pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Declan Marsh

Date of Birth: 04/30/2015
Date of Death: 02/24/2016
Date of Report to ChildLine: 02/23/2016
CWIS Referral ID: [redacted]

FAMILY 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: 09/14/2016

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 Children, Youth and Families (CYF) have convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/07/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Declan Marsh	Victim Child	04/03/2015
[redacted]	Half-Sibling	2008
	Half-Sibling	2006
	Half-Sibling	2001
	Biological Mother	1981
*	Biological Father	1983
	Roommate	1987
	Roommate's Son	2013
*	Roommate's paramour	1981
*	Father of victim child's half-siblings	1981

* 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 (CERO) obtained and reviewed all current case records pertaining to the [redacted] families. Follow up interviews were conducted with the caseworker and the supervisor on 02/23/2016, 02/24/2016 and 07/19/2016. CERO staff participated in the Act 33 meeting that occurred on 03/07/2016 in which medical professionals, agency staff, and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

York County CYF first became involved with this family in May 2015. On 05/26/2015, the agency received a [redacted] report that the home smelled of marijuana and people were drinking alcohol. The referral source also stated there was trash and feces throughout the home where 3-4 children resided. The referral source was unclear as to the ages of the children in the home. An assessment was initiated by the county within twenty-four hours of the referral. An unannounced home visit on 5/27/2015 revealed that the mother's roommate and the roommate's paramour, along with another male, were drinking in the home during the previous weekend. The police were called as a result of yelling and screaming. When police arrived, the roommate's paramour continued yelling at the officers and did not comply with the officer's order. The police then used a Taser on the roommate's paramour. The children were taken to the mother's car for safety during the incident. They did not witness the roommate's paramour when the Taser was used on him. At the time of the interview with the mother, she reported the roommate and roommate's paramour were no longer living in the home. The caseworker did a walkthrough of the mother's home. There was no trash or feces on the floor. The mother also submitted to a drug screen on 05/28/2015 in which the results were negative. The family was offered Family Group Decision Making which they declined. No additional services were provided to the family. The [redacted] report was closed on 06/26/2015.

On 01/04/2016, the agency received a [redacted] report alleging physical abuse on a seven year old female child and nine year old male child in the home. [redacted] was listed as the alleged perpetrator on this case. The allegation consisted of the seven year old having a black eye as a result of [redacted] throwing a toy at her. This incident was said to have occurred during Christmas break. The allegation for the nine year old male was that [redacted] twisted his wrist because [redacted] accused the child of stealing money. There were also concerns of domestic violence in the home between the mother and [redacted].

The agency immediately began an investigation. The two children were interviewed within twenty four hours. At that time, [redacted] was not living in the home however the mother continued to have regular contact with [redacted] was interviewed and he denied the allegations. Neither child had injuries. The report was [redacted] closed on 02/04/2016.

On 05/19/2016 a [redacted] report alleging physical abuse was called into the agency regarding the oldest female child. [redacted] was named as the alleged perpetrator. It was reported that [redacted] has been drinking heavily and [redacted] bit the fifteen year old child on the arm. All parties were interviewed. There were no injuries on the child at the time of the interview. Both [redacted] and the child denied the allegations. The case was [redacted] on 06/10/2016.

Circumstances of Child Fatality and Related Case Activity:

On 02/23/2016, the agency received a near fatality report on the victim child naming [redacted] as the alleged perpetrator. On 02/21/16, the child was found by the mother's roommate not breathing and vomit in the crib. The victim child was transported by ambulance from York Memorial Hospital [redacted] to Hershey Medical Center on 02/21/2016. At Hershey Medical Center, the victim child was placed [redacted] On 02/24/2016 Hershey Medical Center said the victim child was legally pronounced dead.

At the home on the day of the incident was: the mother, the victim child, the child's fifteen year old half sibling, the female roommate, her two year old biological child and the roommate's paramour. It was reported by the mother that she fed the victim child around 7:00 am in the morning and then the victim child went back to sleep. When the victim child woke up around 9:00 am, the mother changed the victim child's diaper and they went to the living room. The roommate, roommate's paramour and roommate's two year old child were in the living room. The mother placed the victim child on the floor with the roommate's 2 year old child to eat breakfast. She reported that she laid the victim child back down for a nap around 12:30 pm then she got dressed for work. The victim child woke back up as she was leaving for work.

