



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Melanie Paltanavage

Date of Birth: 07-29-14

Date of Death: 07-29-14

Date of Oral Report: 08-06-14

FAMILY KNOWN TO:

Schuylkill County Children and Youth Services

REPORT FINALIZED ON: 1/27/2015

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 on 08-28-14 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 Paltanavage	Victim Child (VC)	07-29-14
██████████	Sibling	██████-12
██████████	Mother	██████-91
██████████	Father	██████-89

Notification of Child Fatality:

On 8/5/14 Schuylkill County Children and Youth received information regarding a child's body being found in a trash can outside the residence of ██████████ via the news. Attempts to make contact with ██████████ State Police for additional information were unsuccessful.

On 8/6/14 the Pottsville Republican newspaper indicated ██████████ was arrested 8/5/14 on charges of Endangering the Welfare of Children, Concealing the Death of a Child, Recklessly Endangering Another Person, and Abuse of a Corpse. ██████████ was arraigned by District Justice ██████████ and committed to ██████████ Prison in lieu of \$250,000 bail. The article indicated ██████████ State police were called to the home during the early morning hours of 8/5/14 by a resident at the home. The resident discovered an infant's body, after smelling a strong odor coming from a trash can. The Coroner pronounced the days-old infant deceased at 4:48am 8/5/14. An autopsy was to be conducted 8/6/14 to determine cause of death. CPS Supervisor, ██████████, contacted ██████████, county coroner on 8/6/14. ██████████ reported ██████████ indicated she gave birth on 7/29/14 in the family bath tub but the baby expired and she placed the baby's body into a trash bag. ██████████ reported no one in the home knew about the pregnancy or birth. ██████████ reported the baby's body was badly decomposed but there was evidence the baby took a breath before expiring. He indicated evidence of lungs "floating" during the autopsy. ██████████ stated the exact cause of death is unknown, but is leaning towards death at the hands of another individual.

The information received from [REDACTED] was called into Childline 8/6/14 and [REDACTED]
[REDACTED]

Summary of DHS Child Fatality Review Activities:

The Northeast Regional Office (NERO) obtained and reviewed all current records regarding this case. This includes all interviews and medical reports. The family was known to the agency prior to this incident in regards to the older sibling. Records related to the earlier case were also obtained and reviewed by the NERO office. NERO also attended and participated in the Fatality Review Meeting on August 28, 2014.

Children and Youth Involvement prior to Incident:

There were two prior intakes on the [REDACTED] family prior to VC's death. On 12-03-12 the agency received a referral regarding VCs sibling [REDACTED] on 11-30-12. Concerns were expressed regarding parent's appearance, home conditions and overall issues of neglect. Agency staff met with the family and other household members on at least three separate occasions. Home conditions were assessed 12-03-12 upon child's [REDACTED] [REDACTED] and on two subsequent occasions with no concerns reported. Collateral contacts were made with child's pediatrician [REDACTED] and no concerns were reported regarding lack of follow through with recommendations. Child received high caloric diet and gained weight as recommended. The intake was closed 2-11-13. On 10-08-13 the agency received a second call with concerns for home conditions, supervision and allegations of parent's drug use. The agency visited the home on one occasion; drug screened the parents and discussed the supervision concerns with household members. The parent's drug screens were negative, there were no concerns with home conditions and the family expressed a plan of supervision for child. The case was closed at intake on 11-06-13.

Circumstances of Child Fatality and Related Case Activity:

On 8-06-14 [REDACTED] an unannounced visit to the family home. No one was present. The [REDACTED] then visited a relative's home in [REDACTED] who indicated VC's father and sibling were staying with father's grandmother. This relative was able to provide a telephone number for VC's paternal grandmother.

On 8-06-14 [REDACTED] Supervisor, [REDACTED], held a telephone conversation with [REDACTED] trooper from [REDACTED] State Police. Trooper [REDACTED] disclosed all residents of the home: VCs mother, VCs father, VCs sibling, paternal grandmother, paternal aunt and paramour and two children of paternal aunt. Trooper [REDACTED] did not have much more to disclose than what was already learned from [REDACTED]. On 8-07-14 Trooper [REDACTED] met with [REDACTED] Supervisor, [REDACTED], in the agency office to discuss the current investigation.

