pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Leliana Danowski

Date of Birth: 02/28/2013
Date of Death: 07/31/2016
Date of Report to ChildLine: 07/31/2016
CWIS Referral ID: [redacted]

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

Dauphin County

REPORT FINALIZED ON:
12/29/2016

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.

Dauphin 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 08/26/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Leliana Danowski	Victim Child	02/28/2013
[redacted]	Mother	01/23/1994
	Father	07/26/1992
	Maternal Uncle	05/27/1998
	Maternal Grandfather	Not Known

* 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 (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a meeting with the MDT/Act 33 Review board on 08/26/2016 to review and discuss case information. Discussions concerning the case were conducted with the Dauphin County Social Services for Children and Youth (DCSSCY) Administrator and Assistant Administrator on 08/05/2016, 09/08/2016. Discussion with the caseworker occurred on 08/26/2016, 10/17/2016, and through various email correspondence.

Children and Youth Involvement prior to Incident:

On 04/30/2014, a referral was received regarding unsanitary home conditions. A home visit was conducted and the report was determined to be invalid. The family was closed at intake on 05/02/2014.

On 05/11/2015, the county received a [redacted] referral regarding concerns that 2-year-old Leliana was found walking alone alongside the road in Lower Swatara Township. The child's maternal uncle (MU) and [redacted] were in the home and the [redacted] was working. The uncle and [redacted] denied knowledge that they were to be watching the child at that time. The Agency interviewed the family members and the [redacted] said she left the child in bed with the uncle when she left for work. The uncle noticed Leliana was missing upon waking up. He estimated that the child was out of sight for 5-10 minutes. Upon looking for her, the [redacted] returned to the home with child. The [redacted] was living in her parents' home along with the victim child, the maternal grandmother, maternal grandfather, maternal aunt, the aunt's paramour, and the maternal uncle. The family shares supervision responsibility of the victim child as the [redacted] worked nearly full time hours. The family had a plan for supervision of the child and was using child safety gates and chain locks on doors to prevent the child from getting out unattended. No other health or safety concerns were noted. The assessment was closed 6/30/16. The [redacted] The uncle was a minor at the time of the incident. The [redacted] She completed the [redacted] in March 2016 offered through the [redacted] and charges were dismissed.

On 07/13/2016, a [redacted] was received regarding concerns of Leliana, who was 3 years old, being found wondering alone in Middletown, PA. The referral source reported that child was also observed walking alone on 07/12/2016 in the same area. Concerns for the child's hygiene were also noted upon report. The Agency responded to the [redacted] home the same day as the report. The [redacted] and maternal uncle were also present at the [redacted] home and engaged in the discussion surrounding the supervision of the victim child. The child had been in the care of her [redacted] for an extended period of time due to the [redacted] work schedule. She worked 3rd shift and depended on family and friends to provide child care while she worked. The [redacted] reported that he had fallen asleep and thought the child was asleep as well. He noticed the child was gone. He did not have a chain lock on the door and was advised to obtain one. There were concerns regarding the cleanliness of the home and the child also appears dirty by visual observation. The [redacted] took the child with her to her own apartment to assure for the child's safety. A subsequent visit to the [redacted] home did not reveal any health or safety concerns. She reiterated that her family and a friend are her support system so she can maintain employment and her own residence. On 07/29/2016, the [redacted] called her caseworker to report she had fallen asleep and the victim child again got out of the home. A chain lock had been on the door but it appeared the child pushed an ottoman to the door and was able to unhinge it. The [redacted] did contact the local police and was seeking assistance from landlord to obtain a different kind of lock for her door. The Agency did not receive notification of the incident from the police. The [redacted] was still underway at the time of the child's death on 07/31/2016.

Circumstances of Child Fatality and Related Case Activity:

On 07/31/2016, a report was received from Hershey Medical Center regarding the death of Leliana Danowski. According to the report, Leliana was in the care of her [redacted] Sometime after he put her to bed, she wandered off. Leliana was found drowned in the neighbor's pool that morning a few blocks away. The ambulance was called and the EMS attempted to do CPR while transporting her to Hershey Medical Center ER; however they could not revive her. She was declared dead on arrival at the ER.

The Agency responded to the hospital upon notice of the incident and met with the mother. She confirmed that she continues to work 11:00 p.m. to 7:00 a.m. at a local gas station. When she is working, her [redacted] assumes primary responsibility of babysitting Leliana, with friend or the child's father also assisting on occasion. The night before the child's death, the [redacted] transported the mother to work and the child went home with him. The following morning, the [redacted] picked up the mother from work and transported her to her apartment. The [redacted] kept Leliana with him as the mother wanted to get some sleep after working all night. The [redacted] took the child back to the maternal grandparent's home where he resides. The mother reported that around 9:30 a.m. she awoke to a friend knocking on her door telling her they needed to leave. About that same time she received a call from the [redacted] telling her to go to the hospital. The mother's [redacted] told her that he has set Leliana on the couch to watch cartoons and he had fallen asleep. He told the mother that the chain lock was on the door but the child had gotten out. The child is known to be an "escape artist."

