pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Serenity Palmer

Date of Birth: 12/24/2016
Date of Incident: 03/10/2019
Date of Death: 03/14/2019
Date of Report to ChildLine: 03/10/2019
CWIS Referral ID: [redacted]

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

Washington County Children and Youth Social Service Agency

Cumberland County Children and Youth Services

Franklin County Children and Youth Services

REPORT FINALIZED ON:
01/04/20

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))

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.

Franklin County Children and Youth Services (FCCYS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 04/11/2019. Cumberland County Children and Youth Services was present and Washington County Children and Youth Social Service Agency participated by telephone.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Serenity G. Palmer	Victim Child	12/24/2016
[redacted]	Mother/Perpetrator	[redacted]1990
	Half Brother	2008
	Half Sister	2011
	Half Brother	2012
	Full Sister	2015
	Mother's Paramour	1988
	Father	1989

*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 (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged the FCCCYS Assistant Administrator to discuss the incident. CROCYF Human Services Program Representative attended and participated in the Act 33 meeting that occurred on 04/11/2019.

Summary of circumstances prior to Incident:

Washington County Children and Youth Social Service Agency History:

[redacted] were living in a one-bedroom apartment [redacted] slept

on the floor. [redacted]

[redacted]

On 01/26/2015, WCCYS received [redacted] with concerns that [redacted] children were homeless [redacted] and WCCYS opened the family for in-home services. The family was stabilized, and the case was closed 02/19/2016.

[redacted]

[redacted]

On 01/23/2017, WCCYS received [redacted] with concerns that children were missing school and concern that [redacted] declined services offered to help with attendance issues. The case was accepted for investigation and closed on 04/10/2017 when truancy issues resolved**.**

[redacted]

On 06/26/2018, WCCYS received [redacted] from Cumberland County Children and Youth Services who had been opened with the family when they moved back to Washington County. The case was accepted for services based on this referral. The home was assessed to be appropriate, [redacted] and were enrolled in school. There were no concerns noted and case was closed on 08/24/2018.

Cumberland County Children and Youth Services History:

On 04/16/2018, [redacted] was received with allegations that [redacted] recently moved to Cumberland County to [redacted] lived in the home of [redacted], but [redacted] said that [redacted] were not permitted overnight so [redacted] rented a room in a local motel. [redacted] Cumberland County Children and Youth Services (CCCYS) put [redacted] in the home to address issues and to get [redacted] in school. The family then moved to Washington

County before CCCYS could ever do a thorough assessment. CCCYS made a referral to WCCYS.

Franklin County Children and Youth Services History:

[redacted]

FCCYS had no contact with the family and [redacted] until the child abuse/child death incident on 03/10/2019.

Circumstances of Child Near Fatality and Related Case Activity:

[redacted] took the victim child to the [redacted] Hospital [redacted] Pennsylvania in the late evening of 03/10/2019 when [redacted] found her to be cold and unresponsive in her crib just three hours after [redacted] initially put the child down for bed. At the hospital, the victim child was unresponsive and had to be resuscitated several times until she regained consciousness. It was noted that the victim child had bruising all over her body including a large hematoma on her forehead as well as bruising to her cheek. [redacted] was unable to provide the hospital with an explanation for the injuries on the victim child [redacted]

[redacted] Hospital certified the victim child to be in critical condition based on the suspicion of child abuse or neglect. The victim child was placed on a ventilator and transported to [redacted] in [redacted] On 03/10/2019, the report was listed as a [redacted] for FCCYS as well as a near fatality for the CROCYF. [redacted] on 03/11/2019, within hours of receipt of the [redacted] report.

The victim child arrived to [redacted] in the early morning hours of 03/11/2019 and upon arrival, 'coded' for 12 minutes. Cardiopulmonary resuscitation (CPR) was performed, and she was given four rounds of Epinephrine. She coded again for 16 minutes while being transferred from the emergency department to the Pediatric Intensive Care Unit (PICU). CPR was performed again, and another three rounds of Epinephrine were administered.

At [redacted] the victim child presented with a healing left posterior 7th rib fracture, significant retinal hemorrhages in both eyes, bleeding on the brain (which was

attributed to shaking), a skull fracture, and bruising to the right ear. The victim child's prognoses at that time was poor.

Brain death testing was completed on 03/13/2019 and again on 03/14/2019. The victim child was brain dead both times and the date and time of death was listed at 12:30 PM on 03/14/2019. [redacted] It was believed that the fatal injury would have occurred on 03/10/2019.

The [redacted] Police Department immediately began to investigate the report. [redacted] reported that the victim child had fallen face first outside of a fast food restaurant earlier in the evening of 03/10/2019. [redacted] reported that in the bathtub that evening the victim child was not acting right so [redacted] splashed water on the child while squeezing her cheeks. [redacted] also reported that the child fell forward twice while in the bathroom and hit her head on the floor both times.

[redacted] was charged with aggravated assault, simple assault and endangering the welfare of a child and was taken to [redacted] County Jail. The charges were upgraded to include criminal homicide when the victim child passed away.

[redacted] has been criminally cleared of wrong doing. [redacted] reported to police that the victim child did not fall at a fast food restaurant and that [redacted] beat [redacted]

[redacted] on 04/23/2019. [redacted] remains incarcerated.

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

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;
    - Once the agency was notified, all entities involved in this investigation communicated and information was discussed. Franklin County Children and Youth Service, the [redacted] Police Department, [redacted] communicated and shared information regarding the investigation.
- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>;
    - This Review Team found that there was no other type of intervention that could have helped or anything else that could have been done due to the family's instability in permanent County residency.

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

    - Reach out to area motels/hotels with information on when to contact Franklin County Children and Youth Service and/or PA ChildLine if there are issues or concerns of child abuse and/or neglect of children who are guests of the motel/hotel.

- 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 CROCYF received the FCCYS Child Near Fatality Child Review Team Summary. Upon review of the report, CROCYF assessed that the documentation efficiently described the incident, the actions taken by the agencies involved, and the status of the case. There were no issues or concerns regarding the content of the report. Written feedback was provided to FCCYS accepting the report.

Department of Human Services Findings:

- County Strengths:

    - FCCYS responded to the referral immediately. FCCYS personnel worked closely with the medical team and law enforcement to thoroughly assess and investigate the allegations.

    - FCCYS' Act 33 meeting was well represented by county personnel, medical providers, and law enforcement.

    - CCCYS was able to put [redacted] in place by 05/02/2018, while case was still at the intake level.

- County Weaknesses:

    None noted.

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

After review of the file, it was noted that the county did not hold an Act 33 Child Death Review Team Meeting within 30 days of the date of the oral report. The Near Fatality report was made on 03/10/2019 and the Act 33 Child Death Review Team was held on 04/11/2019, two days beyond the 30th day. The agency was issued a Licensing Inspection Summary.

Department of Human Services Recommendations:

The Department Agrees with FCCYS recommendation to reach out to area motels/hotels with information on when to contact County Children and Youth Services and/or PA ChildLine if there are issues or concerns of child abuse and/or neglect of children who are guests of the motel/hotel.