REPORT ON THE FATALITY OF:

Logan Starliper

Date of Birth: 11/11/2014
Date of Death: 01/06/2018
Date of Report to ChildLine: 01/12/2018
CWIS Referral ID: [redacted]

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

Franklin County Children and Youth Services

REPORT FINALIZED ON:
07/02/2018

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))

Department Human Services/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772.7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696.6180
www.dhs.state.pa.us

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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 01/31/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
	Mother	/1989
	Father	/1985
Logan Starliper	Victim Child	11/11/2014
	Mother's Paramour	/1988
	Half Sibling	/2008

*Did not reside in the child's home and was not a caretaker for the child. He is now deceased.

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYF, reviewed the Franklin County Children and Youth Services, (FCCYS), investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and case dictation. Interviews were conducted with the agency caseworker and supervisor in January and February 2018.

Children and Youth Involvement prior to Incident:

FCCYS was previously involved with the family prior to receiving the report on 01/12/2018. Prior reports involving this child began in 2014 and are outlined below.

11/12/2014 to 12/17/2014: FCCYS received a report that during the with the child the for drugs twice. The assessment was closed after the investigation and

03/16/2017 to 03/22/2017: A [redacted] assessment was conducted based on allegations that the [redacted] was verbally and physically abusive to the child's [redacted] grandmother and the child. The investigation found no injuries to the child and the [redacted] the allegations. The case was then closed.

07/01/2017 to 08/29/2017: FCCYS received a referral alleging that the [redacted] and [redacted] were using drugs and that the children are left unsupervised. The [redacted] the allegations and the case was closed.

Circumstances of Child Fatality and Related Case Activity:

FCCYS received this [redacted] report from ChildLine on 01/12/2018. However on 01/08/2018 [redacted] Trooper [redacted] had notified the agency of the child's death but provided that they were still gathering the circumstances behind the child's death. The Trooper indicated they were awaiting the results of the child's autopsy. FCCYS immediately met with the family in response to this notification and secured a safety plan for the child's [redacted] The [redacted] would be in the care of his [redacted] who would also supervise all contact with this child and the [redacted] The [redacted] of the child is deceased.

The [redacted] provided [redacted] version of events, stating that on the evening of 01/04/2018, the child was sick so [redacted] took her to Urgent Care. The [redacted] stated they only waited 10 minutes and left. The [redacted] had reported that on 01/05/2018, the child was sick throughout the day and did not wake up until 3:00 pm. The [redacted] reported that [redacted] put the child to bed at 10:30 pm that evening. The [redacted] reported being sick throughout that night and did not get to bed until 6:00 am on 01/06/2018 and then slept all that day. The [redacted] reported that [redacted] had checked on the child once during the day on 01/06/2018. The [redacted] stated that when [redacted] cracked the child's bedroom door open she was still asleep in bed with the covers pulled up to her neck. The [redacted] stated that at about 8:30 pm that same evening the [redacted] came to [redacted] home. The [redacted] reported that [redacted] all were outside smoking when the [redacted] inquired where the child was. The [redacted] states [redacted] then decided to go wake the child up so she would be able to sleep later that evening. The [redacted] states when [redacted] went into the child's bedroom [redacted] found her unresponsive. The [redacted] stated [redacted] then called 911. The mother states that [redacted] Police Department responded to their home. At that time the [redacted] Police Department notified the [redacted] Police of the report and requested assistance. The [redacted] Police arrived at the scene around 11:00 pm. The [redacted] Police noted the child's time of death was approximately 11:00 pm on 01/06/2018.

The results of the child's autopsy performed on 01/09/2018, determined that there were no abnormal findings, however the child's toxicology report would not be available for at least 6 to 8 weeks. On 01/31/2018, at the Act 33 Meeting, the [redacted] Police reported that the child's toxicology results were received and determined that the child had toxic drugs in her system that included Methamphetamine and

Buprenorphine which is contained in suboxone or subutex. On 02/15/2018, FCCYS obtained an emergency court order granting the agency temporary legal and physical custody of the [redacted] The [redacted] remained in the care of his emergency kinship caregiver who is his [redacted] On 03/01/2018, at the [redacted] hearing, legal and physical custody of the child was released to the [redacted] No further services for this child were requested by the [redacted] or deemed necessary by the agency. The case involving this child was then closed.

FCCYS, in collaboration and consultation with the [redacted] Police submitted this report as [redacted] on 03/09/2018. On 03/22/2018, the [redacted] were arrested on charges of third degree murder, drug delivery resulting in death, involuntary manslaughter, possession of drug paraphernalia, as well as two counts of endangering the welfare of children. The agency then concluded their investigation and submitted the [redacted] with an [redacted] naming the [redacted] as the perpetrators. The perpetrators remain incarcerated at this time.

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;

  Immediately after FCCYS was notified by law enforcement of Logan Starliper's fatality, a safety plan was implemented for [redacted] by completing family finding with [redacted] Once family was identified, the agency contacted the family to discuss the need for the safety plan. Throughout the course of the investigation, the safety plan was supported by local law enforcement.

  Not just taking [redacted] at their word for what they're going to [redacted] for during a screen and completing two drug screens in the field to determine other possible substances.

  The completion of numerous unannounced home visits, including more than one visit a week after initially receiving the referral, to continue meeting with the [redacted] and to assess with their sobriety.

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

  At the Child Death Review meeting and throughout the agency's investigation, FCCYS communicated openly with law enforcement regarding case information. However, law enforcement and the [redacted] Coroner's Office held back at disclosing information due to the criminal investigation.

  Continued education to the community and mandated reporters in regards to immediate notifications to the agency to allow determination of the risk and safety of children in the home.

- 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 were no recommendations made.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  There were no recommendations made.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  It was recommended by the Child Death Review Team that when the agency receives allegations of drug use in the home and there are concerns that child(ren) are being exposed to the drugs, the agency should take a look at drug testing the children. This would assure that the child(ren) are not ingesting any toxic substances.

  Increased follow up with other professional organizations to determine their level of involvement with the family to determine if drug use is occurring.

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting Report was received by CROCYF on 04/24/2018. The CROCYF attended the Act 33 Child Near-Fatality Review Team meeting on 01/31/2018 and was aware of the discussion, recommendations and outcome. CROCYF finds the county's report content and findings are representative of what was discussed during the meeting on 01/31/2018.

Department of Human Services Findings:

- County Strengths:
  FCCYS conducted the investigation in cooperation with law enforcement and medical services/providers. The record was comprehensive; including medical reports, interviews, risk and safety assessments, and case dictation.

- County Weaknesses:
  There were no areas of weaknesses noted in regard to the agency's investigation, however the agency should follow up on their noted concerns regarding the sharing of information from law enforcement officials.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  There were no areas of non-compliance noted.

Department of Human Services Recommendations:
FCCYS should continue to conduct thorough and timely investigations in collaboration with law enforcement, the court and medical and service providers.

FCCYS should meet with law enforcement officials to discuss the importance of immediate notifications and sharing of case information to/with the agency to allow the agency to immediately assess and determine safety of the children and to hear/discuss law enforcements concerns to the contrary.