REPORT ON THE FATALITY OF:

Hunter Kyle

Date of Birth: 05/04/2016
Date of Death: 07/12/2016
Date of Report to ChildLine: 09/08/2016
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth Services

REPORT FINALIZED ON:
02/10/2017

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))

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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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 09/28/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]/1987
[redacted]	Father	[redacted]/1976
Hunter Kyle	Victim Child	05/14/2016
[redacted]	Half-Sibling	[redacted]/2006
[redacted]	Half-Sibling	[redacted]/2009
[redacted]	Half-Sibling	[redacted]/2015
[redacted]	Sibling	[redacted]/2013

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the Lancaster County Children and Youth Services (LCCYS) child protective service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation.

Children and Youth Involvement prior to Incident:

LCCYS was previously involved with the family prior to receiving the Child Protective Services Report (CPS) on 09/08/2016. LCCYS conducted four prior General Protective Service (GPS) investigations and screened out two referrals.

03/06/2014 – 03/07/2014: A GPS report was received alleging that the home may not have heat, that the mother was allowing her baby to sit in soiled diapers, that the mother's paramour's parental rights to his children in Lancaster County were terminated and that the mother had three other children not in her care. Both parents were interviewed, the allegations were not validated and the case was screened out.

LCCYS also contacted Cecil County Department of Social Services, Elkton, Maryland, and obtained the mother's case history which included the mother being charged with first degree child abuse after the death of her infant son in January 2011. The information provided to LCCYS stated that the mother had left her child on the sofa and he shifted and suffocated. Cecil County Department of Social Services also removed the mother's younger child from her care provided in-home services following that incident. Cecil County Department of Social Services returned that child to the mother on 09/13/2013. Shortly after this the mother left Maryland and moved to Lancaster County, Pennsylvania.

03/10/2015 – 04/07/2015: A courtesy assessment and safety contact was requested from Delaware. That agency reported concerns of emotional mistreatment and neglect of [redacted] when she visits in her mother's home. [redacted] is in the custody of her maternal aunt in Delaware and visits with her mother. Assessment services were provided and the allegations were not validated.

03/25/2016 – 04/04/2016: [redacted] conducted a review of an evaluation that stated that [redacted] was physically mistreated by his father prior to coming into mother's care. No other concerns were noted and LCCYS screened out the report.

05/01/2016 – 06/24/2016: The father of [redacted] called the Maryland Hotline and reported that he heard third hand that his child was beaten by the mother in a five to ten minute period of time for peeing and then refusing to get dressed again. No injuries were alleged. LCCYS completed an assessment and noted that the home had no concerns. The mother stated she does use physical discipline but denies ever leaving marks. Family Based Services were being provided in the home through another agency and no concerns were noted by that agency. Following assessment services the case was closed.

05/01/2016 – 05/01/2016: A [redacted] report was received alleging the same allegations as above. [redacted]

07/12/2016 – 09/08/2016: A [redacted] report was received with the concerns noted that this child had just died with an unknown cause of death and that the mother had another son that died with similar circumstances. This report then became a [redacted] report, certified as a fatality report on 09/08/2016.

Circumstances of Child Fatality and Related Case Activity:

[redacted] on 09/08/2016. This report was initially given to the agency as a [redacted] on 07/12/2016. On 09/08/2016 this report was certified as a fatality report.

The [redacted] was the primary caretaker of the child at the time of the incident on 07/12/2016. The [redacted] was sleeping in bed with the child and the child's three-year-old sibling. The child was in between the mother and his sibling. The [redacted] reported that she last fed the child at approximately 2:00 am and then when she

woke up at approximately 8:00 am the child was deceased. The [redacted] reports that she called 911 and emergency medical technicians arrived at the home. The County Coroner was then called to the residence and he pronounced the child dead. The child's [redacted] had slept on the couch the previous evening as it was reported the [redacted] had gotten into an argument before bed. The following morning the [redacted] got up and went to work and did not see the [redacted] or the child before leaving the home.

The [redacted] had previously been warned about the dangers of co-sleeping from service and medical providers and she had been advised against it. Despite the warnings the [redacted] had made a comment to a medical professional just six days prior to the incident that she would continue to co-sleep with the child. Additionally the [redacted] has prior criminal charges from 2011 regarding another one of her children, a two-month-old male child, that died in her care in Cecil County, Maryland. LCCYS contacted Cecil County, Maryland and obtained the [redacted] case history which included the [redacted] being charged with first degree child abuse after the death of her infant son. The [redacted] had left her child on the sofa and he shifted and suffocated. The [redacted] served jail time and a three year probation period for that crime.

The [redacted] was arrested on 09/08/2016, and charged with Criminal Homicide, Involuntary Manslaughter, and Endangering the Welfare of a Child. She remains incarcerated at this time. Prior to her arrest the mother identified and assisted in the arrangements for her other four children in her care to stay with relatives in Pennsylvania, Georgia and Delaware. LCCYS contacted the respective child welfare agencies for each of the children to coordinate placement/kinship services, ensure the children were safe, the homes were appropriate and that any necessary services were coordinated.

[redacted]

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;
  The caseworker went to the house and did not see any other parenting deficits (no D/A concerns).

- Deficiencies in compliance with statutes, regulations and services to children and families;
  LCCYS was able to make referrals to Georgia and Delaware to seek family members to place the other children into kinship care rather than for them to continue in foster care.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

There were no recommendations made.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  There were no recommendations made.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Continue to tell mothers, fathers, and other family members that co-sleeping is not appropriate.
  Stronger penalties with deaths related to co-sleeping (Murder III).

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting Report was received by CROCYF on 01/27/2017. The CROCYF attended the Act 33 Child Near-Fatality Review Team meeting on 09/28/2016 and was aware of the discussion, recommendations and outcome. CROCYF finds the county's report content and findings are representative of what was discussed during the meeting on 09/28/2016.

Department of Human Services Findings:

- County Strengths:
  LCCYS conducted the investigation in cooperation with law enforcement and medical services/providers. The record was comprehensive; including medical reports, interviews, risk and safety assessments, and case dictation. LCCYS worked with the [redacted] in identifying and coordinating kin resources for the siblings when placement became necessary.

- County Weaknesses:
  Although LCCYS documented their case activity, the documentation specific to each allegation in regard to the prior referrals should have been more detailed.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  There were no statutory and/or regulatory areas of non-compliance noted.

Department of Human Services Recommendations:

LCCYS should continue to conduct thorough and timely investigations in collaboration with law enforcement, the court and medical and service providers. Efforts of child abuse prevention and education should continue and be expanded as possible to reach out to social service agencies not familiar with co-sleeping dangers.