

REPORT ON THE FATALITY OF:

Daniel Howarth

Date of Birth: 09/09/2021
Date of Death: 01/07/2022
Date of Report to ChildLine: 01/07/2022
CWIS Referral ID:

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

Bucks County Children & Youth Social Services Agency

REPORT FINALIZED ON: 06/07/2022

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.

Bucks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on April 04, 2022.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Daniel Howarth	Victim Child	09-09-2021
	Sibling	2018
	Maternal grandmother	1964
	Mother	1999
	Father	1996

^{*} 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.

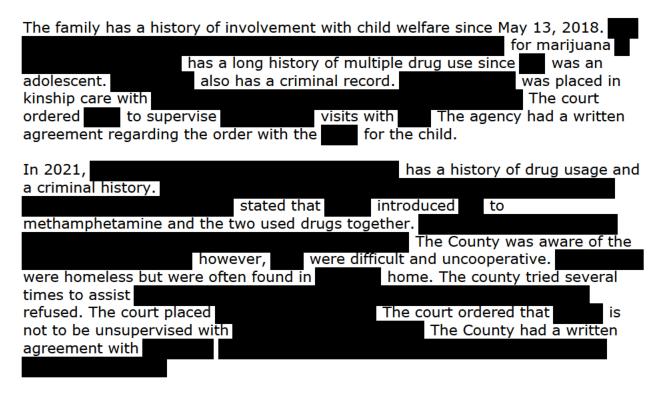
Summary of OCYF Child (Near) Fatality Review Activities:

and obtained verbal and written statements along with the autopsy report.

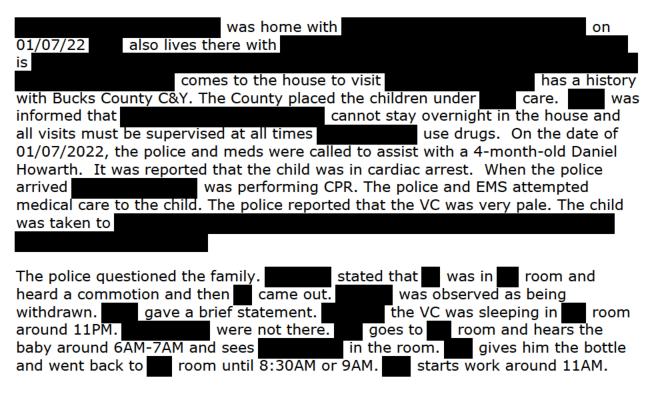
The Southeast Regional Office of Children Youth and Families (SERO) reviewed the historical documents from Bucks County Children & Youth Social Services. The SERO representative attended the Act 33 review. The Act 33 review took place on April 04, 2022, via SKYPE due to COVID-19.

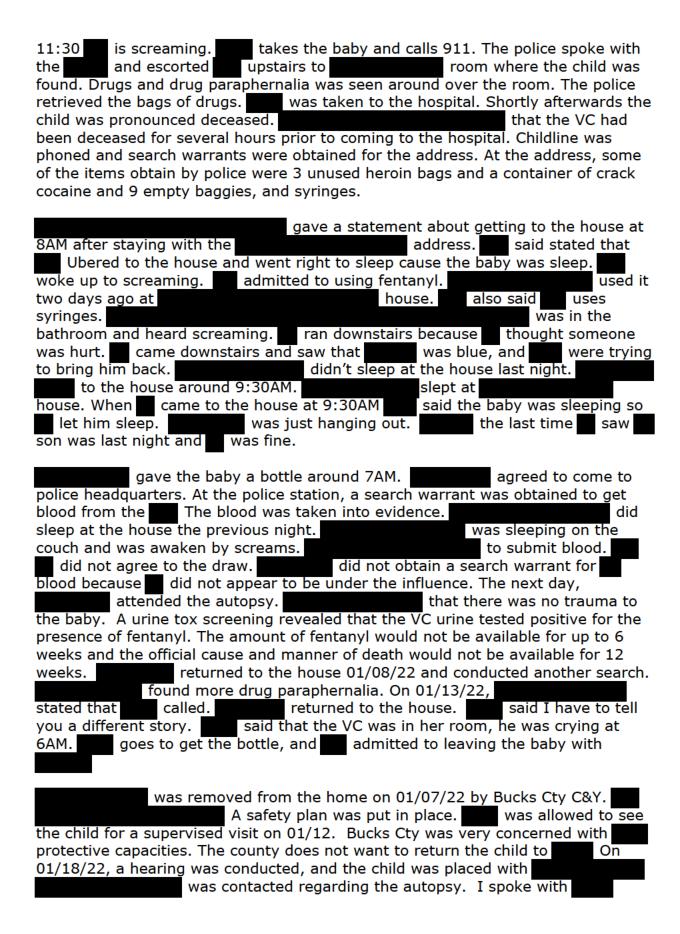
Prior to the Act 33 review team meeting the members of the team reviewed the case summary, referral information, investigation materials and medical information. During the Act 33 review, the medical personnel described all tests and exams completed and responded to questions from the team. Law enforcement was present as well and responded to questions. The caseworker and supervisor were present and were available to be interviewed by the team.

