pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Abagail Hench

Date of Birth: 08/18/2016
Date of Death: 03/11/2018
Date of Report to ChildLine: 03/11/2018
CWIS Referral ID: [redacted]

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

Cumberland County Children and Youth Services

REPORT FINALIZED ON:
09/06/2018

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 the Office of Children, Youth and Families (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.

Cumberland County has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 04/04/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Abagail Hench	Victim Child	08/08/2016
[redacted]	Father	[redacted] 1985
	Mother	1987
	Half-sibling	[redacted] 1982
	Half-sibling	[redacted] 2010

* 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 of Children, Youth and Families (CERO) attended the Act 33 meeting on 04/04/2018 and obtained and reviewed all case records pertaining to the family. CERO staff spoke with Cumberland County Children and Youth Services (CCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:
CCCYS has no prior involvement with the father and victim child; however the agency does have prior involvement with the mother and the victim child's [redacted] A [redacted] was received in June 2014 with concerns that the mother was driving with the children in the car while high. The agency [redacted] and the family was accepted for ongoing [redacted] services in order to address concerns related to [redacted] and the children not receiving appropriate medical care. The mother was not compliant with services and the victim child's [redacted] went to live with their respective fathers. CCCYS closed out the family's case in February 2015.

Circumstances of Child Fatality and Related Case Activity:

Emergency services personnel (EMS) were called to the family's home on 03/11/2018, around noon after the child was found unresponsive with a lanyard around her neck beside a laundry basket in the bedroom shared by the child and [redacted] The [redacted] had worked the evening prior to the incident and had not returned home until between three and four in the morning. The [redacted] aunt, who lived upstairs, stayed with the child overnight during the evenings that the [redacted] worked until [redacted] would return home. When the [redacted] returned home, [redacted] went to sleep until the child woke [redacted] up at 8:00 AM. [redacted] reported that [redacted] then took her out of her pack and play and changed. [redacted] latched the door to their bedroom and then laid back down turning on the television for the child to watch. The [redacted] reports waking up around 10:00 AM to observe the child and then falling back asleep until [redacted] awoke around noon. Upon awaking, [redacted] noticed that the child appeared to be sleeping on the floor in a weird position. Upon closer inspection, [redacted] saw that the child had a lanyard around her neck and was unresponsive with blue lips. The [redacted] screamed for the [redacted] aunt, who then contacted emergency services while the [redacted] performed CPR until EMS arrived. The lanyard was a non-breakaway type of lanyard that had been in a laundry basket which was sitting on a chair in the bedroom. The child had managed to get the string from the lanyard around her neck and the ID portion got caught in the laundry basket, creating a noose around the child's neck.

Following the child's death, an autopsy was performed and her death was ruled as accidental. Law enforcement are not pursuing any criminal charges. [redacted] As there were no other children in the home, CCCYS closed out the case following the completion of their investigation.

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

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;
    - Strengths are the Agency was notified almost immediately regarding the incident and interviews with all parties were able to be completed in conjunction with law enforcement. Information regarding the autopsy was received in a timely fashion and the hospital provided the Agency with all needed information.

- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>: The following challenges were noted by the county, not all of which are deficiencies:
    - None identified

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse</u>;
    - Recommendations for change are based on the team's conclusion of the root cause of this incident being lack of sleep. One recommendation is assuring appropriate child care through the

subsidized day care program is available to parents working all shifts to include child care for parents to sleep when they are working non-traditional shifts. Assuring physicians are talking with parents about the importance of supervision when a child is awake since, at times; physicians are the only provider seeing the child/family. The review team suggested more education at the time of birth, for parents, on the importance of supervision. Another thought was Public Service Announcements by the Department of Human Services regarding the importance of supervision of children. These recommendations all stem from another conclusion made by the team; lack of supervision could be a learned or familial behavior based on the information presented during the review.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - No recommendations for changes at the state and local levels on monitoring and inspection of county agencies were brought to light at the meeting.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - No recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse were brought to light at the meeting.

Department Review of County Internal Report:

The County submitted their report in a timely manner within the required 90 day timeframe. The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
    - The agency immediately began the investigation, cooperated with medical personal, and assured the safety of the children involved.
    - The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.

- County Weaknesses:
    - None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - There were no areas of regulatory non-compliance observed.

Department of Human Services Recommendations:

The Department concurs with the County Review Team's recommendation about better educating parents on the importance of supervising children. An emphasis should be placed on providing education regarding the potential dangers of sleeping

while being the person responsible for supervising a child. In addition, public service announcement should highlight the need for caretakers to consider what common household items could pose a safety risk to children and take action to prevent child access to those items.