pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF

Peyton Barowski

DATE of BIRTH: 09/28/2011
DATE of DEATH: 01/17/2013
DATE of ORAL REPORT: 01/17/2013

FAMILY NOT KNOWN TO:
York County Children, Youth and Family Services

Report Finalized On:
4/9/14

Department of Public Welfare/Office of Children, Youth and Families, Central Region
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Reason for Review

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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

Act 33 of 2008 also requires that County children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated, or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. York County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name	Relationship	Date of Birth
Peyton Barowski	Victim Child	09/28/2011
[redacted]	Sibling	[redacted]2003
	Sibling	2006
	Sibling	2009
	Mother	1985
	Father	1968
	Sibling	1995

Notification of Fatality:

On 1/17/2013 the parents woke up and found the child on the floor by the baseboard heater in the master bedroom. When [redacted] father, went to grab Peyton by his arm, his thumb went through the boy's arm. Father "freaked out" and placed a call to 911 stating his 16 month old had fallen out of the bed and is badly burnt. Father refused ambulance b/c he felt that he would be able to get to the hospital faster than the ambulance. Father remained on the telephone with 911 until he reached the hospital.

Peyton was taken to the Holy Spirit Hospital ER the morning of 1/17/2013 by his mother and father. The family arrived at the ER and parked on the sidewalk. Mother carried the child into the ER screaming for help. Child was [redacted] Peyton was deceased on arrival at the hospital. Child had [redacted] that were severe according to [redacted]

Summary of DPW Child Fatality Review Activities:

For this review Central Region interviewed:

- [redacted] Supervisor at York County Children & Youth Services
- [redacted] case worker at York County Children & Youth Services

Central Region reviewed:

- Child Death Data Tool
- Case file
- Medical records
- Autopsy Report

Children and Youth involvement prior to Incident:
No prior Children and Youth involvement.

York County offered services to the family after the incident , but they declined.
The agency provided the family with a resource guide, information on [redacted] and guidance on obtaining a [redacted] from [redacted] and [redacted] program.

The family is getting [redacted] through their church and the children are attending the [redacted] for [redacted]. The family attends [redacted] Church.

Circumstances of child's fatality and related case activity:
Mother and father went to bed with Peyton in the master bedroom till he fell asleep. The parents then went into the living room and fell asleep on the couch. When they woke up the child was found on the floor by the baseboard heater in the master bedroom. When [redacted] father, went to grab Peyton by his arm, his thumb went through the boy's arm. Father "freaked out" and placed a call to 911 stating his 16 month old had fallen out of the bed and is burnt badly. Father refused ambulance b/c he felt that he would be able to get to the hospital faster than the ambulance. Father remained on the telephone with 911 until he reached the hospital. Peyton was taken to the Holy Spirit Hospital ER the morning of 1/17/2013 by his mother and father. A safety plan was put into effect for the other children. The plan outlined that the grandmother would supervise the children during the course of the investigation. Child's autopsy was conducted on Friday, January 18, 2013. At this point there were no other obvious signs of trauma other than the burns. The child was asphyxiated. Further testing and toxicology were done. Children and Youth [redacted] on March 4, 2013 and the child's death was ruled as accidental.

Current/most recent status of case:
On January 17, 2013 agency staff met with the investigating detective as well as [redacted]. A safety plan was put into effect for the other children. The plan outlined that the grandmother would supervise the children during the course of the investigation. Child's autopsy was conducted on Friday, January 18, 2013. At this point there were no other obvious signs of trauma other than the burns. The child was asphyxiated. Further testing and toxicology were done. The child's funeral was held on January 22, 2013.

On January 24, 2013, the agency met with the siblings individually as well as an additional home visit with the parents and the safety plan was lifted. At this time the initial finding is that it appears to be an accidental death in which the child endured positional asphyxiation and then suffered burns from the heater.

County strengths and deficiencies as identified by the County's fatality report:
A fatality review team meeting was held on February 14, 2013 in conjunction with the Act 33 requirements. The Central Region Program Representative assigned to York County Children, Youth and Families attended the meeting. Also in attendance were: Representatives from York County Children, Youth and Families, Investigating law enforcement from the [redacted] Police and the District Attorney's Office. The medical representative in attendance was [redacted].

County Strengths:

- the agency's collaboration with the law enforcement officials,
- the safety planning completed by the agency and
- the agency's ability to find a kinship care provider for supervision for the children during the investigation.

County Weaknesses:
No deficiencies were noted.

County recommendations for changes at the local (County or State) levels as identified in County's fatality report:
1) To reduce the likelihood of future fatalities/near fatalities
2) Monitoring and Inspection of County Agencies
3) Collaboration of Community Agencies/Service Providers to prevent child abuse and neglect

Department of Public Welfare Findings:
County Strengths:

- the agency's collaboration with the law enforcement officials,
- the safety planning completed by the agency and
- the agency's ability to find a kinship care provider for supervision for the children during the investigation

County Weaknesses:
No deficiencies were noted.

Statutory and Regulatory Compliance Issues:

York County Children, Youth and Family Services conducted a thorough and timely investigation in conjunction with the law enforcement officials. Safety assessments were completed. Referrals for services were completed and necessary services were coordinated for the family.

Department of Public Welfare Recommendations:
None at this time