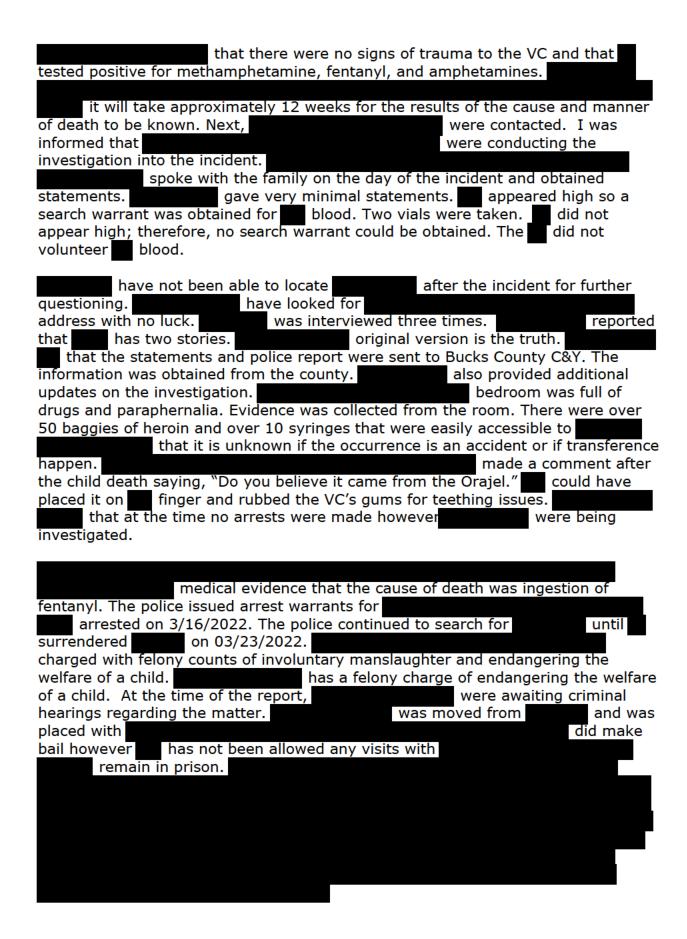
Summary of circumstances prior to Incident:



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







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

•	Strengths in compliance with statutes, regulations, and services to	<u>2</u>
	children and families;	

0	Collaboration and cooperation amongst Children and Youth, Local
	Police, and
0	All parties were responsive relative to regulations regarding child
	abuse investigation and criminal investigation.
0	Child abuse and neglect response times were consistently met within
	state regulations.
0	competently and quickly in
	securing evidence and taking statements from witnesses.
0	The Agency had consistently been clear and consistent with the
	about the specific meaning of "supervised
	contact" between the child(ren)
0	The local hospital acted competently in administering a drug test at

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

the emergency room department.

o If a child is currently under the custodial supervision of a county child welfare agency, all rooms should be thoroughly checked in the home at every home visit. Specific attention should also be given to kinship foster families where parental contact is to be supervised by the foster parent or extended kinship resources.

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

- Provide parental education resources, supportive services, and resource information to caregivers with diminished protective capacities or history of substance abuse.
- o Maintain communication with, and develop strategies with, the court system to maintain accountability with parents who do not make

progress in completing goals of their Family Service Plans. Move forward to promote timely goal change hearings and termination of parental rights when applicable.

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

- All rooms of the foster home should be thoroughly checked regularly, particularly in complicated kinship placements.
- Services and medical testing should be mandated for sibling children of a victim child in cases of serious child abuse and/or neglect.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - None noted at this time.

Department Review of County Internal Report:

On June 10, 2022, the SERO received the county Internal Report. The report was reviewed and found to be a through review of the investigation and fatality of the child.

Department of Human Services Findings:

County Strengths:

The County made numerous visits to the home.

The county had an immediate response when the fatality was reported.

The County worked well, closely, and swiftly with the police and district attorney to gather and share information.

The County acted quickly to remove the sibling form the home. The police secured the home and interviewed swiftly.

The police had the blood tested immediately.

The County assisted the State investigator by providing documentation, records, and other requested information.

County Weaknesses: and

The County did not do a complete inspection of the home prior to the incident. The County worker had an unannounced visit at the home the day before the fatality and would have seen the room where the VC was found. The room was filled with drugs and drug paraphernalia.

The county did not report the sibling's welfare to Childline. The police reported that the sibling could have easily obtained the drugs and the drug paraphernalia.

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

There were none noted.

Department of Human Services Recommendations:

The County must complete a total home inspection for all homes. A full inspection can reveal unknown circumstances in the home and allow the county to prevent and/or address unforeseen matters.

Licensing agency (SERO) can mandate the inspection of all rooms in a home and have a designated checklist that must meet a 100% compliance by the county. If the county/agency is non-compliant then high monitoring and/or revocation can be enforced.

There should be more accountability of the county when parents do not comply with referred services. Reports should be provided for 60 days on the status of the case to supervisors and management so that recommendations and adjustments can be taken to resolve the concerns.

A statewide hotline for substance abusing parents should be provided to those who need support and guidance regarding their addiction and parenting concerns. The hotline could provide verification to the county that the parents are compliant without being penalized.

Children under age 5 are extremely vulnerable. The county should provide a designated worker that is focused on the child's physical, emotional, and other needs to eliminate a substance born child barriers and concerns. The worker should have routine assessments of the child's progress and provide recommendations for concerns that need to be addressed.