pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Anakin Gammon

Date of Birth: 11/25/2014
Date of Death: 09/10/2017
Date of Report to ChildLine: 09/10/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Mercer County Children and Youth Services

REPORT FINALIZED ON:
02/15/2018

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.

Mercer County Children and Youth Services (MCCYS) did not convene a review team related to this report in accordance with the Child Protective Services Law. The agency completed their report prior to the 30th day of the investigation. MCCYS submitted the report as unfounded.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Anakin Gammon	Victim Child	11/25/2014
[redacted]	[redacted]	[redacted] 2012
		2008
		2007
		2001
		1984
		1982

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth, and Families (WRO) obtained and reviewed the electronic case record for this family, a copy of the police report and the Child Welfare Information System (CWIS) reports. Information was also gathered through phone interviews and emails with MCCYS staff.

Children and Youth Involvement prior to Incident:

MCCYS had no prior reports or involvement with this family.

Circumstances of Child Fatality and Related Case Activity:

MCCYS was first made aware of this incident when they received [redacted] on 09/10/2017. According to the reporting source, who was [redacted], "[redacted] was intoxicated and the child wandered off. The child was found unresponsive in a pool. The child wandered several blocks away in Ohio." [redacted] neighborhood borders the state of Ohio. The police received the call at 4:45 PM that the victim child was missing and he was found in the pool at 8:24 PM. The child did not survive the incident.

That same evening, an on-call caseworker from MCCYS made contact with [redacted] at the hospital to ensure the safety of [redacted] in the home. The caseworker made face-to-face contact with [redacted]. The police were also present at the hospital and they advised [redacted] that they were not going to be able to stay in their residence for "a couple days" due to the investigation. [redacted] made arrangements for [redacted] and [redacted] to stay with [redacted]. [redacted] would stay with [redacted]

While at the hospital, the on-call caseworker spoke to the officer that made the report. The officer said that [redacted] neighbor told him that [redacted] was "passed out drunk in the front yard earlier in the day and [redacted] was watching [redacted]." During this conversation, the officers said that [redacted] smelled of "old alcohol" and they were going to attempt to obtain a blood alcohol content level on [redacted] During this contact at the hospital, the on-call caseworker also documented that she observed [redacted] who "appeared disheveled" and smelled of "stale beer" when [redacted] walked past her. The caseworker contacted a casework supervisor, who gave direction to observe [redacted] and run clearances on the persons in that home.

The on-call caseworker went to [redacted] and found the home to be free of physical safety hazards. However, [redacted] reported that [redacted] "had issues with children and got into trouble" 20 years ago in Florida. [redacted] also said that [redacted] was "all better and [redacted] only deals with adults." The caseworker made sure that it was okay to discuss this issue with [redacted] and [redacted] agreed. [redacted] was already aware of the incident. The caseworker advised them of what could happen to them should [redacted] abuse [redacted] while they were in [redacted] home. Despite this information, [redacted] chose to remain in this home with [redacted].

Safety Assessment Worksheets (SAW) were completed on [redacted]. One was completed on [redacted] in [redacted] care and one on [redacted], who was temporarily with [redacted]. Neither document identified a safety threat so [redacted] were all deemed "Safe" with no safety plan necessary.

On 09/11/2017, MCCYS received [redacted] from Childline on this incident: [redacted] Fatality report on the victim child and [redacted] on [redacted] On both of [redacted], [redacted] was named as the alleged perpetrator. MCCYS also received [redacted] on [redacted] naming [redacted] as the alleged perpetrators.

On 09/11/2017, various telephone contacts occurred regarding the incident. The casework supervisor spoke to the Detective and the Detective asked if the agency could [redacted]. The supervisor advised the Detective that [redacted] could be offered but not forced if refused. The caseworker contacted the police to discuss forensic interviews being conducted on [redacted], however, the police asked for the interviews to be delayed until they could speak to [redacted]. The caseworker also said that she would attempt to [redacted] as per their request.

The caseworker also completed a home visit with [redacted] on 09/11/2017 and met with [redacted]. During this visit, the caseworker assessed [redacted] home for safety, as [redacted] had not stayed there the night before. [redacted] said [redacted] did not want [redacted] to return to the home yet, so the caseworker stressed that [redacted] could not be left alone with [redacted]. Also during this conversation, the caseworker advised [redacted] that [redacted] was not to be left alone with [redacted] either. She understood both of these.

