



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Dylan Johnson

Date of Birth: November 11, 2014

Date of Death: February 6, 2015

Date of Report to ChildLine: February 6, 2015

FAMILY WAS NOT KNOWN TO:

Butler County Children and Youth Services

REPORT FINALIZED ON:

July 1, 2015

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 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, DHS 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. Beaver County has convened a review team in accordance with Act 33 of 2008 related to this report on February 26, 2015.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED] 1984
[REDACTED]	Father	unknown
[REDACTED]	Child	[REDACTED] 2005
[REDACTED]	Child	[REDACTED] 2006
Dylan Johnson	Victim Child	11/11/2014
*[REDACTED]	Caretaker	[REDACTED] 1954

*indicates not a household member

Notification of Child Fatality:

On February 6, 2015, Butler County Children and Youth Services received notification of the death of the victim child by [REDACTED] listing [REDACTED] as the alleged perpetrator. The report stated that [REDACTED] was running an unlicensed in-home child care service which the child was attending. [REDACTED] had a total of 12 children in her care ranging from the ages of three months to five years old. She had reportedly taken four children to the bus stop on the morning of the incident and left the other eight children, including the victim child, in the home alone. The other children were infants and toddlers. When [REDACTED] returned, the victim child was unresponsive in his crib. At the time of the report it was unknown how long the alleged perpetrator was gone from the home. Emergency services were called and the victim child was dead on arrival at the hospital (unknown which hospital). An autopsy was completed the evening of child's death and at that time the cause of death was unknown. There were no visible signs of trauma. It was also unknown if [REDACTED] was being arrested or charged.

Summary of DHS Child Fatality Review Activities:

The Western Region Office of Children, Youth and Family Services obtained and reviewed all current case records pertaining to the family. The region office spoke with the Western Region Office of Child Development and Early Learning worker assigned to

the case to gather information about their investigation. The region office also spoke with the assigned Butler County Children and Youth Caseworker to discuss the results of the investigation. The region attended the county internal fatality team meeting scheduled for this case on February 26, 2015.

Summary of Services to Family:

The family was not known to Butler County Children and Youth. The family was not responsible for the death of the child and Butler County Children and Youth determined that the family was not negligent in their action; therefore the case was not accepted for services and was closed shortly after the death of the child. There were no family services provided or requested by the family.

Children and Youth Involvement prior to Incident:

There was no prior family involvement.

Circumstances of Child Fatality and Related Case Activity:

On February 6, 2015, a referral was received by Butler County Children and Youth Services stating [REDACTED] was running an unlicensed in-home child care service which the child was attending. [REDACTED] had a total of 12 children in her care. She was taking four children to the bus stop the morning of February 6, 2015 and she left the other eight children, including the victim child, in the home alone. The other children were infants and toddlers. When [REDACTED] returned to the home from taking the other children to the bus stop, the victim child was found unresponsive in the pack n play. Emergency services were called, however the victim child was pronounced dead on arrival at 9:41am.

The Office of Child Development and Early Learning (OCDEL) field investigator went to [REDACTED] home. OCDEL issued a Code Enforcement on February 9, 2015 to obtain a Cease and Desist order which will prohibit [REDACTED] from caring for children in her home. It was determined that [REDACTED] was permitted to have up to three children in her home as an unlicensed provider. This would also make it very difficult for [REDACTED] to obtain a daycare license in the future.

The Butler County Children and Youth caseworker contacted and spoke with the [REDACTED], who stated that there was no concern of foul play in regard to the victim child's death. [REDACTED] victim child had only been at [REDACTED] home on two occasions and this was his second time. He stated that the child was seen by his pediatrician two days prior for congestion. An autopsy was being performed. The Butler County District Attorney was not interested in filing criminal charges unless there were findings from the autopsy. [REDACTED] felt that the victim child's death was a result of a tragedy.

On February 10, 2015, [REDACTED] reported that the results of the autopsy were "unremarkable" and there were no overt findings of abuse. The toxicology and histology results were negative. The official cause of death was sudden unexplained infant death, with the manner being undetermined.

On March 3, 2015, after several attempts the Butler County Children and Youth caseworker was able to meet with [REDACTED] in her home. Per [REDACTED] she did not consider herself a daycare center she just helped people by babysitting, and rarely had as many children as she did on that day. She stated she received referrals by word of mouth, and babysat for many of the substitute teachers at Butler School District. She stated that morning she did have 12 children, but the older four were only there for about 15 minutes before she put them on the bus. [REDACTED] walked the caseworker outside to show her where the bus stop is, approximately 150 feet from the home. She stated she made sure the younger children are situated and safe, and then as soon as they saw the bus cresting the hill, she walked the older ones outside. She stated she is outside the home for approximately 2-3 minutes.

