pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY:

Kyri Jones

Date of Birth: 12/11/2009

Date of Death: 11/05/2012

Date of Oral Report: 12/06/2013

FAMILY KNOWN:
Dauphin County Children and Youth Services

REPORT FINALIZED ON: 1/27/2015

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. Dauphin County Children and Youth Services (agency) had convened a review team, on 12/23/2013 in accordance with Act 33 of 2008 related to this report. The Central Region Office of Children, Youth and Families (CROCYF) Human Service Representative was a member of the review team.

Family Constellation:

Name:	Relationship:	Date of Birth:
Kyri Jones	victim child	12/11/2009
[redacted]	mother	[redacted]1987
[redacted]*	father	[redacted]1990
[redacted]	brother	[redacted]2005
[redacted]	brother	[redacted]2006
[redacted]	brother	[redacted]2008
[redacted]	brother	[redacted]2008
[redacted]	sister	[redacted]2012
[redacted]*	father	[redacted]1987
[redacted]	son	[redacted]2013
[redacted]	son	[redacted]2013

*The father, [redacted], at the time of the child's death and the date of this report does not live in the family home.
* The father, [redacted] does not live in the family home.

Notification of Child Fatality:
On 11/07/2012 the victim child fell from a second floor window and landed on the sidewalk. Injuries included a [redacted]. These injuries met the criteria for brain death. At the time of the incident, the child's mother was in another room fixing a relative's hair. Four other siblings were in the same room as the child. The mother reported she did not know how the window became opened but believes that one of the siblings in the room opened it.

On 11/07/2012 the agency met with [redacted] at Hershey Medical Center. [redacted] reported to the agency that she did not have suspicions of abuse and that is why she did not call a report into ChildLine. The agency was not involved with the family at the time of this referral. The agency became involved to provide supportive services due to the death of the child. The agency did not initiate a call to ChildLine regarding the accidental death of the child.

On 12/06/2013 a referral was received from staff at [redacted] and numbered as suspected child abuse due to lack of supervision resulting in the child's death. The referral source often sits on the agency's [redacted], learning of the case, felt the referral to ChildLine should be made for lack of supervision by mother. The agency was not providing services to the family at the time of this referral.

Summary of DPW Child Fatality Review Activities:

CROCYF obtained and reviewed the agency's case record pertaining to the [redacted] family which included information regarding the agency's past involvement with the family, Family Service Plans and Reviews, Child Protective Service Reports, [redacted] Police Report, Coroner's Report, Hershey Medical Center's medical reports and agency caseworker dictation involving services and contacts with the family. CROCYS interviewed agency caseworker, [redacted], on 12/06 2013 who related the agency was not currently involved with the [redacted] family. CROCY participated in the Act 33 Review Team Meeting on 12/23/2013. Copies of the [redacted] Police Report, Medical records from [redacted], Coroner's report, [redacted] interviews and the agency case record were presented. CROCYs spoke with agency caseworker, [redacted], again on 9/29/2014. She related that the [redacted] case was closed as of 02/01/2014, but she thought the case was reopened. No services were recommended.

On 09/29/2014 agency supervisor, [redacted], related that on 07/14/2014 the [redacted] family was referred for services due [redacted] and [redacted] medical problems. CROCYF reviewed agency caseworker, [redacted], dictation on this Intake case.

Children and Youth Involvement prior to Incident:

There was an [redacted] report on 03/10/2006 for physical abuse. [redacted] caused a [redacted] to [redacted] arm. He was found guilty of simple assault and placed at [redacted] RTF. [redacted] complied with services and successfully submitted to random urine screens, D&A discussion group, [redacted] and obtained her GED. The case was closed on 02/01/2007.

On 02/24/2010, a referral was received regarding concerns of the children's behavior, condition of the home and supervision of the children. The family was opened for ongoing services on 06/02/2010 and closed on 10/16/2012. During this time, [redacted] was able to locate another apartment and the [redacted] the move. The home was observed a number of times and found to be clean and appropriate. On 07/10/2010, [redacted] was notified she was being evicted due to not paying rent. The family went to [redacted]. [redacted] was approved for [redacted] housing. The agency [redacted] and the family moved into their new residence. On 03/11/2011, [redacted] tested positive for cocaine. A 24 hour caretaker was identified to care for the children. On 03/14/2011 [redacted] tested negative for all substances.

The home was observed to be "messy" and there was a concern that [redacted] was unable to control the children. A referral was made to [redacted] to provide immediate assistance to the family. By the end of April, Family Preservation Services through [redacted] started working with the family. On 05/13/11 a Family Meeting was held to address ongoing concerns about home conditions, lack of supervision, children's behavior and their hygiene. In June, 2011, [redacted] left her 5 children alone. She claimed the person she left them with left the children alone. She was charged with endangering the welfare of her children and placed on Adult Probation. [redacted] to have new flooring installed for the apartment as the carpet was in bad condition. In September, 2011, [redacted] became involved with [redacted]. She was attending [redacted] classes weekly and found a new in-home daycare provider through [redacted]. [redacted] was enrolled into [redacted] [redacted] had made progress and agreed that all services could be terminated. On 09/25/2012, a closing Family Group Conference was held, and the family developed a plan to help [redacted] with maintaining her house and ensuring her children were properly supervised. Family Preservation services were successfully discharged on 10/16/2012. [redacted] was registered to attend HACC for the spring semester in 2013. The agency closed services to the family on 10/16/2012.

