pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Saleem Friend

Date of Birth: 07/17/2016
Date of Death: 04/30/2017
Date of Report to ChildLine: 04/30/2017
CWIS Referral ID: [redacted]

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

Lycoming County Children and Youth

REPORT FINALIZED ON:
12/28/2017

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.

Lycoming County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/25/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Saleem Friend	Victim child	07/17/2016
[redacted]	Biological Mother	[redacted]1989
[redacted]	Biological Father	[redacted]1991
[redacted]	Full sibling	[redacted]2013
[redacted]	Full sibling	[redacted]2015
[redacted]	Paternal uncle	[redacted]1989

*[redacted] was not residing in the home at the time of the death of the child; [redacted] was incarcerated.
** [redacted] is not a household member, but was present in the home the day of the fatality.

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. A discussion occurred with the Director of Special Programs on 05/01/2017 and 05/09/2017. The CRO did attend the Act 33 meeting on 05/25/2017.

Children and Youth Involvement prior to Incident:
Lycoming County Children and Youth (LCCY) became involved with the family on 12/19/2013. [redacted] was domestic violence. The agency responded to the family home and learned that [redacted] had left the home with [redacted] The agency was able to [redacted] had a verbal and physical dispute and [redacted] voluntarily left the home. [redacted] The agency advised [redacted] to file for formal custody to prevent disputes over physical

custody of the child in the future but [redacted] declined. [redacted] also declined agency services and the case was closed on 01/16/2014.

On 04/23/2015, the agency received [redacted] and smoking marijuana during [redacted] for these substances. [redacted] denied [redacted] any substances while [redacted] are in [redacted] care. [redacted] but [redacted] declined services and [redacted] on 05/15/2015.

On 08/17/2015, [redacted] reached out to the agency and requested Family Support Services. The agency was able to connect [redacted] to community supports. [redacted] needs were being met and no safety concerns were noted. The family requested this service be closed on 09/01/2015 due to having everything they need.

On 09/16/2015, the agency received [redacted] for inadequate health care and domestic violence. It was alleged that [redacted] were not attending [redacted] During the assessment period, the agency learned that [redacted] was in the process of moving and missed or rescheduled several appointments. [redacted] moved within walking distance of [redacted] and no concerns were noted. [redacted] both denied domestic violence and the agency [redacted] the agency closed the assessment on 11/10/2015.

On 07/18/2016, the agency received [redacted] admitted to smoking marijuana [redacted] with the victim child. [redacted] stated that [redacted] has medical issues and marijuana was the only thing that allowed [redacted] denied regular use of marijuana. During this assessment; [redacted] in other states. [redacted] was incarcerated for shoplifting; out of jail for 4 days before violating [redacted] probation and was incarcerated again. [redacted] requested outreach services to help [redacted] get services around for [redacted] before [redacted] returned to [redacted] care. The agency closed this referral on 09/13/2016 after connecting [redacted] with community resources.

<u>Circumstances of Child Fatality and Related Case Activity:</u>

Lycoming County Children and Youth Services (LCCYS) received [redacted] from Childline on 4/30/2017 stating that the victim child presented to the [redacted] Hospital with cardiac arrest. [redacted] Initially [redacted] brought the child to the [redacted] Hospital after finding the child not breathing and turning purple at his residence. [redacted] Hospital was able to resuscitate the child and subsequently transferred the child to [redacted]. During the child's medical examination at [redacted] observed retinal hemorrhaging in the

back of the child's both eyes. [redacted] there is only one mechanism by which the child can sustain retinal hemorrhaging. Specifically, the child was "shaken". [redacted] the suspicions regarding the shaking of the child. [redacted] recently regained custody of the victim child. [redacted] to the child; however, [redacted] stated that [redacted] is the sole adult solely responsible for the child at [redacted] home since regaining custody of the victim child. [redacted] also reported that the child was "fussy" that day. [redacted] that the hemorrhaging incident is as recent as the incident that occurred. [redacted] that the shaking of the child contributed/lead to the child's cardiac arrest. [redacted] was searching for other medical causes that could explain the child's cardiac arrest. [redacted] denied any prior medical complications that could explain the child's cardiac arrest. The child's prognosis was poor and the child sustained cardiac arrest three times within 4 hours. At approximately 11:15PM, the child was pronounced deceased [redacted]

Law Enforcement was notified and worked collaboratively with LCCYS to do joint interviews. The agency became aware that there were [redacted] that were not home during this incident. Those [redacted] for the day. The agency immediately assessed their safety once their location was identified and put a safety plan in place that [redacted] must be supervised at all times with [redacted] were all approved to supervise any contact that [redacted] would have with [redacted]

During the interview with [redacted] it was learned that [redacted] was in the home and is the one who called 911. [redacted] was then added to the safety plan that he could not have any unsupervised contact with the [redacted] reported that the child was watching the television when the television shut off. The victim child began to cry because he likes to watch television. [redacted] reported that [redacted] fed the victim child a bottle while the [redacted] was working on the television and then took the victim child to his room for a nap. [redacted] reported that [redacted] swaddled the child in his blanket like [redacted] normally would do and the child seemed fine. [redacted] then reported that [redacted] went downstairs and was reading a book while [redacted] played video games. [redacted] reported that [redacted] went to check on [redacted] about 15 to 20 minutes later and that is when [redacted] found [redacted] face down and [redacted] was a purple color. [redacted] reported that [redacted] then got the victim child and took him downstairs and the victim child vomited but described it as the formula falling out of the victim child's mouth. [redacted] stated that [redacted] decided to run the victim child to the hospital because [redacted] lived so close; however, [redacted] called 911 and called for [redacted] to come back in the house and perform CPR on the victim child. [redacted] reported that [redacted] only did one compression before the ambulance arrived and took over. Law Enforcement shared with [redacted] that there is no natural cause for the child's death. [redacted] was adamant that it was just a normal day and [redacted] was the sole caretaker for the child. As noted above, [redacted] was incarcerated at the time of this incident and did not have any contact with the children.

Therefore, [redacted] was not able to offer any information with regards to this investigation.

[redacted] No criminal charges have been filed at this time; they are waiting for the completed forensic autopsy as well. [redacted] are residing with [redacted] obtained custody of the children and LCCYS made a referral to that state for a courtesy visit. LCCYS received a positive report from North Carolina regarding [redacted] and that they are doing well.

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;

  The family has been cooperative with the investigation with the agency and police. [redacted] cooperated with the safety plan put into place for [redacted] cooperated with interviews with the police and agency.

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

  No deficiencies were noted.

- 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 team did not feel there were interventions that could have been made by LCCYS to prevent this fatality. No additional recommendations were made

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

  None reported

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

  If this death is the result of shaken baby, possibly proper parenting may have prevented this death if the family received this training prior to leaving the hospital at the time of birth.

Department Review of County Internal Report:

The Lycoming County Child Death Review Team held an Act 33 meeting on 05/25/2017 where medical and case information were presented. The county report of the Act 33 meeting was received by the CRO on 06/19/2017. On 06/21/2017, the CRO sent correspondence to the LCCYS Administrator, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:

  The agency responded to the referral immediately.
  Agency personnel conducted joint interviews with Law Enforcement and communicated well with each other.
  The agency's Act 33 meeting was well represented by county personnel, medical providers, and law enforcement. The meeting was very thorough.
  The agency utilized family to assure safety of the siblings.

- County Weaknesses: and

  None noted.

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

  After review of the file, the agency was found to be in compliance with statutory and regulatory requirements.

Department of Human Services Recommendations:

The department does not have any recommendations at this time.