REPORT ON THE FATALITY OF:

Killien Gibson

Date of Birth: 04/20/2018
Date of Death: 05/20/2018
Date of Report to ChildLine: 07/31/2019
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
02/18/20

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))

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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.

Lebanon County Children and Youth Services (LCCYS) convened a review team in accordance with the Child Protective Services Law related to this report. The review team convened on 08/27/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
	Biological Father	1993
	Biological Mother	1984
	Sibling	2017
	Sibling	2016
Killien Gibson	Victim Child	04/20/2018

*Denotes a family member that was not living in the home at the time of the incident.

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. The CROCYF representative engaged the Lebanon County Children and Youth Services Supervisor and Caseworker to discuss the incident. The Human Service Program Representative also attended the agency's Act 33 meeting on 08/27/2019.

Summary of circumstances prior to Incident:

On 10/21/2016 a report regarding inadequate shelter was made to the agency. Specifically, it was reported that the house smelled bad. On 11/01/2016, after face to face contact was made, by the agency.

The agency received another referral on 01/05/2018 regarding inadequate food, clothing, and poor hygiene. That report was determined to be valid on 02/21/2018 and the family was accepted for In-Home services due to inadequate shelter, poor hygiene, and

The family was homeless and lived for some time in a shelter and eventually with a family member until the agency was able to help them secure a small two-bedroom apartment. was then incarcerated for not paying child support for was left to provide care to the three children, including the victim child, alone. The agency visited the home weekly to monitor the children and provided support The agency provided transportation for to various medical appointments.

The victim child passed away unexpectedly on 05/20/2018 while asleep in his home. While the cause of death was unknown at that time, the initial autopsy determined the cause of death to be asphyxiation with no suspicion of child abuse or neglect. The presented as unclean and did not appear to be receiving proper care. As a result, they were placed with relatives on a safety plan to whom later signed over guardianship.

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

On 07/31/2019 LCCYS received an addendum to the original autopsy that stated that the sleeping environment, specifically the sleeping position of the child, contributed to the death. This was numbered on 07/31/2019 by ChildLine as a and Fatality report for LCCYS.

In initial interviews done by LCCYS, reported that swaddled the victim child and placed him in the bed with a few pillows on one side, but forgot to prop him on the other side to keep him from rolling over on his face. then reported that left the room to call someone to watch the children so could go to the store and when returned to the bedroom the child was deceased.

initially told law enforcement that placed the child in the bassinet, swaddled and face up. later admitted that swaddled the child and placed him face down because the child would otherwise be fussy. reported that fell asleep from 11:00 AM to 4:00 PM and when awoke, the child was deceased. also admitted that waited about a half hour after found the child not breathing to call emergency responders because was afraid and did not know what to do.

Law enforcement, through forensics completed on the cell phone, were able to determine that had not been sleeping all day but rather had been on cell phone for most of the day. then confessed that was so preoccupied by having internet access that forgot about the victim child, who had been swaddled and placed face down as had been fussy. was then afraid to call the police when found the child not breathing.

There was speculation that the father may have tampered with the scene as photographs of the basinet and surrounding area taken a few days before the death are different than those taken on the day of the death. Specifically, in earlier

photographs it appears that there were too many things in the bassinet for the victim child to fit safely. It is believed that the victim child was placed in the bassinet after he was found deceased It was also reported by collateral contacts that the child was seen face down on the bed at different times.

had access to familial supports but did not use them according LCCYS. There was suspicion of substance use however, all tests were negative. The agency history also showed that had limited interactions with the children.

The agency report on 08/27/2019 and listed had been in prison since August 2019 on $25,000 bail for child endangerment related to the death of the victim child.

was released from jail in June 2019. were eventually evicted for failure to pay rent in August 2019. is mostly consistent about visiting with the children at the agency since June 2018. did not start visiting the children until March 2019. have not completed the goals of the Family Service Plan. The children remained with the relatives and they have moved forward to obtain legal custody. agreed to the children being placed in the custody of the relatives and will be signing over custody.

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;

Several strengths were noted during this investigation. Children and Youth was very involved with the family making sure that all needs of the infant were being met as well as trying to support engages with the children during visits. Support was present through both the parental and maternal families.

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

Deficiencies appeared in the form of Although support was available to he didn't utilize it and there has been little movement toward reunification as not much has been done to move the service plan forward.

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

  There are no recommendations to change the overall review process. Positive communication and collaboration exists among the county systems to work for the betterment of the families involved and ensures investigations are conducted within a timely manner.

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

  -None Identified.

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

  -None Identified.

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting report was received by CROCYF on 11/27/2019. The CROCYF representative attended the act 33 Child Near-Fatality Review Team meeting on 08/27/2019 and finds the county's report to be representative of what was discussed at the meeting.

Department of Human Services Findings:

County Strengths: The agency responded immediately and completed the investigation in a timely manner.

County Weaknesses: At the time of this report, CROCYF has not identified any County weaknesses.

Statutory and Regulatory Areas of Non-Compliance by the County Agency. At the time of this report, CROCYF has not identified any area of non-compliance.

Department of Human Services Recommendations:

- It is important to provide all caretakers education on safe sleep.