



## **REPORT ON THE FATALITY OF:**

**Vasily Decyk**

**Date of Birth: 12/11/10**  
**Date of Death: 05/05/13**  
**Date of Oral Report: 05/07/13**

### **FAMILY KNOWN TO:**

Franklin County Children and Youth Services

### **REPORT FINALIZED ON:**

01/21/14

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. 6349 (b))

**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. Franklin County convened a review team in accordance with Act 33 of 2008 related to this report on June 6, 2013.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Vasily Decyk	Victim child	12/11/2010
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	Father	[REDACTED] 1983
[REDACTED]	Half-Sibling	[REDACTED] 2006
[REDACTED]	Maternal Grandmother	[REDACTED] 1951
[REDACTED]	Maternal Great grandmother	[REDACTED] 1914
[REDACTED]	Maternal Uncle	[REDACTED] 1983

\*The child's father is not a member of the victim child's household. The child's father was incarcerated in the [REDACTED] County Jail, [REDACTED], PA at the time of the incident and he still remains there.

**Notification of Child Fatality:**

On May 7, 2013, Franklin County Children and Youth Service received a report from [REDACTED] regarding the death of the child which occurred on May 5, 2013 at the home of the child. The child was reported to have drowned in the family swimming pool and the autopsy determined that the child had been in the pool for over two hours. [REDACTED] was babysitting the child when the incident occurred. The [REDACTED] expressed concern to the agency regarding the lack of supervision. Franklin County Children and Youth Services then contacted [REDACTED]

**Summary of DPW Child Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the Franklin County Children and Youth Services [REDACTED] file and a past case record pertaining to the [REDACTED] family. The files were inclusive of [REDACTED] reports, agency safety and risk assessment records and dictation. The CROCYF interviewed Franklin County [REDACTED] and [REDACTED]. The CROCYF also attended the Child Fatality Review Team Meeting regarding this case on June 6, 2013.

**Children and Youth Involvement prior to Incident:**

On May 3, 2012, Franklin County Children & Youth Services conducted a [REDACTED] investigation in which the child's [REDACTED] was the [REDACTED] by [REDACTED]. In that case [REDACTED] had no further contact with the child, no further services were deemed necessary and the case was [REDACTED] and closed on June 19, 2012.

**Circumstances of Child Fatality and Related Case Activity:**

The child, his half-sibling and their mother resided with the maternal grandmother, (MGM), her son, and the maternal great-grandmother. The child's mother left for work at approximately 7:30 am on May 5, 2013. The child was still sleeping at that time and the maternal grandmother was babysitting the children. At 8:00 am the child's maternal uncle checked on the child and reported to the MGM that the child was still sleeping. The MGM then remained in her bedroom until 10:00 am when she came out into the home and found the entrance door cracked open. The MGM stated that she thought the child's mother had not shut the door tightly when she left for work so she shut the door. At 11:45 am the MGM asked the child's half-sibling's father who was in the home visiting to look for the child. When he could not locate the child inside the house, he then looked outside the perimeter of the home and found the child unresponsive in the family's above ground pool. He states he removed the child from the pool and began CPR until the paramedics arrived. The paramedics took over but could not revive the child. The autopsy report determined that the child had been in the pool for over two hours. Franklin County Children and Youth Services [REDACTED] determined that [REDACTED] of the child. The agency [REDACTED] this case naming [REDACTED] as the perpetrator on June 6, 2013. The Pennsylvania State Police/District Attorney decided not to pursue criminal charges against [REDACTED].

**Current Case Status:**

On May 7, 2013 when [REDACTED] contacted Franklin County Children & Youth Service, (FCCYS), regarding this report [REDACTED] also expressed concerns regarding the unsanitary living conditions of the home. They provided the agency with photographs taken on

May 5, 2013 showing extreme clutter throughout the home and further expressed concerned for the safety and well-being of Vasily's sister, [REDACTED], who continued to reside in the home.

On May 7, 2013 FCCYS conducted an unannounced home visit and addressed the home conditions and continued safety planning for the child's half-sibling with the mother. The mother stated that she had family members who were helping her to clean the home. The home conditions had improved from what was visible in the pictures taken on May 5, 2013. On May 14, 2013, another unannounced home visit was conducted. The home continued to improve and there were no safety hazards present. The safety plan which was established on May 5, 2013 for the child's half-sibling, which is that [REDACTED] could not be a caregiver/babysitter for her, remained in place and was continued to be monitored by the agency for compliance.

Despite efforts to improve the home conditions by May 23, 2013 they had significantly deteriorated [REDACTED]

[REDACTED]. The mother then obtained appropriate housing for her and the child's half-sibling [REDACTED]

### **County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:**

A Child Death Review Team Meeting was conducted on June 6, 2013. The agency conducted this investigation in collaboration with law enforcement.

#### **Deficiencies Identified:**

- There were several social service agencies and caretakers involved with the family [REDACTED] that did not report the condition of the home.
- These social agencies are not trained in what is reportable to Children and Youth.
- Agencies have no set clear standards on how bad living conditions have to be before a report is made to Children and Youth.

#### **Strengths:**

- The Pennsylvania State Police and Franklin County Children and Youth Services have an ongoing working relationship with a shared goal of assuring the safety of children.
- The work and cooperation of the Child Death/Near Death Review Team in reviewing child death/near death cases and willingness to make recommendations and changes in practices at the local level to potentially reduce the instances of child death/near death.

Recommendations for Change at the Local Level:

- Social Service agencies will be encouraged to provide their respective staff with clear directions and training in regard to child abuse and/or child neglect reporting requirements.
- Provide clear directions/training to agencies of what should be reported.

Recommendations for Change at the State Level:

- There were no recommendations.

**Department Review of County Internal Report:**

The report from Franklin County Children and Youth Services was received by the Regional Office on July 31, 2013. The report details the topics that were discussed during the Death Review meeting held on June 6, 2013. A meeting to review the report was held with the county on August 23, 2013. There were no deficiencies noted.

**Department of Public Welfare Findings:**

- County Strengths:  
The investigation was conducted timely and in close collaboration with the Pennsylvania State Police. Case documentation was comprehensive including medical reports, interviews, risk and safety assessments, criminal complaint documents and case dictation. The agency also [REDACTED] and provided the mother with supportive services to resolve placement issues and reunify with her child.
- County Weaknesses:  
There were no weaknesses noted.
- Statutory and Regulatory Areas of Non-Compliance:  
There were no areas of non-compliance noted.

**Department of Public Welfare Recommendations:**

Franklin County Children and Youth Services should continue to conduct thorough and timely investigations in coordination with law enforcement officials. Continued efforts of child abuse prevention and education should continue and be expanded as possible to reach out to social service agencies not familiar with this information.