pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Tyler Krolikowski

Date of Birth: 10/21/2011
Date of Death: 07/03/2012
Date of Report to ChildLine: 11/21/2012

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUT GENCY AT TIMEOF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:
Bucks County Children and Youth Services

FAMILY KNOWN TO COUNTY CHILDREN AND YOUT GENCY AT TIMEOF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:
Philadelphia Department of Human Services

REPORT FINALIZED ON:
January 31, 2017

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:

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, 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.

Act 33 of 2008 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. Bucks County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 12/20/2012. Philadelphia County did not participate in an Act 33 review on this case. Due to the initial undetermined cause of death and the later receipt of the toxicology report, Bucks County expedited a review team meeting and did not include Philadelphia-DHS.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1987
[redacted]	VC's Father	[redacted]1990
Tyler Krolikowski	Victim Child	10/21/2011
[redacted]	Sibling	[redacted]2010
* [redacted]	Father (Below Siblings)	[redacted]1985
* [redacted]	Half Sibling	[redacted]2002
* [redacted]	Half Sibling	[redacted]2006

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the caseworker, and the Agency Assistant Director on 01/30/2017. The regional office also participated in the County Fatality Review Team meetings on 12/20/2012 where copies of the medical examiner's reports and autopsy were presented.

Children and Youth Involvement prior to Incident:

It was reported that the Philadelphia DHS had a previous involvement with the half-siblings of Tyler in 2009 based on a referral with concerns regarding the children's care with their father. The county found no validity to that referral.

Philadelphia County received a [redacted] report on 03/3/2012 of 2012 alleging the parent's failure to provide proper supervision for their children. This agency responded the same day and after seeing both children and meeting with their mother determined there was no need for additional services. An additional report was received on 06/21/2012 reporting that the family was residing in a motel and the parents were heroin addicts. Based on the information provided by the referral source, the referral was [redacted] as there were no specific allegations regarding maltreatment of the children, there were no present dangers identified and the threshold for safety concerns for the children were not met.

Bucks County did not have any previous involvement with this family.

Circumstances of Child Fatality and Related Case Activity:

Bucks County Children Youth Services received a [redacted] on 07/03/2012 at the time of Tyler Krolikowski's death. The referral stated that the victim child's father reported that he wrapped Tyler in a blanket on 07/03/2012 and then placed the child between two beds on his back. The mom stated this was done to keep the child from falling off the bed. The family was residing in a motel located in Bucks County at this time; but, they have been living in motels for over a month. The father added that he woke up to find the child face down on the floor. It was reported that the child had a bruise on his forehead and he was unresponsive. The child's mother then attempted CPR and called 911.

The family consisted of four children but only two were residing with the family, Tyler who was 8 months old at the time and his brother, who was almost 2 years of age. Tyler's brother was placed with the paternal grandmother by Philadelphia DHS on 07/03/2012 via a safety plan. The paternal grandmother resides in [redacted] County of Philadelphia.

Tyler's half-siblings resided with their biological father and were not present at the time of his death.

On 07/03/2012, [redacted] Police Department (Special Victims Unit) had responded to this family's tragedy to begin their investigation at the motel. It was reported that Tyler was wearing only a diaper and showed no signs of life. It was also reported that the child's eyes were glassy and as the baby was lifted both his legs and arms were stiff. Moreover, [redacted] could not find a pulse and CPR was started. The medics arrived and transported the child to Aria Hospital where the child was pronounced dead.

Both parents were interviewed [redacted] and the police had obtained a search warrant for the motel room that the family was residing in. The father admitted to the usage of heroin and he informed police that there was evidence of his drug usage in the motel room. The police found needles and heroin bags in the motel room. However, the parents were not charged with possession of paraphernalia. The father admitted that the parents had used the heroin as early as 07/01/2012

and that he had arranged to get more heroin [redacted] on the morning of his child's death. Both parents denied any physical abuse on their children.

