pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Liam Prescott

Date of Birth: 01/12/2017
Date of Death: 09/25/2017
Date of Report to ChildLine: 09/25/2017
CWIS Referral ID: [redacted]

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

McKean County Children and Youth Services

REPORT FINALIZED ON:
03/05/2018

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street, Room 260 | 412-565-3658 | 412-565-7808 |
www.dhs.state.pa.us

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (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.

McKean County Children and Youth Services (MCCYS) did convene a review team related to this report. The internal county review occurred on 10/24/2017 and 11/28/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Liam Prescott	Victim Child	01/12/2017
[redacted]	[redacted]	[redacted] 1995
[redacted]	[redacted]	[redacted] 1995
[redacted]	[redacted]	[redacted] 2015

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) obtained and reviewed the records given by MCCYS on this case and attended the county review team meeting on 10/24/2017. The WRO representative had a call-in number for the 11/28/2017 meeting but no one from the county answered the phone on that date.

Children and Youth Involvement prior to Incident:

MCCYS had prior involvement with [redacted] as a child. When [redacted] was 16-years-old [redacted]. The perpetrator was [redacted] successfully completed [redacted] service plan. [redacted] received [redacted].

On 08/29/2016, MCCYS became involved with [redacted] and [redacted] when [redacted] alleged suspicions that [redacted] and [redacted] were residing with [redacted] and [redacted] who allegedly was a Tier 3 Sex Offender. MCCYS screened out this report because [redacted] was not alleged to be a caretaker and was never convicted of a sex offense and was not required to report under Megan's Law.

A subsequent [redacted] with concerns for the victim child was reported to MCCYS on 01/13/2017 alleging that [redacted] had just given birth and was considering placing the victim child for adoption. The reporting source had concerns for the mother's [redacted]. [redacted] and [redacted] were living with [redacted]. Several visits to the home were made. The home was assessed as being appropriate with adequate supplies for the victim child. On 02/23/2017, MCCYS [redacted] the [redacted] and closed the case.

Circumstances of Child Fatality and Related Case Activity:

On 09/25/2017, MCCYS received [redacted] alleging that the victim child had been found deceased inside [redacted] home and the death was suspicious. MCCYS went to the home with the local police and interviewed [redacted]. [redacted] did not reside in the home where the death occurred as the victim child died in [redacted]. [redacted] had overnight visitation one night a week. [redacted] advised that [redacted] was co-sleeping with the victim child and [redacted] on a mattress lying on the floor of [redacted] bedroom. The mattress was observed to have a small white blanket, a blue and white striped comforter and a single pillow on it, as well as a horseshoe shaped pillow for an infant that was wedged between the mattress and the wall.

MCCYS interviewed [redacted] and [redacted] at the home. [redacted] alleged that [redacted] had the victim child and [redacted] the night before. [redacted] woke up between 4:00 AM and 5:00 AM to feed the victim child. [redacted] reported making two bottles, each containing formula and cereal. The victim child drank some of the first bottle but did not finish it. Shortly after 5:00 AM [redacted] stated [redacted] laid back down on the mattress with the victim child on [redacted] chest and "passed out." [redacted] awoke around 10:50 AM realizing [redacted] was late for the victim child's medical appointment. [redacted] woke up the sibling and took [redacted] to the bathroom to get [redacted] ready and called [redacted] so that [redacted] could call the doctor's office and inform them [redacted] would be late. [redacted] returned to the bedroom to get the victim child and noticed bruises to the child's leg and realized that he was dead. [redacted] called [redacted] who in turn called 911. [redacted] arrived at the home before Emergency Medical Services (EMS). [redacted] was found holding the victim child outside of the home when EMS arrived.

[redacted] had a forensic interview. [redacted] was not able to provide any details about the incident. An autopsy was conducted on 09/26/2017 noting the cause of death was undetermined pending toxicology. The Coroner reported that if toxicology was negative then the likely cause of death would be sleep overlay or Sudden Undetermined Infant Death Syndrome. MCCYS obtained the medical records for both the victim child and [redacted]. It was noted that there were several missed medical appointments for the victim child. The victim child had [redacted] for [redacted] and [redacted]. There were no concerns noted for the victim child's safety and wellbeing. [redacted] was [redacted] and was found to [redacted]

On 11/20/2017, MCCYS [redacted] with ChildLine with the [redacted]." Law enforcement has not filed charges against [redacted]. On 01/19/2018, the Coroner reported that the toxicology came back negative and the cause of death for the victim child was noted as 'no anatomical cause of death' identified at autopsy, and the manner of death could not be determined.

MCCYS, to date, continues to be involved with the family related to recently identified risks which are not directly related to the victim child's death.

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:

Timeliness of the response by EMS and local police, the police's attention to detail and protection of the scene and evidence. The prompt reporting and MCCYS response and the interaction and collaboration with law enforcement, MCCYS, Coroner and [redacted] services.

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

None identified.

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

Universal standards, training, and education for professionals and caregivers on safe sleep environments. An educational campaign on safe sleep environments and develop universal standards/protocols on missed well child appointments particularly for children from birth to 5 years old.

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

None identified.

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

Develop a process for monitoring recommendations from Act 33 reports to ascertain whether recommendations are implemented and are having their intended effects.

Department Review of County Internal Report:

The Department reviewed the County Internal Report and agreed with the recommendations. The report was timely.

Department of Human Services Findings:

County Strengths:

MCCYS made immediate contact with [redacted] and the police at the home where the death occurred. The agency coordinated their investigation with the police. The Agency worked with the [redacted] to coordinate the immediate services that the family needed.

As part of the investigation, MCCYS referred [redacted] for a forensic interview. MCCYS obtained the medical records for both the victim child and [redacted]. MCCYS assisted [redacted] in having [redacted] after the incident.

County Weaknesses:

None identified.

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

None identified.

Department of Human Services Recommendations:

The Department recommends continued training, and education for professionals and caregivers on safe sleep environments. The Department also identifies the need for universal standards and protocols on missed well child appointments particularly for children from birth to 5 years old and suggested guidance to medical providers in determining when those missed appointments should trigger a referral to the county children and youth system.

In addition, the Department agrees with the agency's recommendation that a process needs to be developed to monitor recommendations from Act 33 reports to ascertain whether recommendations are implemented and are having their intended effects.