that he had told the mother. The grandfather was upset because he had heard that one of the friends that had come to the parent's apartment was a paramedic and the father sent them away. The grandfather also said that he had not seen the father be inappropriate with child. He had not seen any signs of domestic violence between the mother and the father. The grandfather said that he had been a medic in the service and when the doctor's described the child had been shaken he did not understand why the father did not call 911. He also did not understand why if the father needed a break that he did not call to ask them for help. They lived nearby and were more than willing to give them a break. He also found it

difficult to be around the father at the hospital and he found the father's lack of emotion to be odd.

The caseworker then interviewed the maternal aunt. She said that the father called her right after he had spoken to the mother. She immediately went to the parent's apartment and started CPR on the child. She had been a medic in the military and she said that she knew that the child was in a bad condition. The father did not say anything to her at the apartment and she did not ask him for an explanation because she knew she would get into an argument with him.

After her last interview the caseworker spoke to the police officers who were also at the hospital. The police told the caseworker that the father told them that he had shaken the baby four times and that he had spanked her one time on her diaper. The mother was not at home or was sleeping when these incidents occurred. The police stated that the father was going to be charged with four counts of aggravated assault and when the child died homicide charges would be added.

According to the [REDACTED] records the child was brought to their hospital in [REDACTED]. Her injuries included [REDACTED] [REDACTED] was acute and occurred within 72 hours. The amount of [REDACTED] and changes on her head CT indicate that the child had a [REDACTED] and was likely never normal following the event. The hospital was not able to date the [REDACTED] injuries. This type of extensive injury is associated with [REDACTED] and likely occurred near the time that the child began to show symptoms of [REDACTED]

The child was declared [REDACTED] after a second exam at 8:41am on 7/26/2012 [REDACTED] was withdrawn and the child died on 7/26/2012 at 8:50am. The primary cause of death was [REDACTED]. The contributing factors to her death were [REDACTED]

An autopsy was completed on 7/27/2012. The findings included that the child had sustained multiple blunt force trauma. The blunt force trauma to the head included [REDACTED] [REDACTED] and healing abrasions across the forehead. The blunt force trauma to the trunk included [REDACTED] [REDACTED] and abrasion on the left lower back. Blunt force trauma to the extremities included [REDACTED] on the right upper arm. It was the medical examiner's preliminary opinion that the child died of blunt force trauma to the head and trunk and the manner of death was homicide.

The father was arrested on 7/25/2012 and charged with four counts of aggravated assault, five counts of endangering the welfare of children and four counts recklessly endangering another person. Once the child died one count of homicide was added. The father has been in the [REDACTED] Jail since 7/26/2012.

On 8/10/2012 the caseworker met with the mother and the maternal grandparents at their home. At this meeting the mother told the caseworker that the child was not receiving [REDACTED]. The mother reported that she had not had further contact with the police. She still had her apartment but was staying with the maternal grandparents. On 8/20/2012 the agency determined that the [REDACTED] was [REDACTED] [REDACTED] the father. The agency closed their case with the family.

Current Case Status:

The criminal hearing for the father has not been scheduled. There have been delays in scheduling hearings in order for the father to have [REDACTED].

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

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. Beaver County has convened a review team in accordance with Act 33 of 2008 related to this report. However the review team did not meet until 11/30/2013.

- **Strengths:**

The team members included representatives from the agency, law enforcement, the Department and two provider agencies. During the meeting the police told the review team that during their interview with the mother they had to phrase their questions concretely in order for her to understand them. She was [REDACTED] like the father. Her mother is [REDACTED]. They were not sure what her level of functioning is. The mother did tell them that she and the father watched the shaken baby video at West Penn Hospital which is in Allegheny County where the baby was born and signed the statement that they understood the video. The conclusion the police reached was that the father [REDACTED] the child numerous times over the week before her death. He made sure that he was alone with baby when he [REDACTED] her.

- **Deficiencies:**

The meeting was not held within 30 days of the agency receiving the oral report from ChildLine. The members of the review team were weighted toward those individuals who had direct involvement with the case. This resulted in a discussion that centered on a

perfunctory review of the case rather than an analysis of the strengths and deficiencies of how the case was managed.

- Recommendations for Change at the Local Level:

The agency's plan of correction from a previous report identified an agency employee other than the assigned caseworker and supervisor who will be responsible for scheduling the review team meetings. Hopefully this change will result in the meetings being scheduled within 30 days of receiving the oral report from ChildLine.

- Recommendations for Change at the State Level:

The frustration with this case is that there have been many initiatives over the years to educate parents of the dangers of shaking a baby. As noted before the parents did watch a video of the dangers of shaking a baby and signed a statement that they understood the video when the child was born. Even with these efforts the child died of being a shaken baby. Local initiatives of identifying at risk families can be hampered as in this case with the baby being born in another county. Counties and the State need to review the current strategies to prevent shaken baby syndrome as to their effectiveness and make the needed changes to prevent this from happening again.

Department Review of County Internal Report:

The Department did not receive the County's internal report until May 6, 2013. The report had discrepancy on the date of the meeting. The report stated that the meeting was on 11/29/2012 when the actual date of the meeting was 11/30/2012.

Department of Public Welfare Findings:

- County Strengths:

The report accurately described the case activity.

- County Weaknesses:

The report was written by the assigned caseworker to the case. The report was not an analysis of the service system to the child and the family. It did not analyze the agency's handling of the case.

- Statutory and Regulatory Areas of Non-Compliance:

The agency did not meet the time frames identified in Act 33 of 2008 for convening the review team and submitting the review team's report to the Department. The agency will be cited under 3130.21(b).

Department of Public Welfare Recommendations:

The review team needs to identify the team member who will be responsible for writing the review team's report and submitting it to the Department. The writer of the report should not be the assigned caseworker or supervisor. It needs to be an individual who can accurately and objectively describe the review team's analysis of services to the child and the family.