



REPORT ON THE FATALITY OF:

Lucille McMillion

Date of Birth: 07/20/2017

Date of Death: 03/07/2018

Date of Report to ChildLine: 03/09/2018

CWIS Referral ID: [REDACTED]

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

Mifflin County Children and Youth Services

REPORT FINALIZED ON:

9/10/2018

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))

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.

Mifflin County has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 04/05/2018.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Lucille McMillion	Victim Child	07/20/2017
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	Sibling	[REDACTED] 2014
[REDACTED]	Sibling	[REDACTED] 2017
[REDACTED]	Half-sibling	[REDACTED] 2007
[REDACTED]	Half-sibling	[REDACTED] 2005
[REDACTED]	Mother's paramour	Unknown
[REDACTED]	Household member	[REDACTED] 1997
[REDACTED]	Household member	Unknown

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) attended the Act 33 meeting on 04/05/2018 and obtained and reviewed all case records pertaining to the family. CERO staff spoke with Mifflin County Children and Youth Services (MCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:

MCCYS did not have any involvement with the family prior to the child's death; however, they did receive a report after the child's passing regarding previous circumstances in the home. A week prior to the child's death, her father had died in the family's home from a self-inflicted gunshot wound. At this time, MCCYS received eight [REDACTED]. Five of these [REDACTED] were regarding the concerns from the week prior when the victim child's father had shot himself in the home after waving the gun around during a fight with the mother. These reports were investigated for the concerns that the victim child's father's reckless discharge of the weapon in the home could have caused injury to one of the children who were at home when the incident occurred. The agency was unable to substantiate these concerns [REDACTED].

The other three [REDACTED] were regarding the incident that led to the victim child's death. A report was received for the victim child, [REDACTED] regarding concerns for an egregious lack of supervision. [REDACTED]

Circumstances of Child Fatality and Related Case Activity:

Emergency medical services personnel (EMS) were called to the family's home on the afternoon of 03/07/2018 due to concerns that the victim child was in cardiac arrest. When EMS arrived on the scene, they found the child was deceased and rigor mortis had set in. A medical examiner declared the victim child's cause of death was suffocation, but the manner of death was ruled as undetermined as it could not be determined how the child suffocated.

MCCYS received notification of the report and immediately acted to ensure the safety [REDACTED]. At the time of the incident, the victim child [REDACTED] who were living in the home, [REDACTED] and [REDACTED]. MCCYS staff put a safety plan in place that [REDACTED] would be cared for by their grandparents and their [REDACTED] would not be permitted to have any unsupervised contact with them. The victim child also had [REDACTED] who were visiting their father. These [REDACTED] remained with their father who was granted custody of [REDACTED].

MCCYS worked collaborative with local law enforcement to investigate this incident. The [REDACTED] had three additional adult individuals staying in her home at the time of the child's death. All of whom reportedly assisted the [REDACTED] in caring for the children. Information presented during the investigation suggests that the child was put to bed on 03/06/2018 around 11:30PM. No adults in the home checked on [REDACTED] until 1:30PM the next afternoon when one of the household members who was sleeping on the third floor of the home reported hearing the [REDACTED] fussing. The child was reportedly unresponsive when two household members then went to check on the [REDACTED]. Information provided suggests that the child was found face down in her crib with a blanket wrapped around her head. Even though the [REDACTED] slept in a second floor room adjoining the room of the [REDACTED] and [REDACTED] neither of them awoke until they overheard the household members screaming regarding the child's condition. The child was taken downstairs and attempts were made to revive her while emergency personnel were contacted. During interviews, the [REDACTED] admitted to taking a [REDACTED] that someone had given to [REDACTED] to help [REDACTED] sleep. [REDACTED] claimed that [REDACTED] had not been able to sleep well since the victim child's father's death. [REDACTED] also reported that [REDACTED] had smoked marijuana. The [REDACTED] reported being unaware of who had put the child to bed and could not identify who in the home [REDACTED] had designated to care for and check on the children while [REDACTED] was under the influence of the substances [REDACTED] had ingested. Following the child's death, the [REDACTED] admitted [REDACTED] to a [REDACTED] for evaluation.

The agency [REDACTED]

██ No criminal charges have been filed regarding this incident.

MCCYS opened the family for ██ following the completion of the investigation. The victim child's ██ and her ██ have been returned to the care of their mother. The agency continues to work with the family to monitor the safety of the child and ensure that the mother continues to participate in needed ██ services and ██. The family is currently receiving parenting services as well as family preservation services.

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;
 - Agency and police have worked well together and met right after the report was received to conduct the investigation together.
- Deficiencies in compliance with statutes, regulations and services to children and families;
 - EMS along with other medical personnel were in the home a week before when the father of the victim child had died and reportedly had concerns regarding home condition and numerous people in the home, but no report was ever made until after the victim child's death.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
 - None
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
 - None
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - None

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, cooperated with medical personal, and assured the safety of the children involved.

- County Weaknesses:
 - None noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - There were no areas of regulatory non-compliance observed.

Department of Human Services Recommendations:

The Department recommends that better education is offered to parents on the importance of supervising children. An emphasis should be placed on providing education regarding the potential dangers of sleeping while being the person responsible for supervising a child.