pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Javier Palmas-Schroder

Date of Birth: 06/26/2014
Date of Death: 09/24/2016
Date of Report to ChildLine: 09/20/2016
CWIS Referral ID: [redacted]

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

Perry County Children and Youth

REPORT FINALIZED ON:
04/13/2017

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))

Office of Children, Youth, and Families, Central Regional Office
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675, Harrisburg, PA 17110 | 717.772.7702 | F 717.772.7071
PO Box 319, Hollidaysburg Community Service Center, Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696.6180
www.dhs.pa.gov

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.

Perry 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 10/17/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Javier Palmas-Palmas	Victim Child	06/26/14
[redacted]	Biological Father	[redacted]/88
[redacted]	Biological Mother	[redacted]/88
[redacted]	Sibling	[redacted]/10
[redacted]	Half-Sibling	[redacted]/08
[redacted]*	Babysitter	[redacted]/74
[redacted]*	Babysitter	[redacted]/72

* 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 Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed old case records pertaining to the babysitter's family. CERO staff conducted interviews with Perry County Caseworker on 9/21/2016 and 9/22/16. CERO staff attended the Act 33 meeting that occurred on 10/17/16 in which Perry County Children and Youth Services (CYS) agency staff, staff from Dauphin County Coroner's Office, Pennsylvania State Police law enforcement officials, Perry County District Attorney and a Perry County Detective were present.

Summary of circumstances prior to Incident:

The victim child's family was not known to Perry County CYS prior to this incident. The babysitter's, who was also a licensed foster parent at the time of the incident, had one prior referral with Perry County CYS on 04/27/2011. Allegations reported

to CYS contend that a foster child, age 4, was pushed by the foster mother causing a bruise near his eye and back, as well as a small cut near his eyebrow. Perry County CYS conducted a courtesy visit on 4/27/2011 as requested by CERO. A safety assessment was done of all of five children in the home. Two of the five children were the foster mother's biological children and the other three were foster children placed with the foster parents [redacted] The children were deemed safe and remained in the home. The case was [redacted] No further information is available.

Circumstances of Child Fatality and Related Case Activity:

On 9/20/2016, Perry County CYS received a report about a possible drowning regarding a two-year-old male child. The two-year-old victim child was dropped off at the babysitter's home by his biological mother around 10:50am on the day of the incident. On this morning, the victim child did not come into the home but rather ran directly from his mother car to the swing set located in back yard of the home. Also at the home that morning was a one-year-old male child who is routinely babysat in the home in addition to the two year-old male victim child. When the one-year-old saw the victim child outside playing on the swing set, the one-year-old ran outside to play. The babysitter reported that she could see both children playing on the swing set from her kitchen windows. The victim child's mother left the home to go to work. Then the babysitter reported that she heard her husband, who had been near the barn, leave on the tractor to go to work at a nearby farm. The babysitter saw the two boys playing outside and decided to go into the bathroom, which is beside the kitchen, to changes clothes. The babysitter reported it only took less than five minutes to change clothes. When she exited the bathroom she looked out the window at the swing set for the two children but did not see them. She walked out the side door of the house, which is connected to the kitchen, and walked to the barn. The babysitter reported she assumed the children were in the barn because bikes and toys were kept in the barn. After she did not see them in the barn, she walked back towards the swing set to see if the children were playing on the other side of the house. When she did not see the boys on the other side of the house she looked towards the dirt lane that leads to the main road. The babysitter saw the one-year-old walking down the lane towards the small wooden bridge that is on the dirt lane. She started running towards the one-year-old yelling his name. At this point she still did not see the victim child. The babysitter ran past the one-year-old who was still walking down the lane towards the wooden bridge. The babysitting was yelling the victim child's name. The babysitter continued to run down the dirt lane over the small wooden bridge towards the neighbor's house which is at the end of the lane near the main road. The babysitter reported that she thought that the victim child might have gone to the neighbor's house to play on their trampoline. She stopped when she did not see the victim child playing in the neighbor's yard on the trampoline. She turned around to see the one-year-old standing on the bridge looking into the water. She ran back to the bridge and found the victim child face down floating in the water. The babysitter pulled the victim child out of the water and started CPR on the bridge for approximately one minute. She then picked up both children, one under each arm, and ran back to the house to call 911. She put the phone on speaker phone and

continued CPR until the ambulance arrived. The child was initially taken to Holy Spirit hospital which was the closest hospital to the babysitter's home but a short time later the victim child was transferred to Hershey Medical Center due to the extensive care needed to assist the child.

Perry County CYS made the initial contact with the family later that day around 2:30pm. [redacted] were already on the scene conducting an investigation. The babysitter was a licensed foster parent and did have a seven-month-old foster child in the home at the time of the incident. This child was alone in the house during the incident. The babysitter's other children were in school at the time of the incident. CYS interviewed the babysitter and her husband. As the babysitter's children arrived home from school, a safety assessment was completed. The assessment of those children, ages 11, nine, nine, eight and five determined it was safe to allow those children to remain in the home. However, the seven-month-old foster child was removed from the home pending the outcome of the investigation.

The victim child [redacted] for four days in Hershey Medical Center. [redacted] The victim child's parents decided to remove the child from life support. The child died later that day on 9/24/2016. The coroner examined the body and found no signs of abuse. The only bruising on the child was from life saving measures done as a result of CPR. Through the course of the investigation, it was determined that the victim child was left unsupervised from approximately 10:50am to 11:12am. [redacted] was [redacted] for abuse on 11/07/2016 [redacted] Police investigated the case and no charges were filed. The incident was ruled an accidental fresh water drowning.

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;
    - After Perry County Children and Youth received this referral, the agency followed established procedures. The review team identified county strengths in the response time by Perry County Children and Youth and the PA State Police.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - The review team identified that the medical facilities who examined the victim did not initially report to CYS concerns of the near fatality.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - No recommendations identified.

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

- No recommendations identified.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - A final recommendation was to improve reporting timeliness and procedures in cases of a near fatality between the medical facilities and CYS/law enforcement.

Department Review of County Internal Report:

The Central Region Office received the Perry County Child Fatality Team report on 12/16/2016. Technical assistance and feedback was given to the county on 01/20/2017. The county resubmitted the report to the Central Region Office on 01/24/2017. DHS finds the county's internal report an accurate reflection of the Act 33 meeting.

Department of Human Services Findings:

- County Strengths:
  - The county demonstrated good collaboration with law enforcement and medical professionals and did so quickly at the beginning of case.
  - The county acted quickly to conduct interviews and assure the safety of all children in the home upon receipt of the initial report.
  - The county constantly updated the Central Regional Office of all important new information they discovered during the course of their involvement with the case.

- County Weaknesses: and
  - No weaknesses were identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - There were no statutory or regulatory areas of non-compliance related to this investigation.

Department of Human Services Recommendations:

  - Due to many counties not having routine experience with child fatalities or near fatalities, it is recommended that counties continue to work on understanding policy and procedures as outlined in OCYF Bulletin 3490-15-01 "Implementation of Child Fatality and Near Fatality Review and Report Protocols As Required by Act 33 of 2008 and Act 44 pf 2014."
  - County Act 33 Teams are encouraged to consider future participation in training being developed by the Department of Human Services, Office of Children, Youth and Families to assist teams in becoming

more familiar with the protocols and procedures of the child fatality/near fatality process.

- Counties should increase their familiarity with the protocol and procedures of the fatality/near fatality process in order to help with educating other major community partners such as hospitals and EMT workers about their obligations in the reporting suspected abuse on fatality/near fatality cases.