On 8-06-14, [REDACTED] made telephone contact with VC's paternal grandmother and scheduled a home visit for later in the day at VCs paternal great grandmother's home. During the home visit, the [REDACTED] saw VCs father, VCs sibling, VC's paternal grandmother and paternal great grandmother. The family reported VC's father and sibling would be staying with the paternal great grandmother temporarily due to the news media at the home and conflict between VC's father and father's sister. VC's father denied knowing mother was pregnant although he indicated he and paternal grandmother had suspicion due to weight gain. VC's father further indicated he did not know whether baby was his or not. VC's father and paternal

grandmother provided PCP (Primary Care Physician) information for VC's sibling who appeared healthy.

On 8-26-14 [REDACTED] visited with the mother at the [REDACTED]. The mother refused to discuss any circumstances surrounding the current criminal investigation but did sign a Release of Information for the PCP of VC's sibling. Subsequent visits were made with VC's father 9-09-14, 9-25-14, 10-24-14 and 11-03-14, VC's sibling 9-02-14, 9-25-14, 10-24-14 and 11-03-14. Subsequent contacts were made with the mother on 10-03-14, 10-21-14 and 11-14-14.

On 10-03-14 the [REDACTED] was completed and [REDACTED]. During the preliminary hearing 10-03-14 for the mother it was learned that the cause of death for the VC was impossible to determine due to decomposition. Additionally, final autopsy results were not able to indicate VC was alive at birth. The mother continues to deny VC was alive at birth.

Current Case Status:

On 8-05-14 the mother was charged with Endangering Welfare of Children, Concealing Death of a Child, Recklessly Endangering Another Person and Abuse of Corpse. She was subsequently incarcerated at the [REDACTED] Prison on \$250,000 bail. On 10-03-14 the Endangering Welfare charge was dropped at the preliminary hearing. The mother returned to prison.

[REDACTED] regards to the VC's sibling. The child is currently residing with the father and paternal grandmother. [REDACTED]

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

A Fatality Review meeting was held on 8-28-14 in regards to this case. The following strengths and deficiencies were noted.

- **Strengths:** Medical records for the VC's sibling were reviewed at this meeting. While the child did have a [REDACTED] within her first year, Medical records revealed that the child was taken to the doctor's frequently. This was viewed as a strength for the family since follow up medical care was provided.
- **Deficiencies:** While the Schuylkill County District Attorney's Office and investigating officer were invited to the Fatality Review, they were not in attendance. These offices were reluctant to share information with CYS due to confidentiality of their investigation. The lack of cooperation in conducting a joint investigation was considered a deficiency. There was discussion regarding working on relationships with law enforcement. Schuylkill CYS acknowledged that they had different relationships with law enforcement depending on the municipality. They acknowledged the need for outreach to those departments where they do not have an adequate working relationship.

There was some discussion regarding the fact that the case involving the older sibling could have remained open a little longer to ensure that the child was thriving, however, medical reports did support follow up treatment and there is no indication that closing the

case had any negative effects on the older child. The mother was not pregnant at the time of that case involvement.

- Recommendations for Change at the Local Level: As mentioned above, it was recommended that the CYS agency reach out to the D.A.'s office, as well as the municipalities where the county sees less open communication, to discuss strategies to improve communication.
- Recommendations for Change at the State Level: There were no recommendations for change at the state level.

Department Review of County Internal Report:

Schuylkill County CYS submitted a report on the fatality of Melanie Paltanavage on 11-25-14. This was reviewed by NERO and on 12-02-14; the NERO issued a letter to the county concurring with the report submitted.

Department of Human Services Findings:

- County Strengths: The NERO concurs with the strengths identified at the Fatality Review. The agency conducted a thorough investigation and made attempts to conduct a joint investigation with law enforcement. Both the D.A. and the investigating officer were invited to the Fatality Review Meeting, but opted not to attend.
- County Weaknesses: The lack of collaboration between law enforcement and CYS was seen as a weakness. The county did discuss making more efforts to reach out to law enforcement to collaborate in these types of cases. It should be noted that there are municipalities within the county where law enforcement works collaboratively with CYS.
- Statutory and Regulatory Areas of Non-Compliance: There were no areas of noncompliance noted regarding this fatality.

Department of Human Services Recommendations:

Recommendations would mirror those discussed at the Fatality Review Meeting. The county needs to identify those municipalities where there is a lack of cooperation/collaboration between agencies, and work to forge better working relationships. This can be achieved through outreach and training.