pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Kajia Houtz

Date of Birth: 12-04-12
Date of Death: 02-26-13
Date of Oral Report: 2-27-13

FAMILY KNOWN TO:

Schuylkill County Children and Youth

REPORT FINALIZED ON:
09/01/13

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

Family Constellation:

Name:	Relationship:	Date of Birth:
Kajia Houtz	Victim Child (VC)	12-04-12
[redacted]	Mother	[redacted]-88
[redacted]	Father	[redacted]-81

Notification of Child (Near) Fatality:

On 2/27/2013, Schuylkill County Children and Youth Services (SCCYS) received a call from [redacted] regarding the death of the VC. The police responded to the VC's home on 2/26/2013 at 9:30 AM per a call to 911 for an unresponsive child. Reportedly, the [redacted] told the police that she and VC were on the couch the night before and she fed the VC between 11:00 PM and 12:00 AM, and then put the VC on her side lying against the back of the couch. The [redacted] stated that she was on the phone with her boyfriend and father of the VC around 12:30 AM when the VC fell asleep. [redacted] reported she woke up on 2/26/2013 at approximately 9:30 AM and needed to be to work by 10:30 AM. The [redacted] reported that the VC was on her belly on the couch and when she turned her over she was blue. The [redacted] said that she immediately called 911 and made attempts to revive the VC but she appeared to be deceased for some time.

Later in the day, on 2/27/2013, the SCCYS made a [redacted] Due to the history of the mother using substances and reported comments of the mother being frustrated with the VC, there was [redacted]

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office (NERO) conducted a full review of SCCYS files. There was a screen out referral at the time of the VC's birth. The record also contained a [redacted] information gathered after the VC's death. This included interviews with the mother as well as

police reports. NERO also attended the Act 33 meeting on 3/22/13 and participated in discussions with key stakeholders.

Children and Youth Involvement prior to Incident:

The SCCYS had involvement with the mother as a child on two different occasions, first in 1997 relating to the mother's [redacted] (as a child) and again in 2004, concerning mother's runaway and behavior problems and her mother's parenting skills. The case was closed in 2005 and there has been no involvement since.

On 12/5/2012, the agency received a call from a local Medical Center regarding the mother giving birth to the VC on 12/4/2012. Reportedly, [redacted] As there were no current allegations of [redacted] and the mother appeared to be acting appropriately toward the VC, an [redacted] was completed. The case was not opened for investigation or agency services.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 2/27/2013, the assigned [redacted] worker participated in an interview of the mother at the [redacted] police department. The interview was primarily led by the police officer and county deputy coroner. At the time of this initial interview with the mother, there was not a report [redacted]. The police officer called the agency on 2/26/2013 and requested agency assistance with the interview but did not have information at that time [redacted]. Based on information obtained from the interview, the agency contacted [redacted] The SCCYS director, [redacted] was verbally informed by a supervisor of the report of fatality on 2/27/2013.

During the interview on 2/27/2013, the [redacted] reported that she and the VC were out all day on 2/26/2013 at the mother's employer and running errands. The [redacted] reported feeding the VC about 9 ounces between 11:00 AM and 12:00 PM. She reported no problems with VC's swallowing. She said she was on the phone with the VC's father [redacted] around 12:30 – 1:00 AM and the VC fell asleep. The [redacted] stated that the typical routine was for the VC to wake up around 6:00 AM however on 2/26/2013, VC did not wake up on her own. The [redacted] said she woke to her alarm at 9:30 AM and found VC lying on her belly on the couch. The [redacted] reported turning the VC over on her back and noticed her to appear blue. The [redacted] said she ran outside screaming and then proceeded to call 911. She admitted to slightly shaking the VC as she was afraid to give her CPR but soon after the police and ambulance arrived.

The mother appeared [redacted] on 2/27/2013. Upon questioning from [redacted], the mother admitted she recently [redacted] She reported to [redacted] According to the mother, she was looking for [redacted] The mother did [redacted]

[redacted]. The police department did not ask the mother [redacted] Reportedly, the primary concern was the mother's [redacted]

The mother self-disclosed that [redacted] The mother did not give a timeframe, nor did she give information as to why she was in Kansas. [redacted] when she returned to Pennsylvania. On 2/26/2013, after finding the VC dead, [redacted] During the 2/27/2013 interview, the mother [redacted]

On 2/27/2013, the [redacted] worker received from the police officer a copy of Facebook comments made by the mother. Some of the comments were of a positive manner concerning her bond with the VC, but some comments were of an inappropriate nature, reflecting the mother as [redacted]. The [redacted] worker also received a copy of a police statement written by the [redacted]. The statement described the mother as neglectful of the VC, that she would allow the VC to cry excessively, put a pillow over the VC's face and cover the VC's mouth with her hand to quiet her. It was also alleged that the mother would [redacted] witnessed the mother's behaviors as described in [redacted] written statement. It should be noted that the mother reported that she had an estranged relationship [redacted]

An autopsy was completed on 2/27/2013, however the samples were sent to the lab for further testing. The deputy coroner reported that findings could take several months. However, preliminary results showed that there were no obvious signs of trauma. The deputy coroner shared that the mother missed several medical appointments with the VC's pediatrician; however there were no reports of ongoing medical problems. The VC was last seen by her pediatrician on 1/30/2013; she weighed 9 pounds, 7.2 ounces and appeared healthy. Reportedly, a pacifier was found embedded in the VC's back which could pose some questions to the [redacted] story that she found the VC lying on her belly. However, this alone was not conclusive that there was intent to harm or cause trauma.