Lower Swatara Police Department received the initial call regarding the child being found in the neighbor's swimming pool. They conducted interviews with the [redacted] and other witnesses prior to CYS being notified. The [redacted] declined an interview with the Agency. The Agency caseworker was able to listen to recordings of the police interviews with the [redacted], maternal grandfather, mother and maternal grandmother, as well as review interviews with witnesses in the area where the child was found.

Information obtained through collaboration with the police and district attorney's office revealed the on the date of incident Leliana was reported as found in the swimming pool at 9:23 a.m. The mother was picked up from work at 7:14 a.m. and dropped at her home at 7:30 a.m. The [redacted] reported that upon arriving at his home, he strapped the child into a high chair in his room, put on cartoons on for her and gave the child a snack. He also reported the door was locked but the child is known to unlock doors. The [redacted] feel asleep and noticed Leliana was gone at 8:20 a.m. He checked for the child in the home and the neighborhood before calling the police to report her as missing at 9:36 a.m. The mother's friend was contacted by the [redacted] at 9:25 a.m. to help find the child prior to the police being notified. An assessment of the [redacted] home determined there was no lock on the father's door and the highchair was not in the room as reported by the [redacted]. The MGF was home when the child was found to be missing and helped try to locate her.

The report was made [redacted] Law enforcement has charged the

[redacted] and mother with involuntary manslaughter. The maternal grandfather is also facing charges associated with tampering evidence. The case was closed as there are no other children in the home.

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;
  - Immediate response by CPS once they received notice of incident and report to ChildLine was made.
  - Compliance with regulations – notified State in timely manner and conducting ACT 33
  - [redacted] offered for mom and dad.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - Joint investigative team was not initiated according to the established protocol. Interviews were unable to be conducted jointly.
  - CYS was not notified immediately of incident by 4-5 hours.
  - Interviews and home assessment was already completed by detective.
  - Pool was not up to code standards.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - None noted

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - Work with DA's office to draft and finalize protocol and education of law enforcement officers regarding notifying and working with CYS in child fatalities.
  - In a similar situation have caseworkers give out ChildLine number and information to neighbors.
  - Partner with Safe Kids to go with CYS to homes with Safe Kits, locks.
  - Have door alarms at agency to hand out to clients with similar situation.
  - CYS partner with families and landlords to allow installation of alarms and locks.
  - Initiate Public Service Announcements regarding pool installation, regulations and safety.
  - CYS have literature on pool safety to pass out to families who have pools, same as Safe Sleep letter.
  - Have local news stations do a report on pool safety and regulations.

- CYS will make contact with the family who owned pool for any needed counseling.

Department Review of County Internal Report:

The Dauphin County Fatality/Near Fatality Review Team held an Act 33 meeting on 08/26/2016 where medical information and case history were presented. The County report was received by the Region on 10/25/2016. The CROCYF notified DCSSCY that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
  - The Agency promptly addressed the supervision concerns noted prior to the child death and was working appropriately with the mother and father during the initial assessment period.
  - The Agency responded immediately upon notice of the report.
  - The Agency promptly addressed the break in protocol established by the county death review team and attempted to resume collaboration as soon as possible.
  - The Agency was persistent in efforts to solicit copies of the police interviews they were unable to attend.
  - The Agency was respectful of and extended supports to the family in response to their loss.

- County Weaknesses: and
  - None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None noted

Department of Human Services Recommendations:

The Department agrees with the recommendations that resulted from the Child Death Review Team's Act 33 meeting regarding public service announcements on pool safety and detailed suggestions for securing homes/apartments when children are known to wander off. The specific recommendations are:

- Partner with Safe Kids to go with CYS to homes with Safe Kits, locks.
- Have door alarms at agencies to hand out to clients with similar situation.
- CYS partner with families and landlords to allow installation of alarms and locks.
- Initiate Public Service Announcements regarding pool installation, regulations and safety.
- CYS have literature on pool safety to pass out to families who have pools, same as Safe Sleep letter.

- Have local news stations do a report on pool safety and regulations.

It is further recommended that the Agency and CDRT team members should work in tandem at address the breakdowns that resulted on the day of the child's death and identify alternative approaches to working with resistant partners.