Although a specific date was not documented, at some point over the next week [redacted] returned to [redacted] care at the [redacted] home. [redacted], one of which was [redacted], had forensic interviews completed on 09/20/2017. The caseworker obtained copies of these interviews to help with the agency's decisions regarding the family.

On 09/26/2017, the caseworker made contact with [redacted] at [redacted] home and made contact with [redacted]. [redacted] was tearful during the visit and the caseworker discussed possible services for [redacted] to ensure [redacted] are meeting [redacted] needs, including emotional issues related to the incident. Another home visit was made on 10/06/2017 and [redacted] were seen. [redacted] gave the caseworker their statements as to what occurred on the date of the incident. This is the last case entry on the case.

Ten day supervisory review meetings were held on 09/18/2017, 09/28/2017 and 10/05/2017. During this review, the supervisor documented that the caseworker spoke to the detective, who had not completed his notes yet. Once finished, the detective will meet with the District Attorney. [redacted] were deemed safe.

The caseworker had conversations with the assigned detective as to the status of the criminal investigation and for the agency to obtain a copy of his notes on 10/3/2017 and 10/06/2017.

On 10/06/2017, the caseworker followed up with [redacted] regarding her decision on how to provide their statements. [redacted] said that [redacted] would be home later that afternoon and the caseworker could come then to speak with [redacted].

About an hour after contacting [redacted] on 10/06/2017, the caseworker received a phone call from the Detective regarding the investigation. According to the case note, the Detective said he was "almost done with his notes" to give to the caseworker and would give them to her by the following Monday. In addition, the Detective said that he spoke to the District Attorney and the District Attorney was going to review the case over the weekend.

Later that same afternoon, the caseworker made contact with [redacted] and saw [redacted]. [redacted] were asked to provide their versions of what took place on the day of the incident. [redacted] provided her account first.

[redacted] stated that [redacted] had been up until 1:00 AM with [redacted] and [redacted] and then [redacted] woke her up around 4:00 AM, so [redacted] was also tired that day. [redacted] prepared to go to church that morning, however, [redacted] went on the church van and [redacted] and [redacted] stayed behind with [redacted]

[redacted] and the victim child. [redacted] made breakfast and they had a "normal" morning, playing and watching movies. [redacted] stopped at [redacted] house after church, but [redacted] came home. [redacted] went to [redacted] that afternoon. This left [redacted] in the home with [redacted]. [redacted] went upstairs to take a nap and [redacted] followed [redacted] upstairs to [redacted] room, but [redacted] took them back downstairs with [redacted] to make [redacted] lunch. The next thing [redacted] remembers was [redacted] waking [redacted] up to tell [redacted] that [redacted] walked away. [redacted] immediately got up, searched the house and went outside to see what was going on. [redacted] contacted the police when [redacted] realized that [redacted] weren't in the house. [redacted] told the caseworker that [redacted] "even checked the inside of the dryer where [redacted] had been found before." [redacted] said the officer thought [redacted] was trying to hide something because [redacted] wouldn't let him in the home initially, but [redacted] just wanted everyone outside looking for [redacted] [redacted] became upset, so [redacted] stopped the mother to tell [redacted] version of the incident.

[redacted] said that, after [redacted] returned from church and [redacted] came home[redacted] wanted to go upstairs and take a nap. [redacted] told her it was okay to do so. [redacted] explained [redacted] is in training at a new job as a store manager and was up late worrying about whether [redacted] had closed the store correctly that night. [redacted] was watching football in the afternoon and [redacted] were "bouncing around" inside, so [redacted] took them outside. While outside, [redacted] said [redacted] "wrestled around" with [redacted] for about 45 minutes. [redacted] went to play with [redacted] and [redacted] who was outside as well[redacted] [redacted] said that [redacted] was exhausted and "dozed off for a moment" until [redacted] heard the neighbor yelling for [redacted]. The neighbor told [redacted] that he had witnessed [redacted] [redacted] go up the alley. [redacted] said he immediately got up and went looking for [redacted], which included looking through an abandoned house nearby. [redacted] [redacted] called out for [redacted], but [redacted] didn't respond. After [redacted] couldn't find them, [redacted] returned to the house to talk to [redacted] and [redacted]. [redacted] [redacted] ended his account at that time and there was no documentation of other questions asked by the caseworker at that time. This entry is the last case note entry for the case.

