pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Demeke Tyler

Date of Birth: 08/21/2017
Date of Death or Date of Incident: 07/19/2019
Date of Report to ChildLine: 07/19/2019
CWIS Referral ID: [redacted]

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

Northumberland County Children and Youth Services

REPORT FINALIZED ON:
1/30/2020

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.

Northumberland 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 08/13/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Demeke Tyler	Victim child	08/21/2017
[redacted]	Biological mother	[redacted]2000
	Biological father	[redacted]1998
	Maternal grandmother	[redacted]1959

* 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 (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff participated in the Act 33 meeting and conferred with Northumberland County Children and Youth Services (NCCYS) staff involved with this case.

Summary of circumstances prior to Incident:

On 12/07/2017, NCCYS received [redacted] on the family. There were concerns that [redacted] family was not accepted for services as [redacted] was not observed exhibiting any inappropriate behaviors nor were any [redacted] concerns received for [redacted] did not appear to be a safety threat to her child and was receiving support of [redacted] in caring for the victim child.

On 12/13/2017, NCCYS received [redacted] on the family. [redacted] While law enforcement officials were at the home of [redacted] due to [redacted]

[redacted] The agency intended to open the family for services for [redacted] stating [redacted] would not work with the agency on anything and [redacted] was not living in the home of the child, the family was not accepted for ongoing services. [redacted] was charged with Simple Assault, Endangering the Welfare of a child and Aggravated Assault (disposed of at lower court). The next court action in regard to the remaining charges of Simple Assault and Endangering the Welfare of a Child will occur on 01/27/20.

Circumstances of Child Fatality and Related Case Activity:

On 07/19/2019, the child was transported to the emergency room at [redacted] at 3:30pm from [redacted] Earlier in the day, [redacted] contacted [redacted] to notify [redacted] that [redacted] was concerned that the child was lethargic and woke up with a 105-degree fever. [redacted] had spent the night at a friend's house and [redacted] was caring for the child as they reside in the same home. [redacted] returned home following the phone call and called [redacted] at the prompting of [redacted] agreed to see the child at [redacted] office at 2:30pm that day but instructed [redacted] to give the child a steroid for adrenal insufficiency (a stress dose of hydrocortisone) in the meantime. [redacted] took child to the appointment and while there, the child went into cardiac arrest which led to the transport by ambulance to [redacted] where he was admitted to [redacted] The child was in cardiac arrest prior to his arrival at the emergency room and died at 6:30pm. The initial cause of death was septic and profound dehydration. An autopsy was scheduled for 07/23/2019.

NCCYS responded that night but the police took the lead with the investigation and interviews. There were no other children in the family and [redacted]

[redacted]

[redacted] was interviewed by law enforcement and provided information on the child's daily routine, diet and medical issues. [redacted] had spent the prior three days with the child and noted that a day prior to the death, [redacted] never mentioned the [redacted] and when [redacted] was asked about it, [redacted] became defensive and left the interview. [redacted] refused to be interviewed by CYS.

[redacted] was also interviewed by law enforcement as well as CYS and made statements that [redacted] felt [redacted] was out to get [redacted] and the child and thought the chicken soup in the refrigerator was poisoned. [redacted] described the child as being lethargic, his fever spiked, and his eyes were glassy on the morning of the child's death. [redacted] stated [redacted] attempted to call the [redacted] but the office would not talk to [redacted] so [redacted] called to make the appointment.

[redacted] refused to be interviewed. [redacted] To date, the autopsy results have not been received by CYS and no charges have been filed pending the results of the autopsy.

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

Information in this section is copied directly from the county report.

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

- Deficiencies in compliance with statutes, regulations and services to children and families; No deficiencies were noted by the team regarding CYS compliance with statues, regulations, and services to the child and family.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; Stress the importance of having all other Agencies involved with the family present at the Act 33 meetings such as Early Intervention to give their professional input.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; No recommendation for change.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. No recommendation for change.

Department Review of County Internal Report:

The County submitted their report in a timely manner within the required 90-day timeframe. The county report was reviewed, and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
  - The agency immediately began the investigation, cooperating with medical personnel and law enforcement.
- County Weaknesses:

- None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None identified

Department of Human Services Recommendations:

No recommendations at this time.