pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Asher Gee

Date of Birth: 3/17/2014
Date of Death: 5/24/2017
Date of Report to ChildLine: 5/24/2017
CWIS Referral ID: [redacted]

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

Clinton County Children and Youth

REPORT FINALIZED ON:
December 4, 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.

Clinton 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 June 13, 2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Asher Gee	Victim Child	03/17/2014
[redacted]	Sibling	07/14/2015
	Biological Mother	05/26/1995
	Biological Father	05/12/1992
	Paternal Grandmother	04/01/1969
	Paternal Grandfather	02/05/1964

* 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 (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed all current records pertaining the family. CRO staff reviewed various reports, assessment and case documentation provide by Clinton County.

Summary of circumstances prior to Incident:

On 08/15/2014, the agency received a referral regarding the [redacted] and [redacted] with concerns about the [redacted] substance abuse. The agency conducted an assessment of the home through announced and unannounced home visits. It was determined there was no [redacted] The family had their basic needs met and the child in the home was adequately supervised by the [redacted]. There were no signs of health or sanitations issues nor were there signs of physical or emotional abuse. The [redacted] admitted he had a substance abuse issue and agreed to drugs tests. He tested positive for THC and suboxone. The case was closed on 10/10/2014.

Circumstances of Child (Near) Fatality and Related Case Activity:

On the morning of 05/24/2017, the three year old victim child's [redacted] were preparing to leave the home for work. The victim's child's [redacted] needed a ride to a [redacted] appointment and was planning to leave with the [redacted] because the family only has one vehicle. The [redacted] woke the victim child's [redacted] and asked her to lock the door behind them. The [redacted] leave the home and the [redacted] reported she locked the front door as they left. The [redacted] reported that she, the victim child and the victim child's sibling were at home and everyone was awake. The [redacted] put on a movie for the children to watch. She stated that the one-year-old sibling fell asleep shortly after the movie started and she thought the victim child fell asleep also. The [redacted] then fell asleep also. The [redacted] reported when she woke up the credits from the movie were on the television. She realized the victim child was not there. She noticed a stool was by the door and the door was unlocked. She looked in the front yard and in the back yard for the victim child but did not see him. She then called her [redacted] followed by a call to the [redacted] and lastly to the child's [redacted]. The [redacted] arrived home within minutes of the call. Upon arriving at home, she heard the victim child's [redacted] screaming the victim's child's name and saw the one-year-old sibling sitting in the drive way dressed in only a diaper. The [redacted] sent the [redacted] to check the creek because the victim child enjoyed playing in the creek. The [redacted] proceeds to check the neighbor's home. She checks two neighbor's homes and does not see the victim child. At the third neighbor's home she walks to the backyard while yelling the victim child's name and notices a pool. The [redacted] indicated she walked on the deck and saw the victim child floating face up in the pool. She immediately started CPR on the child. She began to scream for someone to call for help. The [redacted] said as she was preforming CPR, some water was coming out of his body but she continued CPR because the child was not waking up. A neighbor heard her yelling and called 911. She continues CPR until the ambulance arrived.

The victim child was transported to [redacted] Hospital's emergency department. He was unresponsive during the ambulance ride and upon arrival at the hospital. Resuscitative efforts were made. At 2:45pm the child was pronounced dead. An autopsy was conducted the same day. The coroner stated that the victim child died from drowning. There were no other signs of trauma. The manner of death is considered accidental according the coroner. The coroner could not determine how many hours and/or minutes the child had been in the water.

Clinton County CYS interviewed the [redacted] and [redacted] at the hospital and had several follow up interviews during the course of the investigation. To assure the safety of all children in the home, the victim child's one year old sibling was removed from the home and [redacted] on the day of the incident. [redacted] The mother was to have supervised contacts with the

child. Supervision was permitted to be done by the father or paternal grandparent. Also, the father must continue to reside with the paternal grandparents.

On 05/30/17, during a visit by the father's probation officer, the father tested positive for a drug he did not have a prescription for and was sent to jail. The sibling child was removed from home and sent back to [redacted]. At the [redacted] the sibling to be placed with the paternal aunt. The agency conducted a home visit on 06/03/2017 and determined the sibling child to be unsafe because the paternal aunt did not inform the court that her children's father had an extensive criminal history and was not to be around children. The sibling child was sent back to foster care. [redacted] to be sent home to the biological father who was out of jail and living with the paternal grandparents and the sibling child's biological mother. The agency conducted daily face to face safety checks with the father and sibling child from 06/15/2017 until 07/15/2017. On 07/15/2017, the biological father tested positive for drugs and was sent back to jail. The sibling child was again placed in [redacted] The sibling is currently placed with Paternal Grandfather, [redacted] and his wife, [redacted] The child's father is no longer in jail. The sibling has visits with both parents together four times per week. The visits are held at the home of family member, [redacted]. Three out of the four visits are supervised by [redacted] and the fourth is supervised by a [redacted]. The next [redacted]

