



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Serenity Covert

Date of Birth: 04/22/13
Date of Death: 03/05/15
Date of Report to ChildLine: 03/05/15
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

York County
Lancaster County
Adams County
McKean County

REPORT FINALIZED ON:
8/20/2015

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

York County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on April 7, 2015.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Serenity Covert	Victim Child	04/22/2013
[REDACTED]	Half-sibling	[REDACTED] 2012
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Mother's paramour	[REDACTED] 1978
[REDACTED]	Paramour's child	[REDACTED] 2001
[REDACTED]	Paramour's mother	[REDACTED] 1947
[REDACTED]	[REDACTED] paramour	[REDACTED] 1951
* [REDACTED]	[REDACTED] father	[REDACTED] 1984
* [REDACTED]	[REDACTED] father	[REDACTED] 1985

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the agency Quality Assurance Program Specialist, [REDACTED] the Supervisor, [REDACTED] and the Caseworker, [REDACTED] on 03/05/15, 03/06/15, 03/09/15, 04/06/15, and 07/22/15. The regional office also participated in the County Internal Fatality Review Team meeting on 04/07/15.

Children and Youth Involvement prior to Incident:

York County Children, Youth and Families (CYF) became involved with the family on July 31, 2014. The family started to receive [REDACTED] Services through [REDACTED] in August, 2014. Issues facing the family included: unstable housing, [REDACTED] issues between mother and paramour as well as environmental concerns. The family was referred to York County from Lancaster County Children and Youth Services (CYS). The family was receiving [REDACTED] Services from Lancaster County for approximately one month, during which time the family resided with the maternal

great-grandparents in ██████████, PA. Immediately prior to Lancaster CYF involvement, Adams County CYF was open with the family for approximately 3 months while the mother and children lived with the maternal grandmother in ██████████, PA. Children and Youth Services for the family originated in McKean County. The agency has requested documentation from McKean County to understand the reasons for their involvement.

Circumstances of Child Fatality and Related Case Activity:

The child was put to bed at approximately 7:30PM. The mother's paramour checked on the child at approximately 11:30PM and again at 3:00AM. At approximately 3:00AM the mother's paramour then went to get his mother, who attempted to wake the child, but could not. She began CPR. When the EMT arrived to the home at approximately 3:30 AM the child was deceased. When the coroner arrived at the home shortly thereafter, it was determined that the child had been deceased for at least 5 hours.

The mother and her paramour admitted to giving the victim child and her surviving sibling, ██████████ to help them sleep. At the time of death, the family was residing in the home of ██████████. The victim child's crib was located in the furnace room of the basement, approximately 5 feet from the furnace. The area was tested for carbon monoxide, but was negative. Although the agency knew where the child slept, they did not know it was a codes violation to have a bed so close to a furnace.

The surviving sibling was placed in foster care on March 5, 2015 and the child of mother's paramour was placed in the care of his Aunt and Uncle on that date as well.

Autopsy report dated 05/20/15 reports that victim child died of encephalitis of unknown etiology. Examination and further testing did not reveal any evidence of trauma. Toxicology reports did not show substances in the child's system. The manner of death is considered to be natural. Criminal charges will not be filed in this case. The ██████████ report was ██████████ on 06/08/15 and the children were permitted to return home.

The family continues to receive services through ██████████. The mother and her paramour receive ██████████, in ██████████ County. The surviving sibling receives services through ██████████.

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

- Strengths in compliance with statutes, regulations and services to children and families; Excellent collaboration between law enforcement and the County. York County immediately and appropriately assured safety of the surviving children. Excellent follow up with counties that previously provided services to the family prior to York County CYF. The family has numerous formal and informal supports in place.

- Deficiencies in compliance with statutes, regulations and services to children and families; None identified.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None identified.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None identified.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. Make resources and opportunities for education about safe sleeping, sleep aides and routines more readily available to parents.

Department Review of County Internal Report:

York County Children, Youth and Families provided a report on the Fatality of the Victim Child to the Regional Office on April 20, 2015. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on August 10, 2015.

Department of Human Services Findings:

- County Strengths: The County began the investigation and assured safety of all children immediately upon receipt of the report. The county worked cooperatively with law enforcement and has remained involved with the family.
- County Weaknesses: None identified.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None noted.

Department of Human Services Recommendations:

The Department concurs with the findings and recommendations of York County CYF's Act 33 meeting. The Department suggests that the agency should continue to assess and assure safety immediately on all child abuse reports and should continue to seek input from local specialists as appropriate and as related to child abuse reports. In addition, the Department recommends that all counties with previous involvement with the family participate in the Act 33 meeting.