pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Evan Musselman

Date of Birth: 03/25/2014
Date of Death: 07/01/2016
Date of Report to ChildLine: 07/01/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH WITHIN THE PRECEDING 16 MONTHS:

Monroe County Children and Youth Services

REPORT FINALIZED ON:
12/27/2016

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))

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.

Monroe County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 07/29/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Evan Musselman	Victim Child	03/25/2014
[redacted]	Mother	[redacted]1987
* [redacted]	Father	[redacted]1978
[redacted]	Half Sibling	[redacted]2006
[redacted]	Half Sibling	[redacted]2010
[redacted]	Father of [redacted]	[redacted]1976
* [redacted]	Step Father of Child of [redacted] Mother's Paramour	[redacted]2002 Unknown

* 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 of Children, Youth and Families (NERO) reviewed the available case records pertaining to the [redacted] family. The Human Services Program Representative and Supervisor attended and participated in the Act 33 County Review Team Meeting held at Monroe County Children and Youth Services (MCCYS) on 07/29/2016. In this meeting, MCCYS staff, medical professionals, social service professionals, legal professionals, the coroner's office, and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

In July 2015, MCCYS received three referrals regarding the [redacted] family. On 07/15/2015, MCCYS received a report from an anonymous source. This referral identified the subject children as [redacted] and the responsible person as [redacted]. The incident address was listed as [redacted] home. The referral stated "RS (referral source) reports that the home is filthy inside the home. There is a cat in the home and there is animal feces laying around in the home. There is food sitting out and there are ants crawling on the food. There is garbage piled all over the place. The home is very unsanitary. RS is concerned about the [children] in the home. RS had no further information."

MCCYS received another referral on 07/23/2015 from [redacted] identifying the subject child as [redacted] and the responsible person as [redacted] The referral stated "Child lives primarily in New Jersey with mother and visits the father in Pennsylvania. Yesterday [redacted], child showed pictures of the father's home. The RS says that father's home appears to be in squalid condition from the photos child showed him. There were dirty dishes and trash everywhere. Things were piled on top of every surface. The father's home is infested with bugs. Child reported that there is a baby in the father's home (age one or two). Child said that the father keeps the baby strapped in a car seat or high chair all of the time to keep the baby from getting into stuff. [redacted] contacted the RS this evening and was very distraught. Child is supposed to be going to father's home this evening. Father is saying he wants to keep child for a week but the custody agreement states that fathers' week with child in the summer is supposed to be in August. [redacted] does not want to send child to father's home. RS is concerned because child has asthma and is supposed to [redacted] There is a history of father refusing to give child her [redacted] when she is at his home. RS feels the condition of the father's home also places the child at risk for [redacted]

On 07/28/2015, MCCYS received a referral from [redacted]. This referral identified [redacted] as the identified child and [redacted] as the responsible person. The referral stated [redacted] The mother is alleging that the father has no food in the home, the home is unclean with animal feces. The mother is alleging that the father bought a gun...the father yells at the child. The mother alleges that there is a [redacted], alcohol abuse and father has attempted suicide in the past. The mother also reported that in the past the father has attempted to kidnap the child. The mother stated that one time in the last year the father took the child to an amusement park and the child had to get security as the child did not know where the father was for around 30 minutes...The child lives primarily in New Jersey and visits the father every other weekend."

In response to the referral received on 7/15/2015, the agency sent a caseworker to the home on 07/16/2015. The caseworker was unable to make contact with the

family during the unannounced home visit on that date and left a note, commonly referred to as a "carbon" at the residence, requesting someone in the household contact the caseworker. The caseworker spoke with [redacted] via phone on 07/17/2015. She reported no concerns with the father's home or care of her children. On 07/24/2015, the caseworker again attempted an unannounced home visit. No contact was made on that date and a "carbon" was left. On 07/27/2015, the caseworker again attempted an unannounced home visit. During that visit, the caseworker met with [redacted] and [redacted] The caseworker also noted that three minor children were present in the home and seen. The case note states that the children appeared shy and were asked what they like to do in the summer. The father reportedly told the caseworker that he was not avoiding her but works nights and sleeps during the day and the mother who lives up the street watches the boys. Caseworker noted that the entire home was clean, uncluttered and presentable and that the house was stocked with food and appeared to be well cared for. The caseworker then reportedly asked the father about the child who resides in New Jersey. The father reported that he had not seen her since June, had no medical concerns for child, and that the child never came to his home with any medications.

The county classified their response to these referrals [redacted] explanation for the 07/28/2015 referral is: "Allegations have already been investigated. Home conditions are appropriate. There is enough food as well." [redacted] explanation on the 07/15/2015 and the 07/23/2015 referral is: "Allegations addressed and [redacted] on [07/28/2015 referral]."

Circumstances of Child Fatality and Related Case Activity:

On 07/01/2016 at 8:00PM, the MCCYS on call caseworker was contacted by [redacted] prior to receiving the report from [redacted] reported that the victim child drowned in a pool and that the family was at Pocono Medical Center being interviewed.