During the course of the investigation, the Clinton County CYS, was able to narrow down the timeline of events. The paternal grandparents and father left the home around 9:05 am. The movie the [redacted] put on for the children to watch was timed to be approximately 1 hour and 21 minutes long. The mother's first call to her [redacted] made from her cell phone was at 11:54 am. The mother's phone call to the [redacted] was to 12:31pm and the last call to the [redacted] was at 12:36 pm. EMS arrived at the neighbor's home around 1:10pm to transport the victim child to the hospital. The child was left unsupervised from approximately 9:15 am until the mother woke up around 11:50am.

Clinton County CYS made a referral to a [redacted] The attempted to engage the [redacted] to no avail. The father has [redacted] The father is also being monitored by Adult Probation. The mother refuses to complete a [redacted] The agency offered Family Group Decision Making but the family declined the services.

Clinton County CYS filed their [redacted] investigation report with [redacted] The case was opened for services by Clinton County CYS. The criminal investigation is still pending.

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

Information in this section is copied directly from the county report.

- Strengths in compliance with statutes, regulations and services to children and families;
  - [redacted] Upon receiving this referral, CCCYSS followed established procedures. CCCYSS ensured the safety of the other child in the home by [redacted]
  - CCCYSS staff members came together to respond to this tragic situation and provide the best service possible to the family while, at the same time, supporting one another during a difficult time.
  - Over the past couple years; the CCCYSS has developed an exceptional working relationship with the [redacted] as well as other local law enforcement. The recent collaboration with law enforcement was a key component and added to the strength of CCCYSS during the initial contact with the family and throughout the investigation.
  - CCCYSS remained focused, regardless of the challenges associated with the alternative placement that was deemed most appropriate in a permanency review hearing. While it was the recommendation of CCCYSS that the child remain in care to ensure the means and ability to care for the younger child could be offered and sustained, the [redacted] and other adult caregivers. The agency worked to develop a plan to ensure monitoring which was crucial in regular assessment of functioning in the home. This was conducted by way of daily check-ins with the family. The County solicitor also remained diligent in petitioning the court when concerns presented.
  - CCCYSS immediately reached out to the OCYF for guidance.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - While it was felt that the other child in the home needed to be [redacted] CCCYSS felt the situation could have been handled in a different way, to lessen the trauma for [redacted] (full sibling). Removing the child from the home where all family members gathered following the death of Asher proved to be a daunting task. CCCYSS feels the situation would have been better handled at the agency office. The removal occurred at the home, recognizing this family has the potential to be volatile; it may have been better executed by calling the family into the agency to review and subsequently place their younger child.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - CCCYSS discussed that there should be uniform ordinances for swimming pools in residential areas. Where this incident occurred, no ordinances were in place mandating that a fence had to be around the swimming pool. Therefore, Asher was easily able to gain access to the swimming pool.

    - CCCYSS also discussed the possibility of providing better support to families after closing a case. This particular family had been involved with CCCYSS numerous times prior to the child fatality incident. This may be facilitated in the fashion of aftercare of some type.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
    - CCCYSS discussed the possibility of mandating [redacted] to parents who may lack necessary parenting skills and the subjective monitoring of families.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - The overarching feedback in this area of review was to provide additional information inside the confines of the judicial system working in partnership with agencies to better learn the ramifications of decisions that occur within the placement review hearings throughout the course of placement for some children. It seems that this education and continued education would be invaluable to the process of placement and permanency. It was assessed by all involved parties as part of this process that the community has a strong, cohesive working relationship across settings that allow for the prompt implementation and offering of resources without delay or interruption.

Department Review of County Internal Report:

The Central Region Office received the Clinton County Child Fatality Team Report on 09/05/2017. 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 06/13/2017.

Department of Human Services Findings:

- County Strengths:

- CCCYSS responded to this fatality immediately after hours and conducted interviews in a timely manner.
- CCCYSS began to immediately search for kin to assure the safety of the child's sibling.
- They worked collaboratively with [redacted]
- CCCYSS submitted all regulatory required documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses:
  No weaknesses noted in the agency's handling of the case.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  No Areas of Non-compliance noted.

Department of Human Services Recommendations:

The Department does not have any recommendations as a result of this report.