The victim child was left in the care of the mother's roommate and the roommate's paramour. The roommate and roommate's two year old son lived in the home since November 2015. The roommate's paramour does not live in the home but was visiting the day of the incident. It was reported by the roommate that after the mother left for work in the afternoon, she laid the victim child down for a nap. She checked on the victim child fifteen minutes later and found the victim child face down in the crib but he was breathing fine. She re-adjusted the victim child's position to face up in the crib and the victim child continued sleeping. The roommate's paramour left to get food and when he returned, she went to check on the victim child. She found the victim child face up in the crib covered in vomit. She picked the victim child up and he began to vomit again and then stopped breathing. She flipped the victim child over and yelled for the paramour to call 911 and told the victim child's fifteen year old half sibling to call the victim child's mother. The roommate began CPR. Emergency Medical Services arrived on the scene and the victim child was transported to York Memorial hospital.

The roommate, the mother and the victim child's female half-sibling were asked if anyone was rough playing with the victim child. All parties denied rough play occurred. The mother reported that a month prior to this incident the victim child was taken to York Memorial Hospital by ambulance because she found the victim child non-responsive, eyes rolled back in his head with labored breathing. The hospital found nothing wrong with the victim child and released the victim child home to the mother and instructed her to follow up with the victim child's primary

care physician. Present during that incident was the mother and the mother's roommate.

On 02/23/2016, the agency worked with the mother's roommate to establish a safety plan for the roommate's two year old male child. The roommate agreed for her son to stay with his maternal grandmother in Maryland as part of the safety plan and she agreed to have no unsupervised contact with her son. A referral was made to Maryland DHS to apprise them of the situation with the roommate's mother. Maryland DHS conducted an assessment of the grandmother's home. They determined the child to be safe and no services were needed. Maryland closed the case.

Also on 02/23/2016, the agency initiated [redacted] assessment [redacted] on the victim child's three other siblings. The mother was in agreement to allow the three siblings to stay with the maternal aunt and uncle in [redacted], PA. The mother would only be permitted supervised visits with the children during the initial investigation. On April 28, 2016, the three children were returned to their mother's care. The agency and the police cleared the mother of the abuse allegation against the victim child since she was not home at the time of the incident.

On 02/26/2016 the agency changed the case from a near fatality to a fatality naming [redacted] as the alleged perpetrator. On 03/02/2016, the corner reported that the victim child could have died from brain asphyxia however the manner of death is still unknown. The corner indicated it could be from suffocation or causes unknown. The results of the autopsy are still pending. The agency currently has this fatality listed [redacted] until the criminal investigation is complete.

On 5/11/2016, the agency concluded its [redacted] assessment of the roommate's two year old child. [redacted] was invalidated. The roommate's two year old child is still currently living with relatives in Maryland. Maryland was apprised of the pending allegations [redacted]

Toxicology reports on the victim child were negative.

The police continue to investigate the case, however there have been no criminal charges filed to date.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families;</u>
    - The caseworker and law enforcement have a good teaming approach. They accompanied each other on interviews at the hospital and at the home.

- When the agency received the report, they responded in a timely manner.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - There was a two day period of time from when the child entered the hospital to when the agency received the report on the victim child. Hershey Medical Center stated they had to wait on tests to come back to certify the need to report. During this time, the victim child's siblings were in the home without an appropriate assessment of supervision.

- 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 recommended

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None

Department Review of County Internal Report:

The Central Region received the York County Child Fatality Team Report on 06/03/2016. DHS agrees with the county's report findings and found it to be accurate.

Department of Human Services Findings:

- County Strengths:
  - The agency demonstrated appropriate collaboration with law enforcement and medical professionals.
  - The agency worked quickly to identify appropriate resources for the other children involved in the case.

- County Weaknesses:

- In a previous CPS not involving the victim child, the children who were subject of the abuse allegations were interviewed and safety was assessed. However, the oldest child in the home was not seen within the 24 hour timeframe to assess for safety. The review of the case notes indicated that the children who were subjects of the report were interviewed at school on 01/05/2016. The mother was later interviewed at home. And the safety assessment indicated that the oldest child was not interviewed because she was at school. Subsequently, the oldest child was not seen until 02/02/2016.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. York County was found to be out of compliance in the following area:

  - A Licensing Inspection Summary (LIS) will be issued to the county for the 01/04/2016 CPS, citing 3490.55 (a)(c). The agency is required to assess the safety of all children in the home immediately upon receiving the report of a suspected abuse. The 14 year old female child was not seen within the appropriate timeframe.

Department of Human Services Recommendations:

- There was a two day delay in the agency receiving the report from the hospital. The child was initially seen at York Hospital but later transferred to Hershey Medical Center. It wasn't until the child was at the Hershey Medical Center that the agency received notification of a possible abuse. It would be recommended that the agency continue to work on communication between York Memorial Hospital and CYF to more quickly identify the possibility of abuse.
- In relation to the 01/04/2016 CPS deficiency, the agency needs to review their process in regard to CPS Safety Assessment. All children, not just children who are the subject of the abuse report, in the household should be seen within 24 hours to assure safety.