There was a final supervisory review that took place on 10/10/2017. The supervisor noted that the agency was finally able to obtain the Detective's notes. The supervisory review noted that it did not appear that charges were going to be pursued, but the District Attorney had yet to obtain the case yet from the Detective. At this time, a discussion with the administrative team was held and the supervisor recommended that the case be submitted as [redacted]. This decision was approved by the administrative team and the report was submitted this day. [redacted] [redacted] for both the victim child and [redacted] were submitted to ChildLine on that date with status determinations of [redacted] According to the case record, there is no documentation of any other contacts with the family, nor were any supervisory reviews completed after this decision. Even though [redacted] was not completed until 11/02/2017.

Two more [redacted] were completed on the family, once on 10/10/2017 and the final one on 11/02/2017. Neither of these identified any threats and [redacted] were deemed safe. A [redacted] was also completed on

10/10/2017. Both the "Overall Severity" and "Overall Risk" for this family were rated "L" (Low). The agency officially closed their involvement with the family on 11/02/2017.

On 11/17/2017, [redacted] was arrested and charged with one count of Involuntary Manslaughter (2nd degree felony) and two counts of Endangering the Welfare of Children (1st degree Misdemeanors). These charges were all held for court on 01/12/2018.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

Because MCCYS submitted their [redacted] report prior to the 30th day of the oral report received by ChildLine, a meeting was not necessary and, as a result, not held.

Department Review of County Internal Report:

MCCYS did not hold a meeting or complete a report for review due to completing their investigation within 30 days and submitting an [redacted] status.

Department of Human Services Findings:

The following findings are based on a review of the information provided by MCCYS and contained in their case record.

- County Strengths:
  - MCCYS immediately responded to the incident to assess the safety of the surviving children in the home and address any issues that were discovered.
  - MCCYS collaborated with the investigating law enforcement agency throughout their involvement with the family. The caseworker did a good job documenting the collaborative efforts with law enforcement.
  - MCCYS treated the family with kindness and respect throughout their involvement with the family. They were sensitive not to add to the family's grief and made every effort to not re-traumatize the family.
  - MCCYS made efforts to ensure that the family's emotional needs were being met by offering them services to address their grief and loss.
  - When the status- determination decision was made on the two [redacted] cases, it was reviewed with and approved by MCCYS' administrative team.
  - MCCYS completed Safety Assessment Worksheets and the Risk Assessment Tool at the proper intervals.
  - Because the family lived on the Ohio border, the caseworker also contacted Ohio's child [redacted] system to see if there was any prior history in their state.

- <u>County Weaknesses:</u>
  - MCCYS submitted their determination to ChildLine on the 29th day (10/10/2017). While the Child Protective Services Law requires an investigation to be completed within 30 calendar days, an additional 30 days can be used if warranted. The decision to complete this report within the first 30 days seems ill advised because law enforcement, specifically the District Attorney, had yet to make a decision on whether or not charges would be filed.

    In addition, the caseworker had already informed the family during a phone call on 10/05/2017 that the report was not going to be [redacted] and the agency was planning on closing their case by the following week. This was before the Detective even had his report ready to be presented to the District Attorney for review, and before the autopsy results were available.

    Interviews conducted and documented by law enforcement in their report include statements from the neighbor who witnessed [redacted] asleep/passed out in [redacted] yard. The neighbor stated that [redacted] was initially difficult to wake up, had a strong odor of alcohol and appeared disoriented for a few minutes. The witness stated that, after he told [redacted] that [redacted] wandered away, [redacted] pointed at the witness's children and thought they were his own.

  - The initial report stated that [redacted] was intoxicated and asleep/passed out in the yard when [redacted] left. This was the reason for the report. Despite the on-call caseworker documenting that [redacted] smelled of "stale beer" at the hospital and the police reporting the same thing, the interviews completed with [redacted] on 10/06/2017 do not include documentation that this concern was addressed by the assigned caseworker.

  - A neighbor reportedly saw [redacted] wander away and is the one to wake [redacted] to inform him. The case record does not contain any entry by the caseworker that this witness was interviewed. The neighbor could have provided a timeframe of when he first noticed [redacted], how long after he noticed them did he alert [redacted], etc.

