pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Vonyaira Walker

Date of Birth: 12/27/2012
Date of Death: 04/23/2017
Date of Oral Report: 04/23/2017
CWIS Referral ID: [redacted]

FAMILY WAS 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:

10/02/2017

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. 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 (YCCYF) has convened a review team in accordance with the CPSL related to this report. The review team was convened on 05/19/2017.

Family Constellation:

First and Last Name	Relationship	Date of Birth
Vonyaira Walker	Victim Child	12/27/2012
[redacted]	Biological Mother	[redacted]1991
* [redacted]	Biological Father	1981
[redacted]	Twin Sibling	2012
[redacted]	Half Sibling	2015
[redacted]	Half Sibling	2016
* [redacted]	Mother's Paramour (father of [redacted])	1989
* [redacted]	Mother's paramour's Biological Son	[redacted]2008
[redacted]	Household Member	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 Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all past and current records pertaining to the family. CERO reviewed various reports, assessments, medical records, autopsy report, and case documentation provided by YCCYF. CERO also had ongoing telephone and email communications regarding this case.

Summary of Circumstances Prior to Incident:

[redacted]

On 06/19/2013, YCCYF received a [redacted] referral regarding the victim child and her twin sister. The allegations were that the mother had left the children in the care of a maternal aunt, but the aunt did not know how to properly care for the children. The children [redacted] due to being born five weeks premature and having difficulty breathing on their own. The children were immobile [redacted] There were also allegations that the mother was using marijuana and cocaine. On 06/20/2017, YCCYF conducted an unannounced home visit, the mother denied using cocaine and stated she last used marijuana one month prior. The mother was tested for drugs and the results were negative for all substances. The mother stated that she had left the children with [redacted] overnight and that [redacted] knew how to reach her by telephone. The mother had [redacted] who assisted her in caring for the children throughout the day and overnight. The mother appeared knowledgeable in how to care for the children and was taking them to their medical appointments. The mother stated she had minimal support from the paternal family but her paramour, the children's maternal grandmother and aunt were learning to care for the children so they could better support the mother. The children's father was incarcerated at the time of this referral. The children were determined to be safe in the home. Information for Family Group Decision Making was given to the mother. On 07/25/2013, the [redacted] referral was determined to be [redacted] and the family was closed.

On 02/09/2015, YCCYF received two [redacted] referrals on the victim child and her twin sister. The allegations were that [redacted] was masturbating in front of the children. It was alleged that the mother had heard noises coming from the twin's bedroom and when mother's paramour walked into the room, [redacted] was standing in front of the twin's cribs, he was pulling up his pants and he had an erection. The alleged perpetrator [redacted] stated that he was exercising. The mother stated [redacted] would no longer be permitted in her home. The mother had contacted [redacted] provider regarding the allegations. At the time of this referral, the mother had a third child, who was one month old during this investigation. There were no allegations regarding the third child. The children were determined to be safe and the risk was determined to be low. The mother declined YCCYF services, stating that she has [redacted] for the victim child and her twin sister. She did not feel the need for any additional services at this time. The perpetrator [redacted] was criminally charged with Open Lewdness, Indecent Conduct and Disorderly Conduct. On 03/04/2015, both [redacted] referrals were [redacted]

On 08/07/2015, a fourth [redacted] referral was received regarding the victim child, her twin sister and their seven month old half sibling. It was alleged that the mother's paramour (father of the seven month old child), had kicked in the back door of the home. The police were called to the home several times within that week. It was alleged that the mother's paramour had physically assaulted the mother in front of the children and that the children were in distress when he was in the home. It was alleged that the mother changed her story when the police went to the home but that [redacted] in the home has witnessed the domestic violence and the mother has asked them for help. There were no allegations of abuse against the children and it was stated that the mother protects her children. On 08/07/2015, YCCYF did an unannounced visit to the home and spoke with the mother. The home was appropriate and there were no safety concerns noted. The mother stated that she had recently ended her relationship with her paramour, after several years together. The mother stated that her paramour has been abusive with her, but not the children. YCCYF also interviewed the mother's paramour. The mother's paramour alleged that the mother drinks and he denied any domestic violence. The mother did file a Protection from Abuse Order against her paramour at that time. During the investigation, YCCYF completed four home visits to assure safety of the children. During one of these home visits, discoloration was noted on the youngest child. YCCYF followed up with the doctor and determined that the half sibling had [redacted] The mother's paramour returned to the home and the mother learned that she is pregnant with her fourth child. The mother's paramour is the father of this child also. The mother and her paramour [redacted] and reported things were getting better. The children were determined to be safe throughout the investigation and the risk was low. On 10/27/2015, the [redacted] was [redacted] and closed.

