



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Aamil McIntyre

Date of Birth: 07/10/2014

Date of Death: 08/17/2014

Date of Oral Report: 08/18/2014

FAMILY KNOWN TO:

Dauphin County Social Services for Children and Youth (DCSSCY)

REPORT FINALIZED ON:

August 20, 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. Dauphin County convened a review team in accordance with Act 33 of 2008 related to this report on August 29, 2014.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Aamil McIntyre	Victim child	07/10/2014
[REDACTED]	Mother	[REDACTED] 1969
[REDACTED]	Father	[REDACTED] 1972
[REDACTED]	Half-Brother	[REDACTED] 1997
[REDACTED]	Half-Sister	[REDACTED] 2000

Notification of Child Fatality:

On 08/18/2014 Dauphin County Social Services for Children and Youth, (DCSSCY), received notification [REDACTED] that the autopsy results for the victim child, (VC), determined that he died of traumatic asphyxia. [REDACTED] also reported [REDACTED] due to the blood found on the VC's bedding [REDACTED] DCSSCY then made this report to ChildLine where it was registered as a fatality report.

Summary of DHS Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYP) obtained and reviewed the DCSSCY [REDACTED] file. The files were inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYP interviewed Caseworker [REDACTED] The CROCYP also attended the Child Fatality Review Team Meeting regarding this case on 08/29/2014.

Children and Youth Involvement prior to Incident:

It was initially reported that DCSSCY did not have prior involvement with this family. However it was discovered that DCSSCY did have sporadic contact with the mother's older children, who were now adults, for various general protective service concerns from 1988 to 2006. Additionally, Dauphin County Juvenile Probation was also involved briefly in 2006. Those records have been expunged according to regulatory guidelines.

Circumstances of Child Fatality and Related Case Activity:

On 08/17/2014 between 5:00 am and 6:00 am the child's father, who had been out with his friends the previous evening and early morning hours of August 17, 2014, returned to the family home bringing with him breakfast from [REDACTED] for his 14 year old daughter and other food items for himself and the child's mother. The mother and the children were in the parents' bedroom in the bed where they ate the food. The VC was in the parent's bedroom in the bed with them. Both the VC's father and mother state they remember wrapping the VC in a blanket and propping him on a pillow in the bed next to the father. The mother states that she really needed sleep so she took her blanket and went downstairs to sleep, leaving the VC with the father in bed. She stated the VC's father was awake when she went downstairs to sleep. The VC's half-sister also went downstairs to sleep. The mother stated she heard the VC fuss a few times and had the VC's half-sister check on him and to tell the father to give the VC his pacifier. The VC's half-sister reports she did as asked. The mother stated she woke shortly before noon, went to the bathroom and then went to get the VC. The mother stated that the VC's father was laying high on the bed and was propped up on the pillows and headboard. She stated she asked him "Where's the baby?" two times. She states she then saw the VC under the pillow, face down. The VC's father moved the pillow and picked the VC up. The mother states the father held the VC up facing him and she ran out of the room and down to another bedroom. She states she was asking "Is he okay? Is he breathing?" She was not sure what happened next. She states she either came back into the room or ran downstairs. She states she then ran and got the phone from the VC's half-sister and called 911. She states she asked 911 how to help the VC breathe and states that 911 instructed her and she was yelling the information to the father. She states she then came back to the bedroom and put the phone on speaker as 911 continued to instruct then in CPR. The father put the VC on the trunk, (located at the bottom of the bed), and he was kneeling on his knees to administer CPR. The mother states she was pacing back and forth and stated she saw blood on the bed and also on the VC's nose. She states she then sent the VC's half-sister downstairs to let the EMS staff into the home. The mother states she continued to pace and then stood at the top of the stairs to direct EMS. EMS arrived in the room and took the VC from the father. The VC was then transported by ambulance to the Harrisburg Hospital. When the VC arrived in the Emergency Room he was in cardiac arrest. The VC was then pronounced dead. An autopsy was performed on August 18, 2014. The cause of death is listed as asphyxia. [REDACTED]

The family is resistant to CYS involvement or any counseling for the family or siblings.

██████████ was submitted on 10/15/2014 with the determination of ██████████
██████████ The criminal investigation is continuing at this time.

Current Case Status:

At this time the case determination remains ██████████ Services to the family were offered including ██████████ and Family Group Conferencing but the family declined. The agency's visits/contacts with the family during the investigation/assessment did not find any safety threats for the family's teenage children. The case was closed following the conclusion of the investigation/safety assessment.

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

A Child Death Review Team Meeting was conducted on 08/29/2014. The agency conducted this investigation in collaboration with law enforcement.

- Strengths:
DCSSCY conducted their investigation in collaboration with law enforcement and maintained consistent communication with them. The VC's parents and extended family was very cooperative with DCSSCY and law enforcement. The family members supported the VC's mother and safety was assured for the other children in the home.
- Deficiencies:
There were no deficiencies noted.
- Recommendations for Change at the Local Level:
There were no recommendations made.
- Recommendations for Change at the State Level:
There were no recommendations made.

Department Review of County Internal Report:

The report from DCSSCY was received by CROCYF on 03/31/2015 and is noted to be a "rough draft". The report details the topics that were discussed during the Death Review meeting held on 08/29/2014.

Department of Human Services Findings:

- County Strengths:

The investigation was conducted timely and in close collaboration with the [REDACTED] Police Department. Case documentation was comprehensive including medical reports, interviews, risk and safety assessments, criminal complaint documents and case dictation.

- County Weaknesses:

There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance:

There were no areas of non-compliance noted.

Department of Public Welfare Recommendations:

DCSSCY should continue to conduct thorough and timely investigations in coordination with law enforcement officials. Continued efforts of child abuse prevention and education should continue and be expanded as possible to reach out to social service agencies not familiar with this information.