pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Keaton Kershner

Date of Birth: 03/17/2012
Date of Incident: 07/15/2017
Date of Report to ChildLine: 07/19/2017
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:

01/17/2018

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.

Lancaster 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 07/26/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Keaton Kershner	Victim Child	03/17/2012
[redacted]	Sibling	[redacted]2014
	Sibling	2009
	Biological Mother	1988
	Biological Father	1989
	Mother's Paramour	1986
	Family Friend	Unknown

*Individual is not part of the family constellation, but relative to the report.

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff attended the agency Act 33 meeting on 07/26/2017 and discussed the case with agency staff at that time and on 10/12/2017.

Summary of circumstances prior to Incident:

Lancaster County Children and Youth Agency (LCCYA) received a [redacted] referral on 10/04/16 regarding the sibling of the victim child. It was reported that the child stated he had a broken collarbone and would not talk about how it happened. There were concerns of inappropriate discipline. The agency assessed the report and found that the child did not break his collarbone but did injure it when climbing over and under furniture. The family had followed up with the primary care physician. While this was being assessed, the agency received another report on 10/25/16 regarding domestic violence in the home. The agency

met with the family on several occasions and spoke with [redacted] professionals. The behaviors of the children improved and the agency closed the case on 11/28/2016 with no additional services or concerns for the family.

The agency received a report on 2/10/17 that the sibling of the victim child was seen at the bus stop on a day that the school had a two hour delay. The passerby that saw the child made sure that he got home and the father was present. While this case was eventually [redacted] with no further services, it does not appear that the agency contacted the father to talk about the report until 4/17/17, which is beyond the 60 days for [redacted] investigation.

Circumstances of Child Fatality and Related Case Activity:

Lancaster County Children and Youth Agency (LCCYA) received a report on 07/15/2017 that a 5-year-old child had been playing in the river with his siblings while his family was camping, and went under water and did not come up. According to the family that was present, the victim child was not found for 5 to 7 minutes and was not breathing. CPR was performed by the mother's paramour until river rescue arrived at the scene. The victim child was taken directly to Milton Hershey Medical Center [redacted] The incident was reported as it was unclear if [redacted] had been supervising the victim child and the siblings in the river. The child was declared brain dead on 07/19/2017 and the case was upgraded from a near fatality to a fatality.

LCCYA met with the family immediately. The family had been at the campground celebrating a birthday party for the mother's paramour. The children had been playing by the river. There had been a very heavy rain the day before so the water was higher than normal and possibly with a stronger current. [redacted] had been in the water with the children. The family was able to show a picture from before the incident and the victim child was waist deep in the water. [redacted] left the water and walked up to the mother's paramour to ask about the food. This is when the victim child went under the water. The siblings immediately called for [redacted] and several people went into the water looking for the victim child. The victim child was found by a family friend. There was no alcohol found at the campsite and the family was directly beside the water, within sight of the children. [redacted] called 911 at 3:13pm. The victim child arrived at Hershey Medical Center by 3:50pm. [redacted] This did not revive the victim child and he was declared deceased.

LCCYA filed their investigation report with ChildLine on 08/18/2017 with a status of [redacted] It was determined that [redacted] and other family members were nearby and the victim child's drowning was accidental. No charges were filed by law enforcement as a result of the incident.

The agency closed their case as there were no concerns for the siblings and the family had established their own connections with [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;
  - An immediate response tag was assigned to the case.
  - The Agency started its investigation immediately.
  - The child was transferred to Penn State Milton S. Hershey hospital for treatment.
  - The child's drowning was determined to be an accident. No criminal charges were filed against [redacted]
  - The Agency has no concerns for the other children and will offer [redacted] services to the family through [redacted]

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None Noted

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Public Services announcements and postings in parks regarding the dangers of heavy rains which could create dangerous swimming conditions and unpredictable water currents.

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None noted.

Department Review of County Internal Report:

The Central Region Office received the Lancaster County Child Fatality Team Report on 10/12/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 07/26/2017. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Lancaster County Administration on 10/16/2017.

Department of Human Services Findings:

- County Strengths:
    - The agency demonstrated excellent collaboration with law enforcement from the onset of the case.
    - The agency conducted interviews with the family, remaining sensitive to the tragedy they had just experienced.

- County Weaknesses:
    - In a previous report, the agency did not make any contact with the family until after the 60 day assessment period. While this case was [redacted], it is unknown why the family was not contacted prior to the end of the assessment period.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - 3490.232(e) – In regard to the report that was received on the [redacted] report that was received on 02/10/2017, the agency did not complete the assessment until 04/17/2017. This is beyond the 60 days for assessment required by this regulation.

Department of Human Services Recommendations:

The Department concurs with the Agency's recommendation regarding Public Service Announcements or signage at campgrounds near moving bodies of water indicating the dangers of heavy rainfalls and currents.