On 11/13/2015, a fifth [redacted] referral was received regarding all three children. It was alleged that police had been called to the home on 11/11/2015, due to a domestic violence incident between the mother and the mother's paramour. The mother's paramour was removed from the home and the mother was granted an emergency Protection from Abuse Order. This incident was alleged to have occurred in front of the victim child and her twin sister, causing their heart rates to increase. On 11/13/2016, an initial home visit occurred with both the mother and the mother's paramour present. The mother stated there was a physical altercation between her and her paramour but stated that neither of them would ever hurt the children.

On 12/03/2015, a [redacted] referral was received. The allegations were that the twin sibling had a leg fracture that occurred while in the care of [redacted] was listed as the alleged perpetrator. The alleged perpetrator stated she was trying to put the twin sibling's shoe on and the child kicked, fracturing her leg. A safety plan was initiated that the alleged perpetrator would not care for the children. On 01/11/2016, the investigation was [redacted] The police did not file criminal charges and closed their investigation.

On 02/01/2016, the [redacted] from 11/13/2015 was determined to be [redacted] The family goals were to improve the

mother and the mother's paramour's relationship, better communication, and to assure the needs of the children were being met. After working with the service providers, the family's case was closed on 04/11/2016.

On 04/06/2017, a [redacted] referral was received on all four children (the fourth child was born on 05/19/2016). The allegations were that the mother's paramour (father of youngest two children) had broken down a door to get into the home and that there was broken glass outside the youngest half sibling's bedroom. It was also alleged that none of the children had been fed all weekend. There were concerns cited regarding the twin sibling losing weight, [redacted] and having difficulty digesting food [redacted] There were concerns regarding the cleanliness of the home and that the victim child saw the mother's paramour hold a gun to the mother's head. YCCYF had contact with [redacted] and learned that they could not prove that the victim child and her twin sibling were not fed, but [redacted] had observed that the twin sibling was losing weight, as you could see her ribs. [redacted] At this time the mother's paramour was not residing in the home. On 04/06/2017, an unannounced home visit was completed with mother, the victim child and her twin sibling. The mother denied not feeding children and stated that she also felt that the twin sibling was losing weight from not getting enough calories. The mother stated she planned on speaking with the twin sibling's doctor on 04/24/17, at her next appointment. YCCYF offered services and the mother agreed to accept services. On 04/06/2017, an announced home visit was also conducted at the mother's paramour's home. The two half siblings were with him, as he is their father. The mother and the mother's paramour do not have a formal custody agreement. The children spend time at both parents' homes. The mother's paramour also has a nine year old son who visits him. The mother's paramour's biological son was also seen on this date at the mother's paramour's home. The children were safe in the mother's paramour's home. On 04/20/2017, YCCYF conducted another home visit at the mother's home. All four children were present and determined to be safe. [redacted] The mother stated that her paramour had been at the home and took the half siblings' clothing. [redacted] YCCYF had observed furniture that the mother's paramour had destroyed. The mother had stated that the police had been called and she filed for another Protection From Abuse Order.

Circumstances of Child Fatality and Related Case Activity:

On 04/23/2017, YCCYF received the [redacted] referral regarding the victim child's fatality. It was alleged that the victim child had vomited in the middle of the night, [redacted] and she was not able to breathe. [redacted]

[redacted] Police received the call at 4:53AM on 04/23/2017. When the emergency staff arrived at the home, the mother stated that she performed CPR for

approximately 10 minutes. Emergency staff removed the victim child [redacted] and transported her to the hospital where she was declared deceased. There were conflicting reports given to the Coroner during the initial investigation. A household member stated that he was out drinking until 2:00 AM. The household member stated he had been knocking on the door and calling to the mother to let him into the home but the mother never responded. It was unclear if the mother was actually in the home with the children or possibly at another location, or if the mother was under the influence and slept through the knocks at the door, [redacted]

[redacted]

The autopsy showed that the victim child had enflamed tonsils at the time of death. During the review team meeting, medical personnel stated that it is possible that this could have been an infection at the time of death. It was also believed the victim child had high CO2 levels at the time of death, which is reported to be unusual with a child having a trach. The manner of death has been determined to be of natural causes.

The mother was tested for illegal substances during the initial investigation. She tested positive for THC. The mother was tested again during the investigation and still showed positive for THC. The mother became noncompliant with drug testing.

[redacted] The mother has since moved to [redacted]

A review of medical records for the victim child did not suggest any concerns of medical neglect or noncompliance with appointments and/or care of the victim child [redacted] Police Department and YCCYF received a copy of the autopsy report stating that the death was due to health complications/natural causes. At this time, there has not been a final decision from the District Attorney as to filing charges [redacted] On 06/21/2017, YCCYF submitted the [redacted] as [redacted]

[redacted] Initially the twin sibling was admitted to Hershey Medical Center for observation and assessment to determine the status of her health. During the investigation, YCCYF was able to locate the biological father. The biological father became involved in learning to care for the twin sibling. [redacted]

[redacted] YCCYF remains open with the biological father and twin sibling at this time.

