pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE FATALITY OF:

**Noel Edwards**

**Date of Birth: 03/08/2016**
**Date of Death: 07/07/2016**
**Date of Report to ChildLine: 07/13/2016**
**CWIS Referral ID:** [redacted]

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

Bedford County Children and Youth Services

**REPORT FINALIZED ON:**
12/22/2016

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.

Bedford County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/05/2016.

## Family Constellation:

| First and Last Name: | Relationship: | Date of Birth |
|---|---|---|
| Noel Llewellyn Edwards | Victim Child | 03/08/2016 |
| [redacted] | Mother | [redacted]1975 |
| | Father | [redacted]1970 |

## Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged the following Bedford County Children and Youth Services (CYS) personnel to discuss the incident: the Director, the Casework Supervisor, and the Caseworker.

CROCYF Human Services Program Representative attended and participated in the Act 33 meeting that occurred on 08/05/2016 in which children and youth personnel, an Assistant District Attorney, and a victim advocate were present and provided information regarding the incident.

## Children and Youth Involvement prior to Incident:

Bedford County CYS representatives reported that the agency did not have prior involvement with the family.

## Circumstances of Child Near Fatality and Related Case Activity:

Bedford County CYS was not immediately notified of the fatality of the victim child. On 07/13/2016, the agency's Director became aware of the child's death a week after the incident via [redacted] The agency then engaged [redacted] to obtain

background information surrounding the incident. The agency did commence an investigation immediately and agency stakeholders completed an internal review to ensure that the agency did not receive a telephone call / report of about the child's death. The leadership of Bedford County CYS stated that [redacted] did contact the agency on 07/08/2016 to inquire if the agency had any involvement with the family but that it was never communicated to the agency's screener that a child had died. [redacted] stated that [redacted] made attempts to contact ChildLine on the day of the child's death, 07/07/2016, but she was placed on "hold" for an extensive amount of time and discontinued the telephone call. Then on 07/08/2016, [redacted] contacted Bedford County CYS since the contact with ChildLine was not successful. [redacted] was successful in contacting ChildLine on 07/13/2016 in order to file the report of the victim child's fatality.

[redacted] stated that the victim child's mother reported that the child was left sleeping in a bed, and that blankets and pillows were surrounding the baby, but that she moved them away from the child. Mother reported [redacted] that she came back into the room and found the child with a pillow over his face and unresponsive. The child was in the bed unsupervised for approximately 15-20 minutes. It was reported that cardiopulmonary resuscitation (CPR) started at the house, the child was then transported to the hospital, and child was pronounced dead upon arrival to the hospital. It was reported that a Pack and Play was in the room, but the parents co-sleep with the child if he woke up after being placed in the Pack and Play. It was reported that the child did have a diaper that was saturated in urine upon death and that he had red marks on his buttocks, possible diaper rash upon death.

[redacted] stated the home conditions were not adequate and described the conditions as extreme filth, smelled of urine, unkempt, and a significant amount of animals in the home. The child was in the care of both parents who were present in the home at the time of the incident. The child was transported to Western Maryland Health System in Cumberland, Maryland via [redacted] An autopsy was conducted on the child in Baltimore, Maryland.

[redacted] Bedford County CYS's assigned caseworker did collaborate [redacted] to notify and interview the parents on 08/30/2016.

During the interview, the victim child's mother stated that she relocated from Florida to Pennsylvania during 2007 and moved into a home that was owned by her mother. The father of the victim child stated that he moved from Florida to Pennsylvania during June 2015. The biological mother stated that she laid the child on the parent's bed for a nap. She stated that the child had been crying and appeared tired. She continued to state that a friend was visiting and she spent 10 to 15 minutes engaging the friend. The mother stated she returned to the bedroom to find the child with a pillow on top of his face and that she reported that the child was not breathing. She said that the pillows were out of the reach of the victim

child when she put him down for a nap and that she doesn't know how the pillow would have been on his face.

On 09/09/2016, Bedford County CYS defined the status of the case as [redacted] Bedford County CYS has requested child welfare records from the State of Florida, but at the time of this report, no information has been received. There were reports that the preliminary autopsy results have ruled out sudden infant death syndrome (SIDS) and external head trauma, but [redacted] and the CYS agency continue to await the full autopsy report and toxicology reports.

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

- Strengths in compliance with statutes, regulations and services to children and families

  The Act 33 Team did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

**Department Review of County Internal Report:**

The CROCYF received the Bedford County CYS Child Fatality Child Review Team Summary on 11/10/2016. Upon review of the report, CROCYF assessed that the documentation efficiently described the incident, the actions taken by the agencies involved, and the current status of the case. There were no issues or concerns regarding the content of the report.

## Department of Human Services Findings:

- County Strengths:

  The agency was effective in communicating with CROCYF personnel about the child's death and subsequently agency activities involving the case.

- County Weaknesses:

  Although Bedford County CYS collaborated with law enforcement and cooperated with their request to delay interviewing the parents and relevant parties who were in the home at the time the incident occurred; the agency failed to interview a family friend who was a relevant potential witness to the incident prior to making a case determination. Bedford County CYS interviewed the victim child's parents on 08/30/2016 and case determination occurred on 09/09/2016, but without the family friend being interviewed.

  During the Act 33 meeting that was convened on 08/05/2016, the attendance was minimal and the room where the meeting occurred did not allow for effective exchange of information, concerns, etc. due to the room's expanse size and seating arrangements.

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

  **3490.55**(d) (5) – There was no evidence that Bedford County CYS interviewed a person(s) who are known to have or may reasonably be expected to have information relating to the incident (eyewitness to the suspected child abuse).

## Department of Human Services Recommendations:

While Bedford County CYS conducted an investigation in collaboration with law enforcement, it is recommended that the agency review and establish quality oversight to comply with regulations focused on investigations of reports of suspected child abuse.

Though the need to convene Act 33 meetings is infrequent, Bedford County CYS would benefit by reviewing the membership to ensure that a wide range of specialties and competencies are represented (medical, legal, law enforcement, social services, community, etc.). The agency may want to explore how invite notices are generated to ensure effective attendance and increased participation along with reviewing what environment the Act 33 meeting is convened in.