



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Dylan McCrossin

Date of Birth: 1/8/14
Date of Death: 5/5/14
Date of Oral Report: 5/9/14

FAMILY NOT KNOWN TO:

Any public or private child welfare agency

REPORT FINALIZED ON: 04/02/2015

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. 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, 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 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. Delaware 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>
Dylan McCrossin	victim child	1/8/14
[REDACTED]	mother	[REDACTED]/85
[REDACTED]	father	[REDACTED]/85
[REDACTED]	sister	age 3
* [REDACTED]	daycare provider	6/26/50

At the time of the incident, the child was at the family daycare provider, [REDACTED]. [REDACTED] The daycare provider is listed as the alleged perpetrator.

Notification of Child Fatality:

On 5/9/14, Delaware County CYC received a [REDACTED] report [REDACTED] reporting that on 5/5/14 the child died while in the care of the family daycare provider. On the date of the incident, the provider placed the child on his back in a playpen for a nap in a room separate from the other children. She closed the door to this room as she left. While he was sleeping, she took the other children outside for a small period of time. When she returned to check on the child he was face down in the playpen and not breathing. She immediately called 911 and began CPR. According to OCDEL regulations, daycare providers must be able to see, hear, assess and direct the actions of the child at all times. [REDACTED]

Summary of DPW Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation. SERO reviewed the county's investigation/assessment,

structured case notes, safety assessments, safety plan implemented by OCDEL for the daycare provider, inspection summary issued by OCDEL for the provider for citations and regulatory violations and risk assessments. Interviews were completed with the investigative social worker and supervisor as well as the supervisor from OCDEL and attorney from the Office of General Counsel for DPW. SERO attended the MDT review meeting held 6/4/14.

Children and Youth Involvement prior to Incident:

There was no prior involvement.

Circumstances of Child Fatality and Related Case Activity:

CYS received the referral on 5/9/14 and assigned the case for investigation. The agency worked collaboratively with law enforcement and OCDEL to interview the reporting source, family members, daycare staff and the ME office. A joint visit to the daycare was made by CYS and OCDEL to develop an OCDEL approved safety plan as to the safety of the other children at the facility. The plan is that there will be another staff present at all times when children are present. A safety assessment of the biological home of the child regarding his sibling determined the child was safe in this home and no threats were noted. The sibling will not be returning to this daycare.

On 7/7/14 the report was [REDACTED] There was no evidence [REDACTED] the child's death was a result of a lack of supervision. The ME reported that there were no signs of abuse or neglect, but the final report of cause of death is pending at this time. The [REDACTED] police did not file charges as there was no suspicion of foul play.

Current Case Status:

There were no concerns regarding the child's sibling and the agency closed the case.

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

- Strengths: The county noted they were in compliance with statutes and regulations for the [REDACTED] investigation. CYS and OCDEL worked collaboratively along with law enforcement.
- Deficiencies: Although not a STARS rated daycare, the provider had not had any previous violations. However, she failed to report the child's death in a timely manner as required by regulation.
- Recommendations for Change at the Local Level: None

- Recommendations for Change at the State Level: It was recommended that there be required verification of training hours for family daycare providers on a regular basis, as opposed to randomly, which is current practice. In addition, it was recommended that daycare providers be required to attend training on safe sleeping.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county dated 7/8/14. We are in agreement with the county's findings.

Department of Public Welfare Findings:

- County Strengths: The county provided clear documentation. All relevant parties were interviewed. Children were seen timely. The county collaborated with law enforcement and OCDEL throughout the investigation.
- County Weaknesses: None
- Statutory and Regulatory Areas of Non-Compliance: None

Department of Public Welfare Recommendations: Hospitals need to be educated regarding situations that ought to be brought to the attention of the county agency. If a serious incident occurs in a licensed or registered daycare, the county, as well as the licensing authority, should be made aware of the incident to review for regulatory compliance or supervision issues. Additionally, childcare providers should be made aware of safe sleeping recommendations.