pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Adelina Quinones

Date of Birth: July 27, 2012
Date of Death: July 13, 2014
Date of Oral Report: July 7, 2014

FAMILY NOT KNOWN TO:

Berks County Children and Youth Services

REPORT FINALIZED ON:
June 30, 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, DHS 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. Berks County has convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 meeting was held on September 2, 2014.

Family Constellation

Name:	Relationship:	Date of Birth:	Date of Death:
Quinones, Adelina	Victim Child	06/27/2012	07/13/2014
[redacted]	Biological Mother	[redacted]/1993	
[redacted]	Paramour of Mother	[redacted]/1998	
*[redacted]	Biological Father	[redacted]/1992	

*The biological father does not reside in the household. He lives in [redacted]

Notification of Child Fatality:

On July 7, 2014 Berks County Children and Youth received a [redacted] report regarding Adelina Quinones. It was reported that mother's paramour [redacted] found child face down in the kitchen. He started CPR. Child was taken by ambulance to Reading Hospital. Adelina was [redacted] at the home prior to being transported to Reading Hospital. The child was transported to Hershey Medical Center. It was reported that child had some normal bruising but they also found possible evidence of sexual assault. It was reported that Adelina had [redacted]. Reading Hospital suspected that the [redacted] was hit since the child had no [redacted]

On August 8, 2014, Berks County Children and Youth received a Supplemental report regarding Adelina Quinones. [redacted] Medical examinations determined that the child was not sexually assaulted according to the initial report. The supplemental report stated that the child has since died therefore; this report will be treated as a child fatality.

Summary of DHS Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all medical, police and county investigation records pertaining to the [redacted] family. The regional office also participated in the County Internal Fatality Review Team meeting on September 2, 2014.

Children and Youth Involvement prior to Incident:
There was no children and youth involvement prior to the incident

Circumstances of Child Fatality and Related Case Activity:
On July 7, 2014 the [redacted] of [redacted], reported he was babysitting Adelina while her mother was at work. He reported that he found the child in the kitchen on the floor and she was not breathing so he did Cardiopulmonary Resuscitation (CPR) on Adelina and she vomited but she still was not breathing so he called 911.

On July 8, 2014 the police went to the home of [redacted] and found blood as [redacted] attempted to kill himself, he was cutting himself and it was determined that he was suffering from [redacted]. It was reported that [redacted] was cooperative with the investigation by the detectives. He was [redacted] is the only one named [redacted] has a son [redacted] that resides with his biological mother [redacted] The county administered a safety assessment and determined that the child is safe with his mother. A safety plan was developed to have [redacted] to have supervised contact with his son [redacted].

[redacted] reported that Adelina would fall asleep often and in the most unusual settings. Mother further reported that child had a habit of just falling asleep anywhere if parents did not take her to bed. Mother reported that on the previous day child seemed clumsy and when she tried to wake her up she had difficulty waking her up. [redacted] further reported that [redacted] is [redacted] and has medication which is locked up. She reported that there is no way for the child to get access to the medication. Adelina's toxicology reports were normal.

In review of the medical reports of Adelina's brain, the impression was [redacted] and there was no skull fracture identified. The medical report also stated that her [redacted] (bones) structures are unremarkable. These medical examinations report there is no signs of trauma. [redacted]

Hershey Medical Center stated that there was no sexual abuse and that the body was in a state of relaxation and that everything was normal with the child except for her breathing. Child may have gone into [redacted] and the child had [redacted].

On July 13, 2014 Adelina died at the Hershey Medical Center. A preliminary autopsy report ruled out sexual and physical abuse. There was no indication of sexual abuse, strangulation or suspicious inflicted injuries to the child. However an exact cause of death has not been determined and toxicology results found nothing unusual. The child's death could have been a result of a medical condition. It was reported that the child had a [redacted] injury and [redacted]. This was a pre-existing [redacted] injury and there was no evidence of abuse. The child received a full skeletal survey and the results were negative. The medical examinations determined that the child had [redacted] this is an infection [redacted] that is hard to diagnose, and it is a virus.

[redacted] as she got drunk and started cutting herself.

[redacted] was involved with Children and Youth as a child in New York State.

On September 4, 2014 the Berks County Children and Youth filed the [redacted].

On February 19, 2015, the Berks County Children and Youth [redacted]

Current Case Status:
The family has been provided with referrals [redacted]

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

The Department received the report on March 2, 2015. The report should have been received on December 11, 2014.

- Strengths: The team identified the following strengths:
  Safety of [redacted], was assured. Safety plan was developed to prevent [redacted] from having unsupervised contact with his son.
  Alleged perpetrator was cooperative with investigation.
  Skeletal survey completed; no fractures were noted.
  Mother is employed.
  Paramour, [redacted], is employed.
  Mother and alleged perpetrator denied history of prior substance abuse or prior involvement with the law.
  Mother was involved with CYS as a child for physical abuse. She reports she is [redacted] after "having head slammed against wall."
  Mother and alleged perpetrator denied history of domestic/abuse/violence.
  Cooperation between law enforcement/CYS and medical personnel was ongoing throughout the case.

- Deficiencies: The team identified the following deficiencies:
  Mother was involved with CYS as a child for physical abuse. She reports she is [redacted] "having head slammed against wall."
  Mother visited the child infrequently during hospitalization.
  Mother did not seem to grasp the severity of child's condition and told alleged perpetrator "everything was going to be fine and they are going to be able to fix what's wrong with the child."
  Mother and alleged perpetrator had history of cutting/self-mutilation. Alleged perpetrator was [redacted].
  No cause of death has been determined.

- Recommendations for Change at the Local Level:
  There were no regulatory deficiencies noted.
  Initial report was registered for [redacted]. Reasonable suspicion that child death was related to [redacted] so supplemental report was filed on 8/7/2014.
- Recommendations for Change at the State Level:
  Family to be provided with referrals for [redacted] services.
  Follow up following autopsy report and coroner's findings.

Department Review of County Internal Report:

The Department received the report on March 2, 2015. The report should have been received on December 11, 2014.

Department of Public Welfare Findings:

- County Strengths:
  The county completed a thorough [redacted] investigation. The county provided detailed structured case notes.
  The county and law enforcement collaborated effectively during the investigation.
  The county collaborated effectively with the hospitals that provided care and treatment for Adelina. The county obtained all of the medical reports and medical documentation.

- County Weaknesses:
  The county reviewed more than 30 days after the initial report. The county report was received more than 90 days of the Act 33 meeting.

- Statutory and Regulatory Areas of Non-Compliance:
  There are no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

There are no recommendations.