At 10:00PM, MCCYS received a report [redacted] that the victim child was found unresponsive in an above ground pool. The alleged perpetrator was reportedly babysitting the victim child and his two siblings at his home. It was reported that the 10 year old sibling found the victim child and pulled him out of the pool while the 6 year old sibling helped pull the victim child out of the pool. The victim child was pronounced dead at 6:55PM on July 1 at Pocono Medical Center. The victim child was suspected to have been in the pool for thirty minutes alone. This report was registered as a fatality as the report stated that the child was deceased as a result of the alleged perpetrator's lack of supervision.

The MCCYS caseworker immediately responded to Pocono Medical Center and participated in joint interviews [redacted] upon notification [redacted] The mother's paramour, mother, and alleged perpetrator were interviewed. The 6 year old and 10 year old siblings were interviewed at the Monroe County Children's Advocacy Center on 07/13/2016. MCCYS completed a subsequent

interview with the alleged perpetrator on 07/12/2016 and with the mother on 08/02/2016.

The interviews revealed that the mother worked at a local drug store and the alleged perpetrator worked overnights at a foundry. Although no longer involved in a relationship, the mother and alleged perpetrator got along well and the victim child considered the alleged perpetrator to be his father. The alleged perpetrator would routinely care for the children while the mother worked. On the date of the incident, the alleged perpetrator had worked overnight. He got out of work around 10:00AM and picked up the children from the mother's home. It was reported that the alleged perpetrator and all three children were watching television in the master bedroom. The two older children went into the living room to continue watching television. Around 3:30PM, the alleged perpetrator and the victim child fell asleep. Sometime after 5:00PM, the 6 year old child woke the alleged perpetrator and said something happened. The 10 year old child removed the victim child from the pool and the alleged perpetrator started CPR while the 6 year old child called 911. The mother and her paramour reported no concerns regarding the care that the alleged perpetrator provides to the children. The children's interviews were consistent with the information provided by the alleged perpetrator. They reported that the victim child had been napping with the alleged perpetrator and came out to watch television with them. The siblings reported that the victim child wandered off while they were finishing their television show. After about a half hour, they went to look for the victim child and he was found in the pool. There was some discrepancy regarding whether or not the pool ladder was in the pool and whether or not the victim child entered the pool via a chair that was either dragged to the pool by the victim child or left next to the pool. The alleged perpetrator also submitted to a drug screen and tested negative on the date of the incident. MCCYS initiated a plan of supervision with the family requiring that the alleged perpetrator have no unsupervised contact with his children.

The Act 33 meeting was held on 07/29/2016. During this meeting, the Coroner's Office reported the death was ruled an accidental drowning. It was also reported that the alleged perpetrator may be criminally charged. On 08/12/2016, the case was [redacted] by MCCYS [redacted] There is an open criminal investigation. It is unknown at this time if charges will be filed.

The case has been opened by MCCYS for ongoing protective services. The 10 year old child is [redacted] The 6 year old child is [redacted] The perpetrator has changed his employment and now works day shift. All family members were offered [redacted]

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:

The Meeting and all collaborating agencies worked in a timely manner to identify the needs of the family. Police and Emergency Medical Services responded immediately and MCCYS also were there at the hospital to identify the victim child as well as the maternal children. Mother and paternal aunt were present as well. The Child Advocacy Center worked diligently with the maternal children to get them interviewed as quickly as possible about the events of the day when victim child passed.

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:

The Act 33 Meeting stated that having more community awareness, education and prevention about children with pool safety. A discussion was held about having all pools secured by fencing to not allow the likelihood of a near death or drowning from occurring again.

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:

The Act 33 Meeting team came up with outreach to local pool suppliers about safety of pools and speaking to buyers about proper fencing and cover options for pools to aid in preventing any future drowning episodes.

Department Review of County Internal Report:

The initial county report was submitted in a timely manner on 10/19/2016. The report was reviewed by NERO on 10/21/2016 and it was determined that the report was incomplete. The county was contacted by email and phone and agreed to resubmit their report. The county resubmitted the report on 10/24/2016. The report was reviewed by NERO on 10/24/16. The county was asked to review their report again as the prior involvement section was incomplete, the circumstances of

child fatality section was blank, and although this was a fatality report, the report had several references to near fatality. As the initial submission email reflected that the report had not been reviewed by the Act 33 County Review Team chairperson, the county was also asked to provide an update and inform the NERO if any members of the Act 33 County Review Team, including the agency administrators, reviewed the report. On 11/08/2016, NERO contacted MCCYS via email and asked if they intended to amend the report as recommended as the final report was due on 10/29/2016. The county again resubmitted the report on 11/08/2016. At that time, MCCYS also informed NERO that the report was reviewed by their Act 33 County Review Team chairperson who had verbally approved the report. The report was reviewed by NERO on 11/08/2016. NERO again informed MCCYS that the information regarding their prior involvement with the family was inaccurate and the section entitled "Circumstances of Child Fatality and Related Case Activity" was blank. MCCYS was provided with an example of what the county report should look like as well as a copy of the OCYF Bulletin 3490-15-01 regarding implementation of Child Fatality and Near Fatality Review and Report Protocols. NERO also offered on site technical assistance. On 11/22/2016, NERO contacted MCCYS and inquired if they were resubmitting their report or if the last submission was final. MCCYS then resubmitted their report on 11/22/2016. NERO reviewed the report on 11/22/2016 and the report was accepted at that time as final due to timeliness requirements.

