



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kalesia Witman

Date of Birth: 12/02/2012

Date of Death: 8/22/2014

Date of Oral Report: 8/22/2014

FAMILY KNOWN TO:

Dauphin County Children and Youth Services

REPORT FINALIZED ON:

08/09/2015

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Dauphin County convened a review team on August 29, 2014 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Kalesia Witman	Victim Child	12/02/2012
██████████	Sibling	██████████ 1999
██████████	Sibling	██████████ 2001
██████████*	Sibling	██████████ 2014
██████████	Mother	██████████ 1982
██████████**	Father	██████████ 1981

* The sibling, ██████████, is a current household member but was not yet born at the date of incident.

** The father, ██████████, is a current household member but did not live in the home at the date of incident, as he was incarcerated.

Notification of Child (Near) Fatality:

At approximately 8:30 a.m. on August 22, 2014, the mother called ██████████ Police to report her child missing. Not long after, neighbors to the family found the victim child floating in their swimming pool. The neighbors called the police and attempted CPR on the child until ██████████ arrived. The child was taken to Hershey Medical Center and pronounced dead on arrival. Dauphin County CYS received notification of the incident ██████████. The child's death was registered as a fatality ██████████

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed current and prior case records pertaining to the ██████████ family. Medical records were also reviewed. Follow up interviews were conducted with the Caseworker, ██████████, on August 27, 2014, September 16, 2014, and October 16, 2014. The regional office also participated in the County Act 33 meeting on August 29, 2014.

Children and Youth Involvement prior to Incident:

A general protective services case was opened with the family on May 24, 2014. The focus of the case was [REDACTED], the eldest sibling, and her acting out behaviors resulting from [REDACTED] and domestic violence in the home. The family became active with [REDACTED] through [REDACTED] and the case was closed on July 24, 2014.

Circumstances of Child (Near) Fatality and Related Case Activity:

The mother initially reported waking between 6:30-7:00 am and while getting cup of coffee, she noticed that the victim child's bedroom door was still closed. The door had been closed when she put the child to bed the evening before. The child's mother reported that she fell back to sleep around 7:15 am and when she awoke for the second time between 8:00 to 8:30 am, she noticed that the child's bedroom was open and that the child was not in her room. Upon searching for the child, the mother found the basement door open. The basement door is described as a sliding glass door with screen door. Mother noted that the family dog was missing from the home. She stated that the child was able to open the sliding glass door by herself and the dog often pushes the screen door open if the main glass door is open. It was also stated that the latches on the door "don't latch well." The mother immediately called the police to report the child as missing.

In a follow-up interview with [REDACTED], the mother admitted that she left the home at 7:00 am to meet a friend at McDonalds and returned home around 8:30. She did check on Kalesia before leaving and both siblings were also sleeping when she left. It was upon returning to the home that she found the child was missing and she called the police. It was unknown when the child left the house.

The police suspect that the victim child followed the family dog out of the house and through several yards to the neighbor's home. It is believed that the child entered the pool area through a 7 inch gap between the fence and the shed, which has since been repaired.

The Dauphin County CYS [REDACTED] determined it was common place for the mother to leave Kalesia at home in the care of her older sister. The older sister had taken babysitting classes and was certified in CPR. The mother would be available by cell phone if the teenage sibling needed to reach her mother for any reason. The mother reported that Kalesia had just started learning how to climb out of the crib. The mother was putting socks on Kalesia so her feet would be slippery and she could not crawl out of the crib until they could obtain another bed. On the date of incident, the older sibling was at home and sleeping in her room when the mother left the home. The victim child was also believed to be sleeping and unable to leave the crib without assistance. The case was made [REDACTED] on October 17, 2014 and the child's death was ruled accidental.

Current Case Status:

[REDACTED] reports an ongoing struggle with [REDACTED] issues. She became [REDACTED] after a car accident and is receiving [REDACTED] through [REDACTED]

██████████. She is ██████████ which was deemed suitable during her pregnancy. ██████████ has a criminal history involving assault, terroristic threats, and theft charges. He was serving his sentence at the ██████████ County ██████████ at the time of the victim child's death but was released a few days after the death of his daughter. The parents report being committed to staying together as a family and they reside in the home together.

██████████ gave birth to her fourth child, ██████████, on ██████████ 2014. The child was admitted the ██████████ upon birth due to his ██████████ from the ██████████ to the mother. The family was linked to ██████████ for ██████████ and the newborn was referred for ██████████ if needed.

There has been extensive family support identified both locally and from out of town who were present at the hospital upon the child's death. The maternal aunt, who is local, extended housing to the family when they felt they could not be in their home immediately after the incident. The family has since returned to their home but intends to move from the location. The mother remains active with ██████████ and ██████████ remains in place, providing ██████████ is active with Dauphin County ██████████ as he was charged after taking a knife to school last year. The case was closed with Dauphin County CYS as the family had adequate support from other community services.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Strengths:
 - The family was appropriately concerned and compliant with follow through as requested. Extensive family support was present at the hospital and safety was assured for the other children in the home. The family is looking for other housing as they are not comfortable living so close to where the incident occurred.
 - The fence was up to code and the gap was closed.
 - There was a joint response from the county investigative team members.
- Deficiencies:
 - The Act 33 meeting occurred quickly as the investigation had little time to gather all of the information that would have been useful.
 - There needs to be an increase in communication among the systems.
 - It was questioned as to whether the caseworkers who respond are receiving enough support.
 - There was a concern regarding pool safety and regulation in the county.
- Recommendations for Change at the Local Level:
 - Ensure services are extended to the family members. ██████████ services should be offered through the ██████████.
 - Increase in communication among systems.

- There should be a consult with the crisis management team to be sure that caseworkers are receiving sufficient support service in responding to fatalities.
- Recommendations for Change at the State Level:
None noted

Department Review of County Internal Report:

The County report was received on November 21, 2014. On December 12, 2014, CROCYP notified Dauphin CYS Administrator, [REDACTED], via letter that the report on Kalesia Witman was reviewed and the regional office concurred with the recommendations of the Act 33 review team.

Department of Public Welfare Findings:

- County Strengths:
The County reached out repeatedly to [REDACTED] Police but they did not offer a clear indication on their intended disposition throughout the [REDACTED] investigation time period.
- County Weaknesses:
The case record did not provide significant detail of the interview with the sibling who acts as the babysitter to the victim child. The Agency should ensure documentation reveals a detailed investigative interview.

Statutory and Regulatory Areas of Non-Compliance:

The investigation was initiated on August 22, 2014.

- [REDACTED] was first interviewed about the incident on August 23, 2014. Oral notification was not provided to [REDACTED] until October 1, 2014.
- The non-offending parent was not given oral notification until October 3, 2014.
- Written notification letters were provided to [REDACTED] and the non-offending parent on October 20, 2014. The [REDACTED] were mailed the same date, October 20, 2014.

Supervisory reviews did not occur every ten days. Twenty days elapsed between documented supervisory reviews on September 2, 2014 and September 26, 2014.

A licensing inspection summary was issued on February 2, 2015 citing the areas of regulatory non-compliance listed above. The Department will follow up with the county to assure compliance with their plan of correction.

Department of Public Welfare Recommendations:

The investigation completed by Dauphin County Children, Youth and Families was conducted in a timely fashion and in collaboration with the [REDACTED] Police Department. The Administrative review process for how CPS interviews are documented should provide a clear

explanation for the case determination, as well as assure case supervision and notification timelines are met.