



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

Dylan Bonnett

**Date of Birth: 10/26/2015**  
**Date of Death 12/23/2015**  
**Date of Report to ChildLine: 12/24/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

York County Children and Youth

**REPORT FINALIZED ON:**  
5/27/2016

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. Section 6349 (b))

**Reason for Review:**

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

York County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 01/13/2016.

**Family Constellation:**

<u>Name</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Dylan Bonnett	Victim Child	10/26/2015
[REDACTED]	Biological Mother	[REDACTED] 1995
[REDACTED]	Biological Father	[REDACTED] 1979
[REDACTED]	Half Sibling	[REDACTED] 2012
[REDACTED]	Maternal Grandfather	[REDACTED] 1968
[REDACTED]	Maternal Grandmother	[REDACTED] 1968
* [REDACTED]	Father of [REDACTED]	[REDACTED] 1992

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

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

The Central Region Office participated in the Act 33 meeting held on 01/13/2016. Copies of case notes, safety plan [REDACTED] prior criminal history, and medical reports were obtained.

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

None

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

On 12/24/2015, ChildLine received a [REDACTED] report regarding the death of the victim child. It was reported that on 12/23/2015 the child was in the care of his father while the mother was at work. When questioned [REDACTED] the father stated that he placed the child on his back on the parents' bed with a diaper on and placed a blanket over him at approximately 10pm. The father proceeded to play video games while staying in the room with the child. The mother returned home at 11pm from her 3pm to 11pm shift and proceeded to the kitchen to get a bottle ready for the child. The father found the child on his stomach and his face turned to the right. He attempted to wake the child but he was unresponsive. The father began screaming and brought the child to the kitchen. The mother called Emergency Medical Services (EMS) who responded to the home along with [REDACTED] police. The child was declared dead at the home by EMS and was transported to York hospital. The hospital felt that the father's explanation of events was not consistent with the physical capabilities of a 2 month old.

On 12/24/2016, the hospital completed an autopsy on the child. The results of the autopsy were not completed at the time the [REDACTED] was due, therefore on 02/19/2016 the [REDACTED] was submitted with a [REDACTED] status.

In [REDACTED] report that the agency received, [REDACTED] asked the father to lay a doll down to demonstrate how the father laid the child down to sleep. The written [REDACTED] report states father used the doll to show how he laid the child down partially on the left side. This report was dated on 12/24/2015. [REDACTED] then noted in the report that father's story stayed consistent during his interview [REDACTED] on 01/14/2016.

The family constellation consisted of the father, mother, both maternal grandparents and a 3 year old half sibling from mother's previous relationship. The whereabouts are unknown for the father of that child. Although the grandparents were in the home at the time of the incident, they had not seen the child since 7:45 am on 12/23/2015. A safety plan was developed for the half sibling. Both the mother and grandparents assured that the victim child's father would have no unsupervised contact with the 3 year old half- brother. The family was opened for services on 02/22/2016 [REDACTED] A second safety plan, which was a continuation of the original safety plan, was entered on that date as well. A home visit was done in March 2016 to discuss the Family Service Plan. The mother was interested in [REDACTED] but insisted on setting that up independently. That was the only service being provided by the agency at that time.

On 04/01/2016, the autopsy report was received by the agency. The autopsy revealed no trauma or foul play. [REDACTED] analysis of the right lower lobe of the lung revealed the presence of Rhinovirus which is a virus most commonly known to cause the "common cold". There was no presence of acute pneumonia. Due to the patchy nature of the chronic inflammation of the

lungs and its relative lack of presence in most of the sectioned areas, Rhinovirus cannot be directly attributed to the child's death, however it cannot be ruled out as a possible contributor to the child's death. The cause of death, according to the report, was sudden unexpected infant death.

A new [REDACTED] was submitted by the agency on 04/05/2016 changing the status of [REDACTED]. The District Attorney will not be pursuing charges against the alleged perpetrator and has closed the investigation.

The safety plan was lifted on 04/01/2016 and the case was closed on 04/06/2016.

**County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

- Strengths in compliance with statutes, regulations and services to children and families;

The county agency investigation complied with regulations and response times as required.

- Deficiencies in compliance with statutes, regulations and services to children and families;

The county agency report did not reference any deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The county agency report did not note any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

The county agency report did not note any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The county agency report did not note any recommendations for change at the state or county level.

### **Department Review of County Internal Report:**

The Act 33 report was received on 01/27/2016. There were no issues or concerns regarding the content of the report.

### **Department of Human Services Findings:**

- County Strengths:

Upon review of the documents associated with this case, it would appear there is a positive working collaboration between law enforcement, medical facilities and the county agency.

- County Weaknesses:

The circumstances of this case and the review of the county's work did not identify any systemic weaknesses. This family was not known to the agency.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

There were no areas of non-compliance found during the review of this case.

### **Department of Human Services Recommendations:**

The Department concurs with the findings and recommendations of York County Children and Youth's Act 33 meeting. The Department suggests that the agency continue to assess and assure safety immediately on all child abuse reports and should continue to seek input from medical, law enforcement and other social service agencies as appropriate related to child abuse reports.