pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Eion Dwyer

Date of Birth: 12/25/2014
Date of Death: 04/25/2017
Date of Report to ChildLine 04/28/2017
CWIS Referral ID: [redacted]

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

Lebanon County Children and Youth Services

REPORT FINALIZED ON:

11/02/2017

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) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/23/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Father	[redacted]1988
[redacted]	Mother	[redacted]1987
Eion Dwyer	victim child	12/25/2014
[redacted]	Half-Brother	[redacted]2009
[redacted]	Half-sister	[redacted]2012
[redacted]	Sister	[redacted]2014
[redacted]	Sister	[redacted]2014
[redacted]	Maternal Uncle	[redacted]1997
*[redacted]	Paternal Grandmother	[redacted]1970
*[redacted]	Maternal Grandmother	[redacted]1965
*[redacted]	Victim's half-siblings father	[redacted]1990

*-Not residing in the home

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 [redacted] family. CERO staff conducted interviews with the following Lebanon County Children and Youth Staff: Intake Supervisor and caseworker. These interviews occurred on 05/11/2017 and 05/23/2017. A review of the initial report and law enforcement involvement was reviewed. CERO staff participated in the Act 33 meeting that occurred on 05/23/2017 in which medical professionals, agency staff, law enforcement and legal counsel were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

Family was not known to county children and youth agency.

Circumstances of Child Fatality and Related Case Activity:

This report was received on 04/28/2017 via a ChildLine report [redacted] The date of the incident was 04/25/2017. [redacted] arrived at the home per an Emergency Management Services (EMS) call. Upon arrival [redacted] observed that the victim child was lying of the floor in the living room and he was cold and blue. The mother reported that he was moved to this room as she had provided cardiopulmonary resuscitation (CPR) in an attempt to revive the child.

[redacted] initially questioned both the mother and the father to get a sense of what had happened. The mother reported that she came home from work at approximately 7:00 AM. Her oldest child asked her to play a game which she did for about 15 minutes. At that time, she made her way to the master bedroom where she found the victim child cold in his crib. The victim child was in the room with his father and his sister both of whom were asleep. It was noted that the father was reported by all interviewed to be a very deep sleeper, so he was not awake upon her entrance into the room. The mother reported removing the victim child from the crib and taking him to the living room to perform CPR after waking the father and asking him to call 911. It was reported that at this time the father called 911. [redacted] made some observations of the bedroom scene and noted that a twin size mattress was standing upright next to the crib, but at that time did not question why it was there. [redacted] also thought that it seemed odd that the victim child had been taken to the farthest room of the house (from the master bedroom where the incident occurred) to perform CPR, but allowed mother's description of events to occur without comment. Detectives documented the scene with pictures to assist with the investigation.

[redacted] received a phone call from the [redacted], reporting what he believed to be crucial information that [redacted] had shared with him about events that transpired over the past few months regarding the victim child and sleep practices. [redacted] interviewed [redacted] who reported that in addition to the mattress being placed over the crib, parents had used a television and two 50lb bags of salt to weigh the mattress down. [redacted] reported that the victim child was able to push these items off the mattress and still get out of his crib, so they started using bungee cords to tie the mattress down over the crib. [redacted] was very descriptive and detailed with the items that were used and where to locate them in the home. To further support what had been done with the mattress and the bungee cords, it was found that the notch marks located at the bottom of the crib aligned perfectly with where the bungee cords would fall when the mattress was placed on the crib and being strapped to it.

Both parents were interviewed [redacted]. The victim child's father was not very cooperative and made comments to have the incident "rubber stamped" as an accident. The victim child's mother was initially more cooperative. [redacted] attempts to interview the parents separately were somewhat thwarted as the father and grandmother (accompanied them to [redacted]) followed him to the interview room despite being given instructions not to come with them. [redacted]

[redacted] noted that the mother appeared visibly stressed and became very defensive as he began to discuss inconsistencies in her initial accounting of the events. The mother indicated that the mattress that was next to the crib was no longer being used. When confronted with other information received based on the interview with [redacted] she became angry and requested to have an attorney. [redacted] that interviewed the father indicated that he was very emotional, but did not confess to any role he had in the death of his son. At the conclusion of the interviews, it was deemed necessary to [redacted]. [redacted] instructed the parents not to return to the home. The mother did not go to the home, but went to [redacted] to pick him up, which was not something she customarily did. Also, because of the investigation, LCCYS assigned a caseworker, and put a safety plan into effect which prohibited both parents from having unsupervised contact with their children. This would have also prohibited them from picking the children up from school. There was concern that the mother would try to get [redacted] to change his story or influence him in some way. [redacted] as all items were located exactly as [redacted] had described them and where he said they would be within the home. It is worth noting that both parents were believed to have altered the scene by hiding the salt and moving the mattress off of the crib prior to [redacted] arrival on the day of the incident.

During the course of the investigation, it was learned that there were abrasions on the victim child's back, chin and neck/throat area. These were thought to be a result of his struggle to get out from under the mattress. Once the re-enactment was completed with a weighted doll, it was determined, coupled with the pathologist's findings, that this would be the most plausible rationale for the bruises.

There was discussion about including [redacted] as a perpetrator by co-mission because while he was not in a caretaking role on the day of the child's death, he likely employed the same tactics. However, he was not listed as one of the perpetrators in this case. He also had knowledge of the parents' actions as he was living in the home and often in a caretaking role. He was uncooperative during the initial interviews as he omitted a lot of information. This discussion ensued as a result of [redacted] learning that [redacted] had employed similar tactics to keep her child in the crib which resulted in her son having to be revived. [redacted] attempts to contact her were futile. The team unanimously voted to [redacted].

After the determination regarding [redacted] was made, further discussions occurred concerning [redacted]. The team discussion resulted in [redacted] as a perpetrator by omission.

The family was opened for ongoing services on 06/01/2017. The parents were referred for parenting skills [redacted]. The father was referred [redacted]. The parents were to follow thru with all recommendations.

The two oldest children remain with their biological father. Visitation with the biological mother has been set up. The remaining two children are still with their paternal grandmother along with the parents. The safety plan continues to be that the parents are not alone with the children and must be supervised at all times. The maternal grandparents have been helping in providing supervision.

The parents were charged with involuntary manslaughter and endangering the welfare of a child. They are currently out on bail awaiting trial. They believe they will be sentenced and jailed. The paternal grandmother will be given guardianship of the children when this occurs.

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:

The county agency investigation complied with regulations and response times as required.

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

The county agency report did not reference any deficiencies.

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

The county agency report did not mention any recommendations for change at the state or county level.

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

The county agency report did not mention any recommendations for change at the state or county level.

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

The county agency report did not mention any recommendations for change at the state or county level.

Department Review of County Internal Report:

The county report was received on 06/21/2017. There were no issues or concerns regarding the report.

Department of Human Services Findings:

County Strengths:

Upon review of the documents associated with this case, it would appear there is a positive working collaboration between law enforcement, medical facilities and the county agency.

County Weaknesses:

The circumstances of this case and the review of the county's work did not identify any systemic weaknesses. This family was not known to the county.

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

There were no areas of non-compliance found during the review of this case.

Department of Human Services Recommendations:

The Department concurs with the findings and recommendations of Lebanon County Children and Youth Services' Act 33 meeting.