REPORT ON THE FATALITY OF:

Channing Mullin

Date of Birth: 05/02/2016
Date of Death: 05/30/2016
Date of Report to ChildLine: 10/05/2016
CWIS Referral ID: [redacted]

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

Wayne County Children, Youth and Families

REPORT FINALIZED ON:
03/14/2017

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))

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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.

Wayne 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 11/02/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Channing Mullin	Victim Child	05/02/2016
	Biological Mother	1993
	Biological Father	1985
	Sibling	2012
	Sibling	2013
	Sibling	2015
*	Maternal Grandmother	1966

* 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 Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the prior referral file and the current file.

NERO staff participated in the Act 33 meeting that was held on 11/02/2016.

Children and Youth Involvement prior to Incident:

The agency initially provided services to the VC's biological mother when she was a child and the maternal grandmother was her caretaker. The agency records have been expunged however these services included services for parenting, parent/child conflict, child behavior problems, child substance abuse problems, and

The agency received the first referral on the biological mother as an adult and her family on 11/05/2012. This was a [redacted] referral for Domestic Violence in the home. This referral was assessed by the county and closed at intake with no further services. The mother discussed with the agency that she was able to anticipate when possible violence would occur and would take the children to their maternal grandmother's home on those days.

The agency received a [redacted] referral on 03/18/2013 when the mother called for help [redacted]
The case was successfully closed on 07/12/2013.

On 05/30/2016 the victim child died in his home. At that time, the child's death was determined accidental by law enforcement and no report was made to the county children and youth agency.

Circumstances of Child Fatality and Related Case Activity:

On 09/20/2016 the agency received a [redacted] report with allegations related to domestic violence, parent substance abuse and [redacted] concerns for the parents. The agency began an assessment of the allegations.

On 10/01/2016 the agency received a [redacted] report as the VC's sibling was left in a vehicle outside a bar around 2:00am for a few hours. The report named [redacted] as the alleged perpetrators of abuse for "creating a reasonable likelihood of bodily injury to a child through any recent act of failure to act." The agency responded and a safety plan was put into place with the maternal grandmother. The maternal grandmother was to be the primary caretaker of the children and supervise all contact between [redacted] and the children. The parents were not to be together when around the children due to allegations of domestic violence. Upon investigation of the incident that occurred on 10/01/2016, the agency learned of allegations that the parents were intoxicated the night of the VC's death (05/30/2016), that [redacted] fed the child and fell asleep with the child on the couch, and [redacted] was unable to find the child in the morning until [redacted] discovered the child underneath [redacted] On 10/05/2016 the agency made a CPS report naming [redacted] as the AP in "causing the death of a child through any act/failure to act."

The agency completed interviews of [redacted] The following information was learned from the interviews and an anonymous call received by the agency. It was reported that both parents drink alcohol to excess on occasion and sometimes leads to loudness and altercations between the parents. Both parents were drinking alcohol the evening of 05/29/2016 and into the early morning hours of 05/30/2016. [redacted] left the VC in [redacted] care in the living room prior to going upstairs for the night. The VC woke up around 3:00am on 05/30/2016 and was fed by [redacted] on the couch. At 6:30am [redacted] woke up and inquired about the VC's whereabouts when he was discovered unresponsive on the couch with [redacted] performed CPR while [redacted] called 911 and went to the neighbor's house for assistance, as the neighbor is an EMT. The VC was transported to Wayne

Memorial Hospital and was pronounced dead. No toxicology test were performed

On 12/01/16 the agency the report related to the VC's death stating "This case does not meet the culpability standards of knowingly or intentionally because there is consensus that there was no foreseeability or intent to harm/kill this child. The culpability standard of Reckless cannot be met because, due to the lack of a BAC or toxicology test being performed at the time of incident, there is no way to substantiate the level of impairment of and therefore no way to assess "conscious disregard of a substantial and unjustifiable risk." There is also consensus (with the exception of the pathologist) that this was not an instance of co-sleeping, and therefore not reckless in that nature as well. There are conflicting reports as to where slept that night. It was agreed at this staffing that location of sleeping has no bearing on this outcome. There are conflicting reports as to whether heard and responded to child's crying or whether needed to be awakened by and/or friend. It was agreed at this staffing that even if needed to be awakened, it does not lead to a sufficient conclusion of impairment on part. (could have been a heavy sleeper, and again without a toxicology result, there is no way to distinguish between impaired and tired.)"