  - Also during interviews, opportunities to ask clarifying questions were not taken. For instance, [redacted] told the caseworker that [redacted] fell asleep for "a moment", but there is nothing showing questions to ascertain how long that "moment" was or [redacted] believe it to be.

  - The agency determined that the report wasn't [redacted] because there was insufficient evidence to show anyone was intoxicated. They also stated that [redacted] was babysitting the child at the time of the incident. The agency did not add [redacted] as responsible

caregiver at the time of the incident. [redacted] was not added as an alleged perpetrator even though [redacted] would have met the definition.

- When the family was informed by the police that they would be unable to return to their home for a few days due to the investigation, they chose to stay with [redacted]. During an interview with [redacted], it was learned that [redacted] had prior convictions related to child abuse in Florida 20 years ago, of which [redacted] was aware. The caseworker did address this concern with [redacted] It was decided that [redacted] was not to be alone with [redacted] while in [redacted] home. [redacted] remained in the home at [redacted] request and the caseworker's knowledge.

- In conversations with the police on two separate occasions, MCCYS staff documented that they would ask [redacted] to be [redacted], however, there is no case note that shows this was done. [redacted] denied any [redacted] to the caseworker. When the police executed a search warrant on the home, they found [redacted] paraphernalia and residue inside it.

- In two case notes there is documentation that alludes to [redacted] having difficulty supervising [redacted] in the home, one of which is [redacted]

  One entry dated 09/11/2017 documents a statement made by [redacted] that when [redacted] arrives to pick up [redacted] for church, "it always takes such a long time because [redacted]) has the home barricaded up so [redacted] don't escape."

  [redacted] was interviewed about the timeline of events the day of the incident. During her interview on 10/06/2017, [redacted] tells the caseworker that [redacted] "even checked the inside of the dryer where [redacted] have been found before."

- The police that responded to the home expressed concerns to the agency about the family's living conditions. The caseworkers also documented some concerns and that the family was going to be moving into a new residence. However, the last face-to-face contact with the family occurred on 10/06/2017 and the intake was officially closed on 11/02/2017. There was no documentation showing that the family actually secured safe and/or sanitary housing or whether they remained in their existing home.

- Although safety assessment worksheets were completed on the family, no threats were identified, nor were any plans put in place despite [redacted] being told he could not be left home alone with [redacted].

It should be noted that much of the information in this section was contained in the police report. As stated earlier, the Department reviewed this police report, which was provided by the county. The print date on the report is 10/09/2017, which is one day prior to the agency's determination. This report contained statements regarding [redacted] condition and reported behaviors when the neighbor woke [redacted], as well as other statements by the family members.

It is unclear why the agency did not utilize the additional 31 days to gather more information to further support their determination.

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

MCCYS was found to be in violation of the following:

- *Chapter 3490.55 (d)(6):*
  A neighbor observed [redacted] walking away and alerted [redacted]. There was no documentation that MCCYS interviewed this person.

- *Safety Assessment as per 3130.21 (b)*
  There is a case note that documents that [redacted] was advised by the caseworker that [redacted] was not to be unsupervised with [redacted]. This is a safety plan, however, there were no threats identified in any Safety Assessment Worksheet (SAW), nor was a written plan put into place.

- *3490.235(e)*
  As per agency's electronic case record, the agency completed [redacted] on 11/02/2017, however, the last supervisory review took place on 10/10/2017.

Department of Human Services Recommendations:

Based on the review of this incident, the Department's recommendations are as follows:

1. A public service campaign regarding the importance of securing public or private pools may be beneficial. The pool that this child drowned in was in a back yard that had a fence that connected to a garage. However, the garage door was up and the door from the garage to the yard was open, which allowed the child to walk through both doors and into the yard. In addition, this was an above ground pool that had steps and a gate to a small deck, but it does not appear that the gate was locked or secured. The child was able to climb the steps, enter the gate, and got into the pool. It also does not appear that the pool had a cover secured on it. A well-secured pool cover may have possibly prevented a small child from going into the water.

2. Related to the first recommendation, municipalities may want to consider ways to make safety codes related to pools, such as making sure ladders are removed and/or gates are locked and find a means of enforcement.