The Philadelphia Medical Examiner performed an autopsy on 07/04/2012. The child's body was weighed, measured and photographed. There were no signs of trauma to the child's body and the preliminary toxicology screen was negative. However, a full toxicology was completed and those results could take up to three months. On 08/31/2012, Bucks County closed its [redacted] citing that the sibling child resides in Philadelphia [redacted] and that there is no evidence to support that the deceased child was abused.

There was no further activity until Bucks County received information on 11/21/2012 that the toxicology report indicated that the child had heroin in his system. Based on this new information the county initiated a [redacted] Investigation. Both parents were arrested on 11/15/2012 and charged with endangering the welfare of a child, recklessly endangering another person and possession of drug paraphernalia.

On 01/18/2013, Bucks County concluded their investigation with a status determination of [redacted] citing that the deceased child ingested heroin due to the lack of supervision [redacted] At that time, the parents were incarcerated and the remaining children are in homes where their needs are being met. No further involvement with Bucks County Children & Youth Services were deemed necessary and the agency closed its case.

On 02/28/2013 both parents were before the Court on the charges they faced. The mother pleaded guilty to Endangering the Welfare of Children – Parent and was sentenced to 9 to 23 months and one year Probation. The father was charged with Endangering the Welfare of Children – Parent, Recklessly Endangering another Person and Possession of Drug Paraphernalia. Following his guilty plea, he was sentenced to one year minimum - two years maximum, and two years probation.

Tyler's brother remains [redacted] in relative care with the plan that this placement setting become permanent.

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

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

  The county viewed it a strength that no case had been opened with Bucks County Children and Youth Services. There was communication regarding the initial decision [redacted] based on not having a confirmed cause of death and to wait for the toxicology report. It was stated that even if the report [redacted], the county CPS team would not have been able to substantiate the incident given the initial findings in the case.

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

  No deficiencies noted.

- 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 raised the concern relating to skill levels or protocol needed in order to assist and/or engage family members with accessing the child welfare system when family's substance abuse is endangering their children's safety. Also, the team questioned should there be a crisis team developed to engage families through loss/grieving issues relating to these fatalities. Lastly, this fatality should have been reviewed with Philadelphia-DHS; however, due to the undetermined cause of death and the later receipt of the toxicology report, Bucks County hurried to convene a Fatality Review and did not include Philadelphia-DHS.

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

  No recommendations at this time

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

  Transfer of information between counties (Philadelphia to Bucks; Bucks to Philadelphia) should be streamlined; agency records should be easier to obtain.

  Could a system be developed, such as the JCMS, so that child welfare agencies could more easily and efficiently share information regarding specific cases?

  During 5-County Administrative meetings include a section of fatality reviews in the Southeast Region. Create a 5-County Committee to review/discuss regional fatalities, causes, similarities and recommendations.

  Develop a process to immediately test for substance abuse by caretakers.

Department Review of County Internal Report:

The Department attended the county's Act 33 meeting and received the county's report dated 03/18/2013. The Department concurs with the report. It is noted that at the writing of the Department's report, the recommendation related to ease in exchange of case information between counties is being addressed through the statewide Child Welfare Information Solution (CWIS).

Department of Human Services Findings:

- County Strengths: The collaboration between Bucks County Children & Youth staff and Philadelphia-DHS involvement as well as with [redacted] Police Department is considered a strength in engaging the family as well as each other in this case

- County Weaknesses: Philadelphia County should have completed an Act 33 review if it was not a participant in the Bucks County review.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency: None

Department of Human Services Recommendations:

Consideration must be given to developing critical thinking and decision making guidance around those cases in which multiple referrals of similar nature are received in a short timeframe.

The Department recommends continued awareness on how substance abuse destroys families. Substance abuse education must continue to be one of the priorities that the counties and its providers, stakeholders and families continue to diligently get the word out into the communities.

Due diligence must be made by counties convening the Act 33 review to ensure inclusion of all parties who had prior involvement with the family and any county in which the child and family resided within the 16 months preceding the incident leading to a fatality/near fatality report.