



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Ebin Baker

BORN: 03/05/2011
Date of Fatality: 10/27/2011

Report Date: 04/24/2012

The family was not known to Cumberland County Children and Youth Services

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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 No. 1147, Printer's Number 2159 was signed into law July 3, 2008 by Governor Edward G. Rendell. 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 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. Cumberland County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Ebin Baker	Victim Child	03/05/11
[REDACTED]	Mother	[REDACTED]/88
[REDACTED]	Father	[REDACTED]/82

Notification of Fatality:

On 10/27/11, Pennsylvania State Police were notified by emergency response (911) to respond to a call from the home at [REDACTED]. The seven month old victim child was found dead in the home by his parents. The victim child's father contacted 911 on the morning of 10/27/11 when the child could not be awakened by his parents. The child was found face down in his crib by the child's mother. The Pennsylvania State Police contacted Cumberland County Children and Youth Services on 10/27/11. A caseworker and supervisor from Cumberland CYS went to the home immediately after receiving the call from law enforcement.

The child's father put the child to bed in his bedroom on 10/26/11 at approximately 11:30 pm. This would be a normal time for the parents to place their child into his own room for the remainder of the night. It is reported that the child would normally sleep through the night. The victim child's father reported that when he placed the child in the crib, the child was placed lying face up. On the morning of 10/27/11, the victim child's mother entered the child's room at approximately 9:00 am to find her child was unresponsive to attempts to wake him, the child was not breathing and his body was stiff. The child was removed

from the crib and placed on the living room floor as the father attempted to perform CPR to resuscitate the child.

When the emergency response and police members arrived, the death was reported as suspicious due to some of the conditions found in the home and with the child. The child had [REDACTED]. The crib the child was placed in had several blankets and a pillow placed in the crib with the child. The home was extremely warm, especially in the child's bedroom. The trailer the family was living in did not have a functioning heating system. The family was utilizing a space heater to heat the child's room since the temperature outside was unseasonably cold around the time of the incident. The heater was not functioning properly and would later be discovered that the space heaters thermostat device to regulate or turn off the unit was broken. The blankets in the crib were soaked in urine. In addition, response crew at the home found areas of mold in the kitchen and bathroom. The county children and youth agency reported the incident to ChildLine and the report [REDACTED].

Documents Reviewed and Individuals Interviewed:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. The family was not known to the agency so there was no prior information to review. Follow up interviews were conducted with the agency caseworker, the casework supervisor, the Director of Social Services, and the Agency Administrator on 10/28/11, 11/17/11, and 12/1/11. The regional office also participated in the County Internal Fatality Review Team meeting on November 17, 2011.

Summary of Services to Family:

Previous Children and Youth Involvement:

The family did not have involvement with Cumberland County Children and Youth Services nor was the family known to the agency.

Circumstances of Child's Fatality:

On 10/26/11 the victim child's father placed the child to bed in his bedroom at approximately 11:30 pm. This would be the normal time for the parents to place their child into his own room for the remainder of the night. Prior to placing the child in his own bedroom, the child would have been with the parents in their bedroom. It was reported that the child would normally sleep through the night. The victim child's father placed the child face up in his crib. On the morning of 10/27/11, the child's mother entered the child's bedroom at approximately 9:00 am to find her child was unresponsive to attempts to wake him. The child was not breathing and his body was stiff. The child was removed

from the crib and placed on the living room floor as the father attempted to perform CPR to resuscitate the child. The parents contacted 911 immediately after discovering their child lying face down and unresponsive.

When the emergency responders and police members arrived at the home, the death was reported as suspicious due to some of the conditions found in the home and with the child. The child had [REDACTED]. The child had [REDACTED]. The crib the child was placed in had several blankets and a pillow placed in the crib with the child rather than a mattress. The blankets in the crib were soaked in urine. Police and emergency response personnel noticed the home was extremely warm, especially in the child's bedroom. The trailer the family was living in did not have a functioning heating system. The family was utilizing a space heater to heat the child's room since the temperature outside was unseasonably cold around the time of the incident. The heater was not functioning properly and later it was determined that the thermostat setting on the space heater's thermostat was broken; which resulted in the unit continuing to heat up without automatically shutting off once the sensor determined the surrounding air temperature was sufficiently heated. Additional testing of the unit by law enforcement determined that the heat coming out of the unit reached 160 degrees within minutes. When the heater was placed in the room and power turned on, the temperature of the room rose ten degrees in less than ten minutes. The family reported that they used the heater before and were not aware of the heater not functioning properly. The emergency response personnel at the home found some areas of mold in the kitchen and bathroom.

Upon investigation, the county agency, law enforcement, and the county coroner determined the result of the victim child's death to be [REDACTED]. The result of the investigation found no signs of child abuse, neglect, or foul play. Law enforcement is not going to pursue charges against the biological parents. The county coroner did not have concerns regarding the [REDACTED] found on the child's body. They have witnessed cases more severe, in addition, the child's parents appeared to have [REDACTED]

[REDACTED] It was reported that the victim child's [REDACTED] as the child was experiencing the effects of a common cold. The child was [REDACTED]

[REDACTED] as the parents had limited access to transportation.

The family may have been a candidate for receipt of community services. Those services could have been a benefit to the family, possible knowledge around safe sleeping practices for young babies. The family participated in what

could be considered by some as an isolated lifestyle, with few family supports in the area. However, [REDACTED] by the county agency could not determine that the parents intended any harm to their child. Through interviews and information gathered, it appears the family was doing the best they could to get by on what few resources they had. The county agency [REDACTED]. The family was provided contact information for [REDACTED] services which may be available for the parents in the county. The county children and youth agency completed their investigation on 12/15/11. [REDACTED]

Current Case Status:

Upon completion of the county agency investigation regarding the [REDACTED]. The victim child was the parents' only child, there were no other children in the home and [REDACTED]. The agency was able to provide the parents information regarding [REDACTED] within the county area for the parents to utilize, should they choose to attend. [REDACTED]

County Strengths and Deficiencies as Identified by the County's Fatality Report:

The county's report did not note any strengths or deficiencies identified from the Fatality review meeting.

County Recommendations for changes at the Local Levels as identified by Fatality Report:

The county's report did not indicate any recommendations for change at the local level in their report.

Recommendations for changes at the State Level:

None indicated in the report.

Department Review of County Internal Report:

The Department received the county's report on 12/15/11. Participation in the county agency's internal child fatality review meeting along with review of information in the case record, the Department found the county report to be accurate. The county agency did not identify specific strengths, weaknesses, or

recommendations of change due to the agency having no knowledge of the family prior to this incident.

Department of Public Welfare Findings:

County Strengths:

This is a family which may have benefited from services initiated or implemented by the county agency, however; the family was not known to the agency. In discussion over the completion of the county's report, the communication between law enforcement and the county agency from the time of the initial report through completion of the investigation was indirectly identified as a strength. The Departmental review determined both agencies have a commitment to service and a positive working relationship.

County Weaknesses:

The Department found no areas of weakness to identify in this section.

Statutory and Regulatory Compliance issues:

Review of the county investigation and case file review found no areas of non compliance regarding this particular case.

Department of Public Welfare Recommendations:

There were no recommendations as a result of this fatality review.