pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY

Steven Killion Jr.

Date of Birth: 12/11/2014
Date of Death: 05/29/2017
Date of Report to ChildLine: 05/29/2017
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:
01/02/2019

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 the Office of Children, Youth and Families 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 06/13/2017.

Family Constellation:

First and Last Name	Relationship	Date of Birth
Steven Killion Jr.	Victim child	12/11/2014
[redacted]	Biological Mother	[redacted]/1980
	Biological Father	[redacted]/1981
	Full sibling	[redacted]/2012
	Maternal half sibling	[redacted]/2002

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed all case records pertaining to the family, which included case records that outlined contact with the family. A discussion occurred with the Assistant Administrator and the CPS supervisor on 06/06/2017 and 06/09/2017. The CRO did attend the Act 33 meeting on 06/13/2017.

Children and Youth Involvement prior to Incident:
Clinton County Children and Youth Services (CCCYs) became involved with the family on 07/29/2016. The [redacted] allegation was that the parents were mean to the victim child's full sibling. These allegations were invalid and the referral was closed on 09/19/16. Prior to closing the referral, the agency assisted the family with services since they were new to the area. The family accepted assistance for the children to receive early head start, [redacted] for the family.

On 04/06/2017, the agency received a GPS allegation of corporal punishment toward the victim child's full sibling. The agency responded to the home the same day. It was reported that the victim child's full sibling cut her own hair and her mother was angry. The victim child's sibling was interviewed and no injuries were reported and the allegations were denied. The mother also denied the allegations. Educational parenting classes were offered but declined by the family. This referral was closed on 05/05/2017 with invalid allegations.

Circumstances of Child Fatality and Related Case Activity:

Clinton County Children and Youth Services (CCCYS) received a report from the [redacted] on 05/29/2017. It was reported that on the date of the incident, the [redacted] went to check on the victim child at approximately 8:00am and found the child with a bag over his head and unresponsive. The [redacted] stated that the previous night the child was given a Ziploc bag with cereal in it. The [redacted] took the child to bed with the bag of cereal. It was reported that the child will typically play, eat his cereal and then will go to bed. The [redacted] reported that the [redacted] checked on the child that night at 9:00PM. The [redacted] stated that he did not check on the child at all until he found him with the bag over his head in the morning. 911 was called at 8:25AM and the first responder was there at 8:28AM. The police and EMS arrived at 8:29AM. The child was transported to Lock Haven Hospital and was pronounced dead.

On 05/29/2017, both [redacted] were interviewed individually by the police and agency personnel. The [redacted] stated that he forgot to go get the bag from the victim child before he went to bed and never checked on him. The [redacted] stated that the next morning, he heard the victim child in his room playing around 7:30AM. The [redacted] reported that the [redacted] was making breakfast while he was to check on the children. It was reported that the [redacted] did not appear with any emotions while talking with the police and agency personnel. The [redacted] stated that she did not check on the victim child prior to going to bed but that the [redacted] checked on him at 9:00PM.

On 05/29/2017, the police, along with CCCYS, interviewed the victim child's full sibling. The full sibling reported seeing the [redacted] carry the victim child downstairs. It was reported that the [redacted] put a bag on the victim child's head once he was downstairs. The full sibling made the statement, "[redacted] killed Boo Boo," which is how the full sibling referred to the victim child. The agency then made arrangements for that full sibling to be interviewed at a [redacted] the next day. The interview did occur the next day, however, the full sibling did not disclose anything significant regarding the victim's child's death. The older maternal half sibling could not be interviewed due to having [redacted]

On 05/29/2017, both of the victim child's siblings were [redacted] They both have a goal of reunification with a concurrent goal of adoption.

Clinton County Children and Youth (CCCYS) [redacted] the case on 07/14/2017 naming the child's [redacted] as the perpetrators for causing the death of a child through any act/failure to act. The law enforcement investigation in this matter is still ongoing. They are awaiting a completed autopsy report. Law Enforcement did report that both [redacted] submitted to polygraphs. The [redacted] test was inconclusive-pass and the [redacted] test was inconclusive-fail.

Summary of 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:

  After CCCYS received this referral, the agency followed established procedures. All household members were seen the date of the incident. To ensure their safety, the two living children who resided in the home were [redacted]

  There was strong collaboration between CCCYS and local law enforcement.

  CCCYS was diligent in [redacted] the 14-year old in an environment designed to accommodate children with [redacted].

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

  During this review, CCCYS identified that a major deficiency in this case was CCCYS not being aware of the family's prior [redacted] in other states. After the fatality incident, it was learned that the family had extensive [redacted] in other states. Had CCCYS known this information during the past referrals, perhaps more services would have been in place for this 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 review team identified that an interstate database to research [redacted] in other states when an agency receives a referral on family would be helpful to investigations.

  The review team also identified that the definition of mandated reporters could possibly be expanded to include people such as landlords who may have crucial information or may have been witness to situations that would be reportable to an agency.

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

  No recommendations identified.

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

  The review team identified agencies being hyper vigilant when it comes to working with children who have severe [redacted]

It was also discussed that CCCYS should continue to ask families with no CCCYS prior involvement if they ever lived in a different state and/or if they had any type of Child Welfare involvement in a different state/county.

The members of the review team discussed how to create an umbrella release of information in order for CCCYS to speak with other agencies who may work with new families to the Agency.

Department Review of County Internal Report:
The Clinton County Child Death Review Team held an Act 33 meeting on 06/13/2017 where case information was presented. The county report of the Act 33 meeting was received by the CRO on 09/10/2017. On 09/12/2017, the CRO sent correspondence to CCCYS Assistant Administrator, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:

  The agency responded to the referral immediately. Agency personnel conducted joint interviews with Law Enforcement and communicated well with each other.

  The agency's Act 33 meeting was well represented by county personnel, medical providers, and law enforcement. The meeting was very thorough.

  The agency assured safety of the victim child's siblings immediately. The agency was diligent in finding and [redacted] the 14-year old in an environment designed to accommodate children with [redacted].

- County Weaknesses:

  The agency did not inquire from the family if they ever had any prior involvement from any child welfare agencies in state or out of state. The agency recognizes that they are in a small community where everyone knows everyone and they very seldom receive referrals on families that are not known to the agency.

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

  After review of the file, the agency was found to be in compliance with statutory and regulatory requirements.

Department of Human Services Recommendations:
The department agrees with the county's recommendation that an interstate database to research [redacted] in other states when an agency receives a referral on a family would be helpful to investigations.