



**REPORT ON THE FATALITY OF:**

Marlin Banks

**Date of Birth:** 05/01/2003

**Date of Death:** 11/15/2015

**Date of Report to ChildLine:** 11/17/2015

**CWIS Referral ID:** [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

York County Office of Children, Youth and Families

**REPORT FINALIZED ON:**

04/27/2016

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))

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**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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/08/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Marlin Banks	Victim child	05/01/2003
[REDACTED]	Mother	[REDACTED] 1970
[REDACTED]	Father	Deceased
[REDACTED]	Sibling	[REDACTED] 1992
[REDACTED]	Maternal Cousin	[REDACTED] 1963

**Summary of OCYF Child Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CROCYF) reviewed current case records pertaining to the [REDACTED] family. CROCYF representative engaged the following York County Children, Youth and Family (CYF) Representatives: [REDACTED] Division Director of Intake Services, and [REDACTED] [REDACTED] Continuous Quality Improvement and Professional Services. CROCYF representative attended and participated in the Act 33 meeting that occurred on 12/08/2015. The meeting included individuals representing the medical profession, social services, the legal profession and law enforcement. York County CYF personnel provided information regarding the incident, as well as historical information.

**Children and Youth Involvement prior to Incident:**

York County CYF did not have a prior history with the identified child/family.

**Circumstances of Child Fatality and Related Case Activity:**

On 11/15/2015, Marlin Banks, a 12-year-old male child, died due to a fatal gunshot wound to the head. Reports indicate that the victim child was able to find a loaded

firearm and it is presumed he was playing with the weapon when it accidentally discharged. York County CYF became aware of the incident via the local media on 11/16/2015 and a representative of York County CYF engaged law enforcement to obtain additional information on the child's death. ChildLine received the report of the child's fatality on 11/17/2015 and CROCYF was notified of the child fatality on the same date. York County CYF identified [REDACTED] of the victim child and an [REDACTED] as the alleged perpetrators. The report was registered for creating a reasonable likelihood of bodily injury due to an unsecured and loaded firearm, and serious physical neglect – repeated, prolonged or egregious failure to supervise. York County CYF indicated that there were no other children in the home that needed to be assessed for safety.

The victim child's mother reported that the child had cognitive delays and that the child was dependent on others to care for him. The victim child discovered a loaded gun underneath a couch on the first floor of the home where his adult sibling was sleeping during the day of the incident. The gun belonged to the adult sibling who admitted that he placed the weapon under the couch. The victim child's mother heard the gunshot at approximately 7:40AM and she discovered the victim child on his bed on the second floor of the home with the gun on his chest. He was pronounced dead at York Hospital. An autopsy was conducted in Allentown, PA, but results have yet to be submitted to York County CYF. The mother reported that she was in her second floor bedroom praying when she heard the weapon discharge. The adult sibling reported that he was asleep on the couch on the first floor and the adult cousin reported that she was in her living quarters on the third floor when the incident occurred. York County CYF interviewed all three (3) adult household members, and indicated that each offered consistent reports in relation to the incident.

On 12/16/2015, [REDACTED] for causing the death of child through any act/failure to act and for creating a reasonable likelihood of bodily injury to a child through any recent act/failure to act. The [REDACTED] allegation of causing serious physical neglect of a child was [REDACTED] since it was determined that she was not aware that the firearm was in the home. Services were not provided to the family and the case was not opened by York County CYF since there are no children in the home. Local law enforcement has interviewed family members and gathered evidence and the investigation is ongoing.

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

Strengths in compliance with statutes, regulations and services to children and families:

It was identified that there was effective collaboration between York County CYF and the [REDACTED] Police Department.

Deficiencies in compliance with statutes, regulations and services to children and families:

The Act 33 Team did not reference any specific recommendations.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

The Act 33 Team did not reference any specific recommendations.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

The Act 33 Team did not reference any specific recommendations.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

The Act 33 Team did not reference any specific recommendations.

**Department Review of County Internal Report:**

The CROCYF received York County CYF's Child Fatality Report on 01/28/2016. Upon review of the report, CROCYF assessed that the documentation efficiently described the incident, the actions taken by the agencies involved and the current status of the case.

**Department of Human Services Findings:**

County Strengths:

York County CYF was expedient in informing CROCYF of the fatality of Marlin Banks as soon as the incident was reported to ChildLine.

County Weaknesses:

CROCYF has not identified areas of non-compliance.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

CROCYF has not identified areas of non-compliance.

**Department of Human Services Recommendations:**

CROCYF completed interviews and obtained records as required. The case is not active with York County CYF. From CROCYF's review of the fatality and subsequent involvement by York County CYF, there are no recommendations developed.