REPORT ON THE FATALITY OF:

Abryella Kirkwood

Date of Birth: 02/13/2016
Date of Death: 04/27/2016
Date of Report to ChildLine: 02/02/2017
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:
8/21/2017

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 02/21/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1996
[redacted]	Father	[redacted]1995
Abryella Kirkwood	Victim Child	02/13/2016
*[redacted]	Paternal Uncle	[redacted]1994
*[redacted]	Uncle's Ex-girlfriend	[redacted]1995
*[redacted]	Maternal Grandmother	[redacted]1975

* 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:

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 02/03/2017 and 04/13/2017. A review of the initial report including law enforcement involvement occurred. CERO staff participated in the Act 33 meeting that occurred on 02/21/2017 in which medical professionals, county children and youth agency staff, and the district attorney 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 prior to the child's death.

Circumstances of Child Fatality and Related Case Activity:

The child's death occurred 04/27/2016.The district attorney's office and law enforcement investigated the death. There were no suspicions of suspected child abuse and the district attorney's office contacted the CCYA to check for current or prior involvement. The child [redacted] a heart condition and had been seen by the doctor the day before her death. The police completed an investigation. The cause of death was ruled SIDS secondary to accidental suffocation.

This report was made via a ChildLine call on 02/02/2017 as a result of a conversation that [redacted] had with [redacted]. The [redacted] then shared this information with a mandated reporter due to believing that [redacted] was culpable for the child's death.

During the course of this current investigation, based upon information from interviews conducted by law enforcement and by the CCYA caseworker, it was determined that the findings at the time of the incident were true and accurate. The detective conducted the interviews at the time of the child's death and assisted with the suspected child abuse investigation. The investigation revealed that the [redacted] misunderstood the conversation she had had with the [redacted]. While there had been reports of drug use on the evening prior to the infant's death, there was not a level of impairment that would have contributed to or caused the death. [redacted] did admit to co-sleeping and that he may have may have rested his arm on the child but this was not found to be the cause of death. [redacted] stated that when the child went to sleep she was on her back. When he woke up, the child was lying face down. The infant was known to have a heart condition and had been sick, with difficulty breathing, in the days prior to her death. The child was seen the day before by her doctor. These factors coupled together were indicated as the cause of death.

[redacted] was submitted to ChildLine on 02/23/2017 with a status of [redacted] The family was not opened for services but [redacted] was recommended.

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 03/13/2017. 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:

Sudden Unexplained Infant Death (SUID) protocol was not used. Using a protocol is an essential component of a systemic approach to a complete investigation.

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.