The agency also completed their investigation of the 10/01/2016 incident of the sibling being left alone in the car and found that was responsible for creating the likelihood of bodily injury to the VC's sibling. was also charged related to this incident with endangering the welfare of a child and plead guilty on 01/26/2017 sentencing is scheduled for 03/09/2017. was found to have no responsibility on this report.

The family has been accepted for services as of 11/30/2016. A Family Service Plan was developed with the family on 01/13/2017 to address domestic violence, for both parents, for the VC's siblings,

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

- <u>Strengths in compliance with statutes, regulations and services to children and families;</u>
    - The County Review Team Chair praised Wayne County investigators, providers, and other officials for demonstrating strong compassion and commitment to children as evidenced by the number of high level

people in attendance at the 11/2/16 County Child Fatality Review Team meeting.

- Wayne County demonstrates strong collaboration between county departments and outside agencies. The attending Commissioner mentioned hearing from other commissioners who voice a lack of such collaboration and cooperation in their counties.
- The Supervisor from the OCYF Northeast Regional Office commended the agency for the number of interviews conducted, and the work, information gathering, and research put into the investigation.
- Administrator remarked about the expertise of the agency caseworkers, supervisors, and others as they reported out their past and present involvement with this family. A school Resource Officer also commented on the level of expertise present at the table for the meeting.
- remarked about the cooperation in working with Wayne Memorial Hospital, the benefit of small town connections, and their willingness to provide information on such a quick basis.
- Administrator remarked about the immediacy of the response time of the Coroner and PA State Police to the incident on 5/30/16.
- Many attending members voiced praise for the "good, sound judgement" used by law enforcement, the Coroner, and the agency as evidenced by the report out in the 11/2/16 meeting.

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

- discussed the need to ensure notification occurs as per the CPSL mandated reporter laws and to not assume that "someone else" has made the call.
- It was agreed by many in attendance that the lack of a joint investigation from the initial incident compromised the agency's ability to obtain answers to some critical questions. Those critical questions may have had bearing on whether the agency was able to meet its differential burden of proof in substantiating this case.
- The attending Commissioner suggested hosting occasional (perhaps quarterly) meetings with providers, investigators, school, and other stake holders in order to educate each other about significant changes in each other's respective laws that may have implications for practices.
- Administrator offered assistance in instances where service wait times are impeding timely There are ways to think about and leverage quicker response times.
- There is a need for the public, providers, and officials to be educated about the difference between the Cause of Death and Manner of

Death, as well as the differing roles between the Coroner's Office, the District Attorney's Office, and Law Enforcement.
  - There is a need for better understanding between the main investigatory entities (Children and Youth, Law Enforcement, District Attorney, and Coroner) with regard to each other's roles, definitions, and burdens of proof. This enhanced understanding and appreciation will answer why certain questions/processes/procedures may not be necessary for one arm of the investigation, but may be very relevant to another, and thus necessary to occur, enhancing the collaborative investigatory process.

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

  - There is a need for on-going community health education about the dangers of co-sleeping.
  - There is a need for on-going community health education about the importance of sober, clean parenting and the critical safe care decisions that are met or neglected as a result of parenting sobriety or the lack thereof.

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

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

Department Review of County Internal Report:

The NERO received the county report on 01/21/2017. The county completed a comprehensive Act 33 report. NERO requested minor revisions be made in regard to grammar and report structure on 02/13/2017. As of this writing of this report the Regional Office has not received the requested revisions.

Department of Human Services Findings:

- County Strengths:
  Despite receiving this report 4 months after the child's death the agency completed a thorough investigation given the resources available to them. The county's Act 33 meeting was well attended by various disciplines and information was communicated respectively and thoroughly among all professions.

- County Weaknesses:

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  n/a

Department of Human Services Recommendations:

Due to the high number of infants who pass away while co-sleeping with a parent it is recommended that toxicology screens be completed by law enforcement when drug and/or alcohol use is suspected.