pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Trevor Wise, Jr.

Date of Birth: 04/04/2018
Date of Death: 05/06/2018
Date of Report to ChildLine: 05/08/2018
CWIS Referral ID: [redacted]

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

Adams County Children and Youth Services

REPORT FINALIZED ON:
April 5, 2019

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.

Adams County has not convened a review team in accordance with the Child Protective Services Law related to this report because they [redacted] the report prior to the 30th day.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Trevor Wise, Jr.	Subject Child	04/04/2018
[redacted]	[redacted]	1998
[redacted]	[redacted]	2000
[redacted]	[redacted]	1975
[redacted]	[redacted]	1978

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the Wise family. CROCYF representative engaged Adams County Children and Youth Services administrator and supervisor to discuss the incident.

Summary of circumstances prior to Incident:

The agency was involved with [redacted] of the subject child when they were children. The agency worked with [redacted] from 2015 until 2017 due to untreated [redacted], truancy and ungovernable behavior. [redacted] was placed on probation during that time period and continued to be truant from school. In April of 2016 he was [redacted] due to truancy, but was eventually able to obtain his General Education Diploma and was subsequently reunited with his family. Following his return home, [redacted] completed his probation and worked successfully with the agency's [redacted] until his successful completion in July of 2017.

The agency began involvement with [redacted] in 2016 for ungovernable behavior (running away from home for up to a month at a time) and drug use. [redacted] eventually began to live with [redacted] and the agency [redacted] when she turned 18 years old after providing her with [redacted]

The agency became involved with [redacted] as [redacted] on 04/06/2018 when they received a report that the subject child was born at 33 weeks gestation with respiratory distress and [redacted] for [redacted] at the time of the birth. The child was released to [redacted] with [redacted] in place. The agency was completing its' assessment and helping [redacted] to secure appropriate services such as [redacted] and the Women, Infants and Children program. In addition, the agency was assuring that [redacted] had appropriate resources and supports to care for the child. [redacted] called the agency on 05/07/2018 to report that [redacted] had passed away in the early morning of 05/06/2018.

Circumstances of Child Fatality and Related Case Activity:

On 05/08/2018 a report was made to ChildLine in which it was alleged that [redacted] of [redacted], [redacted], witnessed [redacted] suffocate the child. The report was numbered as a [redacted] report for Adams County and assigned a Fatality for the Central Region Office of Children, Youth and Families. [redacted] was listed as alleged perpetrator of the report.

Through investigation and an interview at [redacted] in Adams County, it was learned that the witness reported that the victim had suffocated, not that he was suffocated by anyone. The police suspected no foul play at any point in time of their involvement and the death was determined to have been accidental. The child abuse report was [redacted] on 06/07/18 with no criminal charges filed.

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;
    - While an Act 33 meeting was not held, the agency completed a Fatality Report and identified the following strengths: excellent collaboration between Law Enforcement and Children and Youth Services; diligent interviews with all parties; and frequent supervision that occurred more frequently than the required 10-day intervals.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - An Act 33 meeting was not held, but the agency noted no deficiencies in their Fatality report.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - An Act 33 meeting was not held, but the agency expressed interest in having additional training on [redacted] and a similar screening tool to discuss with [redacted].

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - An Act 33 meeting was not held and no changes were recommended for the state or local levels on monitoring and inspection of county agencies.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - An Act 33 meeting was not held, but the Fatality Report generated a recommendation of development of training and a screening tool for [redacted].

Department Review of County Internal Report:

An Act 33 meeting was not held, but a Child Fatality Report was generated by the agency.

Department of Human Services Findings:

- County Strengths:
    - The agency responded immediately and completed the investigation in a timely manner.

- County Weaknesses:
    - At the time of this report, CROCYF has not identified any County weaknesses.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - At the time of this report, CROCYF has not identified any County weaknesses.

Department of Human Services Recommendations:

The Department has no recommendations in regards to this incident but concurs with the county that additional training and awareness related to [redacted] will further support new parents.