On 04/23/17 the two half siblings were placed with the paternal grandmother. On 05/26/2017 they were returned to the mother's paramour's care. [redacted] The mother's paramour was also recommended to attend parenting classes, which he completed. [redacted]

[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, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;

- The Agency and Police Department worked together closely during the investigation to interview parties and determine next steps for the investigation.

Deficiencies in compliance with statues, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;

- The Act 33 team did not identify any deficiencies.

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 team, did not have any recommendations for changes at the state or local levels regarding reducing future fatalities or near fatalities.

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

- The review team recommended that in cases in which a criminal investigation is pending, it may be helpful to reconvene the team once the investigation is complete in order to make a more thorough assessment regarding recommendations. The ACT 33 regulations would need to be reevaluated in order to allow for a meeting to occur at a later date.

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

- The family had [redacted] in the home. [redacted] were allegedly witnessing domestic violence between mother and the father of the younger siblings. Further training for [redacted] about domestic violence and the effect on parenting may assist domestic violence victims in their homes.

- There were numerous police reports made with multiple visits by police to the home due to domestic disturbances between the mother and paramour. However, no referrals were made to the CYF agency. A recommendation was made by the review team to explore the protocol for how police respond to domestic disturbances with children in the home, and when to report concerns to local CYF agencies.

- Due to the victim child's and her sibling's special needs, both children were seen frequently by various doctors. Further training for medical staff surrounding the issues of domestic violence and its effects on parenting may also be warranted. Domestic violence information and services could be given to parents during medical visits for their children.

Department Review of County Internal Report:

The Central Region Office received York County's Child Fatality Team Report on 08/17/2017. The Central Region found the internal report to be an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 05/19/2017.

Department of Human Services Findings:

- County Strengths:
  YCCYF responded to this fatality immediately and conducted interviews in a timely manner. There was also thorough documentation of interviews in the file.

  YCCYF obtained all medical records and the autopsy reports.

  They worked collaboratively with the [redacted] Police Department.

  YCCYF submitted all regulatory required documentation to the Central Region Office and ChildLine in a timely manner.

On 08/25/2017, a follow- up Act 33 team meeting was held to discuss updates and findings on the case.

- <u>County Weaknesses:</u>

  On 08/07/2015; 11/13/2015; and 04/06/2017, YCCYF received [redacted] reports. All of these reports had concerning allegations of domestic violence between mother and her paramour. The paramour had an older son that resided with his mother and had visits with his father (mother's paramour). This child was only seen/interviewed during the last investigation (04/06/2017). There was no notation that YCCYF attempted to interview him or the reason why this did not occur.

  The [redacted] report received on 08/07/2015 was [redacted] on 10/27/2015, which is beyond the 60 day assessment period.

  On 11/13/2015, YCCYF made a home visit to the mother's home. Her paramour was present in the home, this was a violation of the Protection From Abuse Order the mother filed against her paramour. There is no documentation that YCCY notified the police or addressed this with the mother and her paramour.

  Further, throughout all of the reports of domestic violence received and confirmed, there is no documentation in the record regarding offering information and assistance to the mother regarding domestic violence services that would be available to her.

- <u>Statutory and Regulatory Areas of Non-Compliance:</u>

  3490.232(g): The county agency shall interview the child, if age appropriate and the parent 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 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. YCCYF had received 3 reports regarding domestic violence instigated by the mother's paramour. The mother's paramour has an older son that was not seen or interviewed during the first two [redacted] referrals. There was no notation as to why this did not occur.

  3490.232(e): [redacted] assessments shall be conducted within 60 days. The [redacted] report received on 08/07/2015 was [redacted] on 10/27/2015, which is beyond the 60 day assessment period.

  3490.232(i): The county agency shall provide or arrange appropriate services to assure the safety of the child during the assessment period. On 11/13/2015, YCCYF made a home visit to the mother's home. Her paramour was present in the home, this was a violation of the Protection From Abuse

Order the mother filed against her paramour. There is no documentation that YCCY notified the police or addressed this with mother and her paramour. Further, in all of the reports of confirmed domestic violence, it is not documented in agency records that the mother was provided information and resources regarding domestic violence assistance.

Department of Human Services Recommendations:

The Department recommends YCCYF meet all regulatory guidelines regarding the Child Protective Service Law, child fatalities and near fatalities. CERO also recommends YCCYF continue to work collaboratively with law enforcement, medical personnel, service providers and CERO.