pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Josiah Anderson

Date of Birth: 08/24/2018
Date of Death: 06/12/2019
Date of Report to ChildLine: 06/12/2019
CWIS Referral ID: [redacted]

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

Dauphin County Children and Youth Services

REPORT FINALIZED ON:
12/19/19

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.

Dauphin County Children and Youth (DCCYS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on June 28, 2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Jasiah Anderson	Victim Child	08/24/2018
[redacted]	Father	[redacted]1997
	Uncle	1997
[redacted]	Mother	[redacted]2000

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff conducted interviews with the Dauphin County Children and Youth intake caseworker. This interview occurred on 09/11/2019. A review of the initial report and law enforcement involvement was reviewed.

Summary of circumstances prior to Incident:

There were no prior reports regarding this family.

Circumstances of Child Fatality and Related Case Activity:

A referral was received by DCCYS on 06/11/2019 regarding the victim child. [redacted] dropped the victim child off at [redacted] residence on 06/10/2019 at 8:00 am. [redacted] called [redacted] on 06/11/2019 and [redacted] picked the child up. The child's clothes were too small and dirty. [redacted]

[redacted]

DCCYS received the [redacted] referral on 06/12/2019 [redacted] regarding the victim child and [redacted] The information provided was that [redacted] found the child in cardiac arrest and called emergency medical services. The child was being transported via ambulance to [redacted] hospital due to being in cardiac arrest. The victim child was pronounced deceased at 4:42pm on 06/12/2019 at the hospital.

[redacted] stated that the victim child was found headfirst off the side of the bed closest to the wall. [redacted] reported that next to the bed, between the mattress and the wall, was a laundry basket that was piled full of clothing, which prevented the child from falling entirely off the bed. However, during the reenactment with law enforcement, the basket was only one-third of the way full. Also, during the reenactment, [redacted] also reported that [redacted] fed the victim child a bottle in the bedroom, prior to laying him down for a nap, but stated that [redacted] could not locate the bottle in the bedroom.

On 06/13/2019 an autopsy was conducted. During the autopsy, the [redacted] first observation was a “pressure mark” on the back of the victim child’s head. [redacted] requested that law enforcement obtain the laundry basket from the home to see if this basket could have caused the pressure mark. After obtaining the laundry basket, it was determined that the pressure mark could not have been caused by any part of the laundry basket. It was also determined through demonstration, that due to the weight of the victim child’s head and upper body, the child would not have been able to lay halfway off the bed without falling off completely, and thus [redacted] explanation of how [redacted] first found the victim child was implausible. The autopsy revealed a significant amount of hemorrhages throughout the child’s body.

On 06/18/2019 the agency received a call from [redacted] who spoke with [redacted] who preliminarily ruled the victim child’s death as a homicide. [redacted] provided information from [redacted] who stated this decision was made, after making the observation, that the victim child’s “whole body” was compressed at some point and that there were compressions to the victim child’s neck and esophagus along with white blood cells found around all the hemorrhages that were collected and examined. On 06/27/2019, a follow up interview was conducted by law enforcement. There was minimal information provided to [redacted] related to the injuries that were observed on the child and it was explained that the initial story that was presented by [redacted] was not plausible. [redacted] then stated that [redacted] did not find the victim child halfway off the bed, but the whole way in the laundry basket. [redacted] adamantly denied causing any injuries to the victim child.

On 08/11/2019 the agency [redacted] lack of formal autopsy report regarding cause of death.

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:
  Children and Youth responded immediately with law enforcement to the hospital when referral was received to begin the joint investigation following protocol procedures.
  Contact was immediately made with [redacted] and preliminary interviews conducted
  Throughout the completion of [redacted] there was open communication between Dauphin County Children and Youth, [redacted] Police Department. CDRT Act 33 meeting took place and all these agencies were represented.
  Police reports and medical records including photos were shared among team members. Dauphin County Children and Youth updated the team regarding progress and service actions.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  CYS was not given adequate information from the [redacted] related to the findings at the autopsy.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  None

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:
  Establish [redacted] a protocol to expedite receipt of requested medical records. [redacted] will send an email regarding the problem.

Department Review of County Internal Report:

The report was received on 09/16/2019. There were no issues or concerns regarding the county report and the agency concurs with its finding.

Department of Human Services Findings:

- County Strengths: The county agency investigation complied with regulations and response times as required.

- [redacted]County Weaknesses: The circumstances of this case and the review of the [redacted]

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no areas of non-compliance found during the review of this case.

Department of Human Services Recommendations:
None