On 11/07/2012 a referral was received regarding the [redacted] falling out of a second floor window. The agency re-entered the family's life to provide supportive services due to the death of the child.

[redacted], Child Interview Specialist for the [redacted] interviewed [redacted] on 11/21/2012. The children said their brother climbed up on the window sill and fell out the window. The [redacted] also had the children's medical history reviewed and they received physical examinations on 11/21/2012. No concerns were noted.

On 12/06/2013 a referral was received [redacted] due to lack of supervision resulting in Kyri's death. On 02/01/2014 the report was determined to be [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 11/05/2012 the child fell from the second floor window in the family's apartment and landed on the sidewalk. The child's mother was in a bedroom fixing a relative's hair. Four other siblings were in the same room as the child. The mother said she did not know the window had been opened. The child's injuries included a [redacted] These injuries met the criteria for brain death. The mother agreed to have the child's organs harvested. [redacted] assistant deputy coroner, ruled the child died on 11/08/2012.

On 02/01/2014 the agency determined the status of the [redacted] report to be [redacted] The agency found the children were not left alone in the living room for a long period of time. A witness, who was at the home, also stated the children were not left alone for a long period of time. The mother was working with the landlord to put screens in the windows so they would be safer.

Current Case Status:

- The agency closed this family for services on 02/01/2014 in regards to the child's death.

- On 07/14/2014 the agency received a referral from [redacted] who has been working with him since May, 2014. [redacted] is diagnosed with [redacted] due to all the medical conditions he has had since birth. [redacted] issues which are why he is currently being [redacted] also has a cardiac condition. The referral source is concerned that the mother seems to be increasingly overwhelmed. [redacted] is in the home weekdays from 11:00 P.M. until 7:00 A.M. There is also a weekend [redacted]. The older children's grandfather, [redacted], and his girlfriend, [redacted] come daily to take the older children out of the house to give the mother a break.

- On 07/26/2014 [redacted] was hospitalized with a cough and shortness of breath. He was diagnosed with [redacted]. The doctors thought [redacted] had either [redacted] or [redacted]. Both are very serious conditions and may cause [redacted] to need a [redacted]. The agency and staff at Hershey Medical Center determined [redacted] could not be cared for in his mother's home. A family friend offered to take [redacted] but on 08/05/2014 decided she could not comply with all the requirements of the child's care. On 08/13/2014, the agency was informed that both boys, [redacted] have [redacted]. At a team meeting on 08/13/2014, it was determined that both boys would be scheduled for [redacted] in September, 2014. The agency was to continue to seek foster home placement for [redacted] as they will need a [redacted] environment to be released to when they [redacted] Both children will remain at [redacted] for 6-8 weeks [redacted] as their [redacted] will be healing. However, in the interim, [redacted] planned on returning [redacted] to his mother. The agency, Safety Team and hospital staff felt [redacted] should not be returned to his mother. [redacted] and on 08/15/2014 [redacted] hospitalization to continue at [redacted]. On 08/18/2014 [redacted] was returned to his mother's home. The plan for after the [redacted] is for the mother and both boys to go to [redacted] until their doctor feels it is safe for them to go home. All of the other children are residing with relatives.

- On 09/12/2014 medical staff reported [redacted] was responding well to [redacted] but [redacted] is still [redacted] Therefore, he cannot now receive a [redacted] until he [redacted] On 09/29/2014 agency staff reported [redacted] had his [redacted] and is doing well at [redacted]

[redacted] still is [redacted] for the [redacted] and hopefully will have his [redacted] in the near future.

- The family was accepted for ongoing services on 09/12/2014. No Family Service Plan has been developed as of 09/29/2014.

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

The Dauphin County Child Fatality/Near Fatality Review Team met on 12/23/2013.

- Strengths:
  - The mother is cooperative and has been willing to work with the agency and private providers.
  - There is family support present.
  - The mother has been willing to address her mental health needs.

- Deficiencies:
  - A county protocol needs to be developed to determine when a call should be made to ChildLine for a child death and who is responsible for that? The agency vs. a private provider making the report. How will that be decided? The agency will need to define a plan for when calls need to be made.
  - Continued lack of supervision in the home.

- Recommendations for Change at the Local Level:
  - Agency caseworkers can take responsibility to call in a report to ChildLine.

- Recommendations for Change at the State Level:
  No recommendations.

Department Review of County Internal Report:
On August 21, 2014, CROCYF notified Dauphin County Children and Youth Services' administrator [redacted] that the report on Kyri Jones was reviewed and as a result of the preliminary review CROCYF concur with the recommendations of the Dauphin County Act 33 team. CROCYF found the report to be thorough and presented a complete description of the case involvement.

Department of Public Welfare Findings:

- County Strengths:
  - The agency provided supportive services to the family and referred the family for [redacted].
  - The agency arranged for the [redacted] to interview the children regarding the incident and the children's physical examinations.

- County Weaknesses:
  - The agency did not initiate a call to ChildLine regarding the possible lack of supervision surrounding the child's death.

- Statutory and Regulatory Areas of Non-Compliance:
  A report was not immediately made to ChildLine for concerns of supervision and neglect.

Department of Public Welfare Recommendations:

CROCYF completed interviews and obtained copies of the family record as required. The agency provided appropriate services to the family during the investigation and ensured the safety of all the children in the family. The agency closed the family on 02/01/2014 but has reopened the family on 09/12/2014 due to serious [redacted] with [redacted]. CROCYF completed interviews and obtained copies of the agency's Intake record. The agency has provided appropriate services during the Intake period and plans to develop the Family Service Plan with the family.