Department of Human Services Findings:

County Strengths:

MCCYS responded immediately upon receipt of the report.

MCCYS and law enforcement completed initial joint interviews with the alleged perpetrator, mother, and mother's paramour.

MCCYS completed their investigation and scheduled the Act 33 meeting within the required time frame.

MCCYS has made efforts to ensure that discussion occurs in County Review Team meetings regarding county strengths, deficiencies, and recommendations for change. These discussions are productive in encouraging a more comprehensive and detailed review that will hopefully lead to the identification of solutions to address the service needs of all children within the county, not just those served by child welfare.

County Weaknesses:

MCCYS was not notified when law enforcement scheduled interviews for the children at the Children's Advocacy Center.

MCCYS initiated a plan of supervision for the alleged perpetrator and the children requiring that he have no unsupervised contact with his children.

Review of the preliminary and conclusion safety assessments reveals no safety threat identified and an overall risk assessment of low.

MCCYS requires the assigned child protective services staff to complete their county review team report. The report is not reviewed by the team members prior to submission.

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

3490.321 pertaining to Risk Assessment requires the county agency to make an initial determination of risk to the child. 3490.232 pertaining to receiving reports and assessing the need for services requires the county agency to "interview the child and the parents or the primary person who is responsible for the care of the child. The county agency shall also conduct interviews with those persons who are known to have or may have reasonably be expected to have information that would be helpful to the county agency in determining whether or not the child is in need of general protective services." In July 2015, MCCYS received three separate referrals from three separate referral sources regarding the perpetrator and his children. Review of the case record provided to NERO by MCCYS revealed all three referrals [redacted] There was no indication in the record that would reflect how the decision was made [redacted] these referrals as the record did not reflect that a determination of the initial risk to the children was made. The record also did not reflect that an initial safety determination was made. There was also no documentation in the record provided that would reflect that interviews were conducted with the children, all parents, and those with information regarding the care and supervision provided to the children.

The Safety Assessment and Management Process Reference Manual requires the county agency to "develop a safety plan when there are present danger or impending danger threats identified and these threats cannot be managed by the caregiver of origin's protective capacities. A child welfare professional would not need to develop a safety plan when there are not any present danger or impending danger threats or the protective capacities in the family can adequately manage foreseeable safety threats." Review of the case record and information provided by casework staff revealed that MCCYS issued a plan of supervision or safety plan on 07/01/2016 stating that the perpetrator cannot be unsupervised with his 6 year old and 10 year old sons during the investigation which can take up to 60 days. Review of the preliminary and conclusion safety assessments revealed no safety threats identified by MCCYS that would justify development of this plan of supervision requirement. The "safety plan" consists of a statement on a piece of paper that is signed by the on call worker and the mother. The plan is not signed by the father and does not specify responsible parties or specific actions to be taken.

Department of Human Services Recommendations:

The Department agrees with the County Review Team's recommendation for more community education and prevention regarding children and pool safety.

A discussion occurred at the Act 33 County review team meeting regarding the MDIT process as it related to interviews conducted at the Children's Advocacy Center after it was learned that MCCYS was not notified of or present of the interviews of the 6 year old and 10 year old siblings of the victim child. The Department recommends that the County Review Team follow through with their plan to identify a MCCYS liaison to the Children's Advocacy Center who would be provided with a courtesy call to ensure MCCYS in notified when interviews are scheduled by law enforcement.

The county continues to recommend that MCCYS develop and implement a more formal process for the response to reports of child fatality and near fatality and completion of the county review team report. Specifically, it is recommended that a protocol be developed that will encourage a detailed review of child fatalities and near fatalities in an effort to identify solutions to address the service needs of all children and families served within the county, not just those served by child welfare. The protocol should also include the sharing of the report with and approval of the report by team members prior to the submission of the report to the Regional Office.

In June 2016, NERO issued a Licensing Inspection Summary to MCCYS issuing citations pertaining to the requirement of the county agency pursuant to 3490.55 to conduct interviews with those persons known to have information pertaining to the incident of suspected child abuse. In September 2016, NERO issued a Licensing Inspection Summary to MCCYS issuing a citation pertaining to the requirement of the county agency pursuant to 3490.232 to interview the child, the parents or person responsible for the care of the child, and those persons known to have or reasonably be expected to have information that would be helpful to the county agency in determining whether or not the child is in need of protective services. NERO approved the plan of correction submitted by MCCYS for the agency to hold safety support sessions in conjunction with the Child Welfare Resource Center and NERO. As review of this record revealed additional citations in these areas, The Department recommends that MCCYS implement their plan of correction immediately and schedule safety support sessions to promote and encourage staff competency as related to the process and documentation of decision making in the acceptance, assessment, and determination of intake referrals.