

Office of Children, Youth and Families

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REPORT ON THE DEATH OF

Tristan Clive Duke

**DOB: 09/04/2009
Date of Fatality: 07/20/2012
Date of Oral Report: 7/20/2012**

**FAMILY NOT KNOWN TO:
York County Children, Youth and Family Services**

REPORT FINALIZED ON: 01/02/2014

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. Section 6349 (b)).

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

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 Child Line. York County Children, Youth and Family Services has convened a review team in accordance with Act 33 of 2008 related to this report.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Tristan C. Duke	Victim Child	09/04/2009
██████████	Mother	██████████ 1991
██████████	Father	██████████ 1990
██████████	Alleged Perpetrator	██████████ 1988
██████████	Cousin	██████████ 2010

Notification of Fatality/Near Fatality:

Corporal ██████████ of the Northern York County Regional Police Department was dispatched to the ██████████ home on July 20, 2012 for a cardiac arrest involving a 3 year old that had fallen into a swimming pool. ██████████ called York County Children Youth and Family Services to report the circumstances. At the time York County Children, Youth and Family Services received the referral Tristan was found in the family pool unresponsive and was being transported to the hospital but was not expected to survive. The County agency had concerns for lack of supervision. A caseworker was sent out to speak to the AP and put a safety plan in place for ██████████ 2 year old daughter who was still at the scene. The safety plan was for ██████████ daughter to stay with ██████████ who is supervising all visits. The parents reside in separate residences. No other children are in the ██████████ home. Tristan did pass away a few hours later.

2. Documentation Reviewed and Individuals Interviewed:

For this review Central Region Office of Children, Youth and Families (OCYF) interviewed:

- ██████████ Supervisor at York County Children, Youth and Family Services

- [REDACTED] case worker at York County Children, Youth and Family Youth Services

Central Region Office of Children, Youth and Families reviewed:

- Child Death Data Tool
- Police Report
- Case file
- Autopsy Report

Case Chronology:

Previous CYF Involvement:

There was no previous involvement with York County Children, Youth and Family Services.

Circumstances of Child's Fatality or Near Fatality:

On 7/20/2012 [REDACTED] and [REDACTED] two year old daughter spent the previous night at [REDACTED] s sister's home, [REDACTED] (mother of Tristan). [REDACTED] was supposed to be watching the children, as Tristan's mother was sleeping. [REDACTED] also fell asleep and when [REDACTED] awoke, everything was quiet. [REDACTED] looked out the sliding glass door and saw [REDACTED] child sitting on the back porch staring at the family's pool. Tristan was face down in the pool. There were no barriers between the in ground pool and the patio door.

Current/Most Recent Status of Case:

The Agency determined that the drowning was accidental. This does not meet the criteria as defined by the Child Protective Services Law. The case was [REDACTED] on 9/11/2012. Law enforcement did not press any charges.

Services to Children and Families:

The Agency offered Family Group Decision Making services to the family, which the family declined. The caseworker provided them with a 2012 Resource Guide including community resources for [REDACTED].

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

A near fatality review team meeting was held on August 16, 2012 in accordance with the Act 33 requirements. The Central Region OCYF Program Representative assigned to York County Children, Youth and Family Services attended the meeting. County strengths include the agency's collaboration with the law enforcement officials and the safety planning completed by the agency.

County Recommendations for changes at the Local Levels as identified by Fatality Report:

Recommendations for change at the local level identified by the Fatality Report include the need for public awareness campaigns regarding pool and water safety as well as the continued inclusion of this safety topic at well child checks.

Recommendations for changes at the State Level:

There were no recommendations for change at the state level identified by the Fatality Report.

Central Region Findings:

The investigation completed by York County Children, Youth and Family Services was conducted in a timely fashion and in collaboration with the Northern York Police Department. Safety assessment and planning was completed thoroughly. The safety plans were timely, inclusive of family and care providers input and signatures. Referrals for services were offered to the family but the family declined.

Statutory and Regulatory Compliance Issues:

York County Children, Youth and Family Services conducted a thorough and timely investigation in conjunction with the law enforcement officials.