pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

John Shermeyer

Date of Birth: 12/08/2015
Date of Death: 12/26/2016
Date of Report to ChildLine: 12/26/2016
CWIS Referral ID: [redacted]

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

York County Children, Youth, and Families

REPORT FINALIZED ON:
05/31/2017

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))

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 convened a review team in accordance with the Child Protective Services Law related to this report on 01/12/2017.

Family Constellation:

Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1979
	Father	[redacted]1960
John Shermeyer	Victim Child	12/08/2015

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all case records pertaining to the family. The Central Region had ongoing contact with York County Caseworker, and Supervisor and attended the Act 33 meeting. The Central Region ensured the Child Fatality Data Collection Form was sent to ChildLine within 60 days of the report. Central Region [redacted] confirmed that the investigation was indicated.

Summary of circumstances prior to Incident:

The family was not known to York County Children, Youth, and Families prior to the child's fatality.

Circumstances of Child Fatality and Related Case Activity:

On 12/26/ 2016, York County Children, Youth and Families (YCCYF) learned of the child's fatality through news reports. [redacted] Earlier on this date the Pennsylvania State Police had been called to the home to conduct a welfare check. A Facebook friend of the mother had read a concerning post the mother posted on her Facebook page. She had posted "all I can think about is leaving this world, putting a gun in my mouth and leaving. Which is what is going to happen". She had alleged domestic violence in her relationship with her husband as being the reasons for her actions. When the State Police arrived at the

home the father had answered the door and stated he did not know if the mother and child were in the home. The State Police found the mother and child deceased in the bedroom. The child had a bag over his head and the mother had a single gunshot wound to her head. The State Police through their investigation were able to verify that the father was running errands between 10:45 AM and 11:50 AM. When the father returned home he assumed the mother and child were sleeping in the bedroom and did not check on them. The State Police then arrived to do a welfare check and found the mother and child. The State Police determined this to be a murder-suicide. The autopsies concluded the child's cause of death was asphyxiation and the mother's cause of death was a self-inflicted gunshot wound. The State Police located several suicide notes in the home, written by the mother alleging domestic violence. It was also learned that both the father had [redacted] and the mother had [redacted] It was also noted the father had a criminal history with various charges related to drugs and alcohol. The State Police had located various guns in the home, registered to the mother. The mother was unemployed and the father [redacted] Both parents seemed to have little contact with the community.

[redacted] YCCYF was able to speak with the father [redacted] and he stated that he had a fight with his wife in the days prior to the incident but denied domestic violence issues. [redacted] the YCCYF Caseworker provided the father with additional resources. It was also learned through the investigation that the mother had another son who was living in North Carolina with his father since February 2015. YCCYF notified that child's father of the mother's death.

On 02/12/2017, YCCYF [redacted] for the death of her son and closed the case.

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

An Act 33 Team meeting was held on 01/12/2017.

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

  Strengths noted in the review of the case include the police and Coroner's office were thorough and they responded quickly to assist father at the time of the incident.

  YCCYF became aware of this incident and reported it to ChildLine, knowing that the incident would meet the Child Protective Services Law definition of abuse by an alleged perpetrator.

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

  There is concern that the incident was not immediately reported to ChildLine by the mandated reporters on the scene of the incident.

- 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 suggestions were offered by the Act 33 review team.

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

  No suggestions were offered by the Act 33 review team.

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

  The Review Team had recommended that further education regarding the mandating reporting laws be provided.

  Due to [redacted] concerns noted, the fatality review team recommended increased screening of new mothers for signs of depression and other mental health concerns. One recommendation would be for a depression screening of mother's at their child's well-baby appointments.

  The review team also recommended that there be more information on parenting support groups and that this information be provided in hospitals, Pediatrician and Doctor's offices.

  The fatality review team also discussed ways in which Facebook and other social media sites can be monitored for posts that raise a concern to the health and safety of individuals and what regulations there are or could be put into place to allow police or crisis officials to quickly respond to the home for a welfare check [redacted]

Department Review of County Internal Report:

Central Region Office of Children, Youth and Families agrees with the strengths, deficiencies and recommendations identified by the Act 33 team. Notification of acceptance of this plan was provided on 03/09/2017.

Department of Human Services Findings:

- County Strengths:

  Central Region determined that YCCYF worked collaboratively with the Coroner's office and State Police Department.

  YCCYF reported this incident to ChildLine and immediately responded. [redacted] They also provided him with information for various community services that may be of assistance to him

  YCCYF has worked collaboratively with the Central Region Office of Children, Youth and Families in compiling case specific information and evaluating the overall process of the Fatality/Near Fatality in an effort to promote consistent, quality services to children, youth and families.

- County Weaknesses:

  The Central Region has not identified any areas of weakness pertaining to this child fatality.

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

  There were no statutory or regulatory areas of non-compliance pertaining to this child fatality.

Department of Human Services Recommendations:

The Central Region Office of Children, Youth and Families recognizes the quality and procedural mechanisms that have been put in place over the past several months as they relate to the assessment and investigation of Child Protective Services cases and recommends their continuation.

The Department of Human Services, Office of Children, Youth and Families also concurs with the Act 33 Team recommendations regarding, screenings of new mothers for signs of depression and other mental health concerns at their child's well-baby appointments. Also, that there be more information provided in hospitals and Doctor's offices regarding parental support groups. The Department also agrees that there should be ways in which social media sites can be monitored for posts that raise a concern to the health and safety of individuals and what regulations there are or could be put place to allow police and crisis officials to quickly respond to the home for a welfare check and /or mental health assessment.