On 3/6/2013, the [redacted] worker completed the CY 104 and sent the report to the District Attorney's office. The [redacted] worker also submitted a [redacted]

On 3/23/2013, the [redacted] worker and police officer met with the mother at her residence. She demonstrated how she positioned the VC on her left side between the couch cushion seat and the back support cushions of the couch. She was consistent with her story that she fed the VC

between 11:00 PM and 12:00 AM and the VC fell asleep while she was on the phone with her boyfriend. The [redacted] again stated that when she awoke on the morning of 2/26/2013 at 9:30 AM, she found the VC on her belly and she appeared blue. During this visit, the [redacted] admitted that she was still [redacted]. The [redacted] was cooperative in signing release of information consents regarding her [redacted] in Kansas.

On 3/25/2013, the [redacted] worker sent letters with signed consent releases to a [redacted] in Kansas, to the mother's obstetrician, and to the VC's pediatrician. The [redacted] was received by the agency on 4/1/2013. Reviewing these records indicated that the [redacted]. Records indicate that the [redacted] reported being sexually abused by her uncle between the ages of 5 and 14 in Reno, Nevada. Also reported was that at the age of 21, the [redacted] alleged that she was kidnapped and raped repeatedly and the kidnapper tried to sell her into prostitution. As a result of these [redacted] On 4/25/2013, the [redacted] was completed and submitted to [redacted]. The [redacted] worker has discussed with the police officer the possibility of interviewing the [redacted] who reportedly was with the [redacted] most of day on 2/26/2013; however the officer reported that he has not been able to contact this person. The [redacted] worker will continue to maintain contact with the police officer to inquire about any updates regarding possible witnesses and final autopsy findings. The criminal investigation is still considered to be pending at this time.

Current Case Status:

As the agency submitted the [redacted] and in order to meet regulatory time frame guidelines, this case was processed as opened for agency services. A risk assessment was completed on 4/26/2013. Safety assessments were completed on 2/27/2013 and 4/29/2013. Additionally, a Family Service Plan was not developed as VC is deceased and there are no other children in the home. (Note, NERO does not feel that the risk assessment or safety assessment were necessary due to the child being deceased and no other children residing in the household).

The [redacted] worker attempted another home visit with the mother on 4/26/2013 but it was unsuccessful. A card was left for the mother and she did call the worker at which time it was explained to the mother that the [redacted] until further information was obtained and/or conclusion of autopsy report. [redacted] The [redacted] worker will maintain monthly contact with the mother until the conclusion of the [redacted] investigation. NERO does not believe it is necessary to continue to monitor the mother as an open case.

The [redacted] worker previously requested medical records from the mother's OB doctor and the VC's pediatrician; however these records have not yet been received. The worker will follow up to inquire about the request for these records.

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

- **Strengths:** Schuylkill County convened a review team in accordance with Act 33 of 2008 related to this report. A review team meeting was held on 3/22/2013 with various members of the community and community providers. The family was briefly known to SCCYS but was not known to any of the community providers who attended the meeting. SCCYS has a good working relationship with the [redacted] and there was a team approach to the investigation. The Act 33 meeting had a variety of participants and a full critical analysis of the case was conducted.

- **Deficiencies:** There were no identified deficiencies regarding this case. There was team discussion in regards to the agency receiving a referral at the time of the VCs birth pertaining to the mother and concerns of possible drug use and concerns that this referral was not opened for agency investigation. There were questions and discussion about SCCYS policy of accepting referrals for mothers who have not given birth yet. It was explained that referrals can be accepted by SCCYS when a mother is late (8-9 months) in her pregnancy and there are issues of possible dependency, however there could be no court action to compel cooperation until after the birth of the child. There was also discussion as to whether local OBGYN practices and WIC offices were aware of the possibility to make a referral to SCCYS and the need for awareness.

- **Recommendations for Change at the Local Level:**

1) A team member offered to coordinate a meeting with the local OBGYN practice in which a Drug and Alcohol, Mental Health, and Children and Youth representative would attend to explain referral criteria and procedures. This meeting has already been scheduled for July 11, 2013.
2) It was suggested that SCCY should be more conscientious in the practice to accept referrals of late stage pregnant mothers with [redacted] and recommended that the agency should complete an investigation to assess the need for agency services, [redacted], and to offer referral information for support services. The agency is also looking at their policies regarding hospital referrals on new mothers.
3) It was recommended to continue to provide information to parents regarding the risk of co-sleeping with an infant.

- **Recommendations for Change at the State Level:** There were no identified recommendations for change at the state level regarding this case.

Department Review of County Internal Report:

The county report was received on May 30th, 2013. NERO concurs with the report provided by the county. As mentioned above, NERO does not feel a risk assessment and safety assessment were necessary due to the fact that the VC was deceased and there were no other children in the home, but this would not change the case outcome.

On May 31, 2013, NERO sent a letter to the County verifying receipt of their county report. The letter also indicated that NERO concurred with the county report's findings.

Department of Public Welfare Findings:

- County Strengths: The County appears to do an excellent job of teaming. This is apparent in their work with the police department, as well as their attendance and community input into the Act 33 meetings.

- County Weaknesses: There was discussion regarding this case not being accepted for intake investigation when it was referred at the time of the VC's birth. The SCCYS took this under consideration and advised they will be revisiting policies to look at better assessing the need for services in similar cases in the future.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of noncompliance related to this fatality. While the agency could have been more proactive with the referral at the time of the VC's birth, since there was no present allegation, there was not a requirement for the case to be accepted for investigation.

Department of Public Welfare Recommendations:

As mentioned, the SCCYS will be looking at their current practice as it relates to hospital referrals on new mothers. The SCCYS is also looking to educate the community on services they can provide to new mothers and when a referral can be made.