pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Stephen Williams, Jr.

Date of Birth: 05/14/2014
Date of Death: 06/03/2017
Date of Report to ChildLine: 06/03/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Delaware County Children and Youth Services

REPORT FINALIZED ON:
12/28/2017

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.

Delaware 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 06/26/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Stephen Williams, Jr	Victim Child	05/14/2014
[redacted]	Mother	[redacted]1990
[redacted]	Father	[redacted]1989
[redacted]	Sibling	[redacted]2011
[redacted]	Sibling	[redacted]2009
[redacted]	Sibling	[redacted]2013

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed current [redacted] investigative information including [redacted] as well as written case documentation from the Delaware County Children & Youth Social Services Agency (CYS) which included structured case notes, [redacted] investigative information, legal proceedings and an autopsy report. The SERO Program Representative also spoke with the Delaware County caseworker and/or supervisory staff on an occasional basis to request and clarify information as well as to receive any updates.

Children and Youth Involvement prior to Incident:

There was one previous agency involvement with the family which occurred on 01/27/2017. A [redacted] report was received alleging possible physical abuse by the mother concerning the victim child's sibling. A [redacted] investigation was initiated. The sibling [redacted] was being interviewed by the school social worker and disclosed that her mother had punched, pinched and scratched the child. A verifiable timeframe related to the alleged abuse could not be given by the child. The child did have bruises on her back which looked old. The child reported being stressed out and afraid in the home. The case was investigated and closed with an outcome of [redacted] The case was opened for assessment from 01/27/2017 until its

closing on 06/05/2017, two days after the fatality. No other services appeared to be recommended or provided.

Circumstances of Child (Near) Fatality and Related Case Activity:
On 06/03/2017, the victim child and his brother were playing in [redacted] bedroom where a gun was kept. [redacted] who was the sole caretaker of the victim child and siblings at the time of the incident, was named as the alleged perpetrator (AP). The gun used in the shooting, belonged to the AP who had a license to carry the weapon. The victim's sisters were playing in the living room where the AP was sleeping on the couch. In the bedroom, the victim child got access to a gun located in the top dresser drawer, which is normally in a locked box, according to the AP. The child shot himself in the chest and was pronounced dead at the scene due to a self-inflicted gunshot wound. The AP admitted to failing to unload the gun and securing it in the lock box which allowed access to the children who were playing in the room unsupervised.

All of the siblings were interviewed during the CPS investigation and stated that they all knew the location of the AP's firearm and often played in the same room. There was also a conflicting account as a result of the interviews with the siblings which stated that the child was shot by his brother, age 5, however this could not be confirmed. [redacted] was not home at the time of the incident however is on parole and is not supposed to be around firearms. [redacted] was aware that the AP had a gun. A criminal investigation was conducted and it was determined that the shooting was accidental and the police declined to press charges as a result. It should also be noted that the police found what appeared to be a drug like substance, paraphernalia and cash in the room where the incident occurred and where the children were playing. A police investigation is continuing related to that matter.

On 08/02/2017, the results of the [redacted] investigation conducted by Delaware County CYS was determined to be [redacted] on [redacted] On 06/03/2017 the children were allowed to go with a maternal great grandmother as a part of a safety plan arrangement. The parents were allowed contact with the children under the strict supervision of the relatives. [redacted] The family continues to reside with relatives and will not return to the home where the incident occurred. The family is currently receiving [redacted] services for both the parents and children, including [redacted] services as well as concrete services, and is being monitored through the Agency's [redacted] unit. [redacted] continues to be monitored [redacted] parole officer. [redacted] continues to be

gainfully employed. The children's basic needs are being met and they have received [redacted] The family is considered to be cooperating [redacted] services at this time and agency intervention will continue.

Summary of 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;

  None were noted.

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

  The Act 33 Panel determined that a previous [redacted] investigation which was completed with an [redacted] finding did not appear thorough and as a result parenting skills education and other services were not offered which could have benefited the family.

- 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 Panel recommended that the intake unit be trained to ask about guns and should also provide gun safety during the assessment.

  The Panel recommended that there be education provided to children on gun safety, given that children may be exposed or have access to guns.

  There should be resources available with an automatic response, so that a family is able to access grief intervention/counseling immediately.

  The Panel suggested that the police should be able to access other supportive individuals (chaplain, grief counselors) to accompany them when accessing the family when appropriate.

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

  There were no recommendations.

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

The Act 33 panel suggested a community needs assessment to identify the needs of the community and provide information on services that are available.

The Panel also suggested accessing and utilizing a mobile crisis unit when needed to help individuals and/or families with an immediate crisis.

The Panel also recognized the high level of stress facing child welfare caseworkers. In this case, the caseworker sat with the children at the police station following the incident. There should be a formal mechanism to offer help and support for staff assessing traumatic incidents.

Department Review of County Internal Report:

The Act 33 meeting occurred on 06/26/2017. The County's Review Team Report was received on 10/25/2017 and a response from the Department was sent on 10/31/2017.

Department of Human Services Findings:

The Department has reviewed case records from the Delaware County CYS and is in agreement with the [redacted] investigative findings of [redacted] The police department determined the incident to be accidental and declined to pursue charges against the AP.

- County Strengths:

  Delaware County CYS conducted and completed an appropriate [redacted] investigation within 60 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

  County Weaknesses:
  In a previous investigation to the incident, CYS did not follow regulatory protocols with respect to timeframes. The case was not opened for services within the specified time frame. Since the case was active, a family service plan should have been developed within 30 days after the acceptance of the case for services, which also did not occur. A risk and safety assessment did not occur within the time frame. Structured case notes were missing describing agency intervention occurring.

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

  A case review was conducted by the SERO Program Representative on a previous [redacted] investigation conducted by Delaware County CYS involving the family which occurred on 01/27/2017 and was closed on 06/04/2017. The following regulatory issues were found:

  - A Risk assessment did not occur within the time frame.

- A Safety assessment did not occur within the timeframe.
- The case was not opened for services during the timeframe.
- An initial family service plan was not written or shared with the family.

A citation will be issued to the agency as a result with respect to 3490 regulatory requirements.

Department of Human Services Recommendations:

The Department should develop a major media campaign regarding the importance of gun safety around children to help reduce child deaths occurring as a result of guns. Pamphlets and brochures, which are family oriented, attractive to the eye, and easily read, should also be included and distributed throughout the state of Pennsylvania.

As a result of vicarious trauma experienced by caseworkers, support, information and training should be offered as early as possible to new social workers during CORE training (if not already occurring), with continued support for experienced workers. Workshops with creative topics and inspiring speakers should be developed and occur on a regular basis.