[REDACTED] stated that morning she had laid the victim child down in his pack-n-play at approximately 8:08am before taking the older children out to the bus. She stated when she came back inside she changed a diaper, gave one child breakfast, and put another child on the potty. She stated it was approximately 30 minutes after she laid the victim child down that she went to check on him. She stated he "didn't look right", and that she went to pick him up and he was not breathing. She stated that she called 911 and then patted his back and chest in an attempt to get him to breathe, but she did not perform chest compressions. [REDACTED] was not cardiopulmonary resuscitation (CPR) certified and was not familiar with performing CPR. [REDACTED], she was rocking the baby when [REDACTED] the ambulance arrived. She stated that she called 911 twice because if felt like "forever" before they responded, but after the fact she realized they responded in about six minutes. She stated that the victim child was taken in the ambulance. [REDACTED] the victim child took a few breaths in the ambulance. She stated her husband, a bus driver, came home from work. She stated they contacted the parents of the other children and had them picked up. [REDACTED] stated it was only the second time the victim child had been in her care as his mother had just gone back to work, maternal aunt also watched him on occasion.

[REDACTED] stated that she went to the hospital and found out that the child had passed away. She said that child's mother and father came to [REDACTED] home that night to get the victim child's car seat and other belongings. She stated she and her husband had gone to the funeral, and comforted her and told her it could have happened to anyone and they did not blame her.

[REDACTED] took the Butler County Children and Youth caseworker upstairs to the room where the victim child was sleeping. His pack-n-play was located in the bedroom right at the top of the stairs, within earshot of the living room where [REDACTED] would have been with the other children.

The caseworker explained that the autopsy had been completed, and there was no evidence of abuse or neglect. The caseworker informed [REDACTED] that no criminal charges were pending, and there were no findings of abuse made.

Current Case Status:

There were no signs of abuse or neglect, resulting in the death of the victim child. The caseworker completed the investigation [REDACTED]. An autopsy was completed and there was also no evidence of abuse or neglect. The death was ruled as sudden unexplained infant death. The Butler County Children and Youth caseworker was unable to make contact with the child's parents. There were no previous reports and/or current, however the caseworker was unsuccessful with meeting with parents. [REDACTED] was interviewed by the caseworker, [REDACTED] and OCDEL and proper steps were taken prohibiting [REDACTED] from having more than three children in her care at a time. [REDACTED] was completed and sent on March 10, 2015 and [REDACTED]. There were no additional safety concerns noted per the safety and risk assessment. The case was closed on March 10, 2015.

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

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. Butler County has a convened a review team in accordance with Act 33 of 2008 related to this report on February 26, 2015.

- **Strengths:** The Act 33 review identified several strengths with the case management and investigation of the report. The Butler County Children and Youth caseworker maintain contact with the important members of the investigation and remained diligent in her efforts to meet with the family and the caretaker. The caseworker also made sure that she obtained the autopsy report and medical information regarding the victim child's cause of death.
- **Deficiencies:** The Act 33 team review found no deficiencies with the investigation process at the time of the review.
- **Recommendations for Change at the Local Level:** There were no recommendations at the local level, as the family was not actively receiving services from the agency.
- **Recommendations for Change at the State Level:** The Act 33 review identified that this was a tragic accident that may have occurred even if the caretaker only had the allotted amount of children in care for one person, however they also recognize the importance of educating parents of regulatory requirements for child care provides.

Department Review of County Internal Report:

The Department has not received the County Internal Report.

Department of Human Services Findings:

- **County Strengths:** The county agency responded immediately upon receiving the report. The Butler County Children and Youth caseworker made several attempts to complete a home visit with family. The caseworker also made several attempts to meet with the caretaker and left messages and cards until she was able to meet with her. The agency gathered detailed information which contributed to the thorough assessment surrounding the circumstances.
- **County Weaknesses:** There were no weaknesses identified on the part of the county agency.
- **Statutory and Regulatory Areas of Non-Compliance:** The County Internal Report was not received outlining the strengths and deficiencies and recommendations at the local and state level. A Multi-Disciplinary Team Meeting was held on February 26, 2015 and recommendations were made; however, the County Internal Report was never received by the Department. This has been addressed with the Butler County Children and Youth Office through technical assistance.

Department of Human Services Recommendations:

In addition to the above mentioned recommendations made within the Internal County Report, the following recommendations are brought forth by the Department.

- It is recommended that parents and home daycare/ babysitters be aware of the regulatory requirements for caring for children.
- It is also recommended that non-licensed babysitters be familiar with regulatory requirements and be required to have year CPR training.
- It is recommended that Child Care Information Services and/or childcare partnerships, which provides payment for identified babysitters and Daycares expand their requirements for individuals that are seeking payment for caring for children. It is suggested that they require and provide educational information surrounding childcare regulatory requirements and that CPR be a requirement.
- It is also recommended that parents provide medical information or updates to individuals that are caring for their children. If the caretaker was aware of the victim child's preceding respiratory issues she may have been more incline to check or the victim child more frequently.