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REPORT ON THE FATALITY OF

JOSHUA PARKINSON

Date of Birth: 08/20/2007
Date of Death: 05/21/2011

FAMILY WAS KNOWN TO
CLEARFIELD COUNTY CHILDREN AND YOUTH SERVICES

FAMILY WAS NOT KNOWN TO
JEFFERSON COUNTY CHILDREN AND YOUTH SERVICES

REPORT FINALIZED ON:
August 2, 2012

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, 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.

Family Constellation

Name	Relationship	Date of Birth
Parkinson, Joshua	Victim Child	08/20/2007
[redacted]	Sibling	[redacted]2004
[redacted]	Sibling	[redacted]2005
[redacted]	Half-Sibling	[redacted]2001
[redacted]	Half-Sibling	[redacted]2000
[redacted]	Mother [redacted]	[redacted]1981
[redacted]	Father	[redacted]1957
[redacted]	Mother's Paramour	Unknown
[redacted]	Mother's Paramour	Unknown

Notification of Child Fatality

On May 21, 2011, the on-call after-hours caseworker received a [redacted] referral from the [redacted] at 6:30pm, which stated that the victim child had died as a result of drowning in the Mahoning Creek. The [redacted] reported that not all of the details were available, as the incident had just occurred, but he was concerned as there were three other children present when the drowning occurred. The [redacted] requested the County arrive at the scene of the fatality to assess the situation.

On May 23, 2011, a forensic interview was conducted, at which time information was gathered that prompted Jefferson County Children and Youth Services to contact [redacted] to have the incident [redacted]. Working in conjunction with the Punxsutawney Police Department and the Pennsylvania State Police, the agency learned new information that led them to believe that the children were without parental supervision.

The children and their mother were in Jefferson County ([redacted] Punxsutawney, PA) at a friend's home. The mother was sleeping and told the victim child and the 9-year old sibling to go outside. The children were outside for approximately one hour. The child died as a result of drowning after he fell into the Mahoning Creek in the backyard of the home they were visiting. It was

reported by the responding emergency personnel that the mother was hard to wake up, as she appeared to be overmedicated.

Summary of DPW Child (Near) Fatality Review Activities

The Western Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Jefferson County Children and Youth Services granted the Western Regional Office access to CAPS, their electronic case management system, in order to provide the Regional Office with the most up-to-date information related to the case. This access had been provided prior to the fatality, and the Regional Office was able to gather information immediately upon the [redacted]. Also, the Regional Office reviewed documents from Clearfield County Children and Youth Services, as they had completed two assessments of the family. This information was also made available immediately, as the Regional Office had access to Clearfield County Children and Youth Services electronic case management system, CAPS.

Additionally, interviews were conducted with Jefferson, Clearfield and Butler County caseworkers, supervisors and directors. The Regional Office also participated in the County Internal Fatality Review Team meeting that occurred on June 22, 2011.

It should be noted that Butler County Children and Youth Services is involved with this case, as the safety plan included the father of the [redacted] children, who resided in Butler County.

Summary of Services to Family

At the time of the child fatality, the mother was receiving [redacted] from numerous providers in Clearfield County. The service consisted of [redacted]

Children and Youth Involvement prior to Incident

Jefferson County Children and Youth Services did not have any prior history with this family, as the family resided in Clearfield County and were visiting the home of a friend when the fatality occurred.

The family was known to Clearfield County. There was a past intake received March 11, 2011 for [redacted] and the mother leaving the children alone overnight. The referral also indicated [redacted] regarding the mother. The agency closed the referral at intake after discovering the mother had a paramour that was in the home to help with supervision and that the mother had quit her job, resulting in her being home with the children.

A second referral was screened out by Clearfield on May 11, 2011 after the agency received information that the mother was being admitted to the [redacted]. The children were going to remain in the care of the mother's boyfriend.

Circumstances of Child Fatality and Related Case Activity

The victim child, his nine year old sibling and their mother were visiting the home of the mother's paramour, [redacted] in Punxsutawney, PA. The mother told the children to go outside and play, reportedly telling the 3 year old victim child that he was to listen to the nine year old. The children were outside by themselves for approximately an hour, while the mother and her paramour were inside of the home, sleeping.

The nine year old sibling reports that the victim child did not want to play outside anymore and left the area of the trampoline in the back yard where they had been playing. Instead of returning to the inside of the home, the victim child ran toward the flood control dike which bordered the back yard. Upon reaching the top of the dike, the victim child tripped and fell, rolling down the other side of the dike and into the Mahoning Creek, which was deep and had a strong current due to recent storms and winter melt-off.

The nine year old sibling attempted to rescue his brother from the water, but the child was quickly swept downstream by the current. The sibling reported that he yelled to his brother to hold his breath; then ran into the house to get his mother, who he found sleeping. He was unable to awaken her. He then attempted and successfully woke the mother's paramour, who contacted 911 emergency services. The child drowned in the creek prior to the emergency services arriving on scene. His body was found downstream, and attempts to revive him were unsuccessful.

Emergency personnel who arrived on scene reported that the mother remained in the home, and was not outside when they arrived. Emergency personnel and eyewitnesses report that the mother appeared unconcerned with the fact that her child had drowned. She had no affect and made no attempt to locate her child who was swept away by the current and drowned. It was believed at that time that the mother was highly intoxicated by an unknown substance. Additionally, the 911 emergency call made by the mother's paramour was partly incoherent, largely due to the fact that he was under the influence of an unknown substance.

Due to the mother and her paramour's physical state of impairment, the Jefferson County Children and Youth caseworker, along with local and State police, spoke to the mother in an attempt to get information as to who could care for the children on this date. The mother reported that her mother lived in Texas and she would not be an option. She then stated that she did not want the children to go with any other family members. The Jefferson County caseworker suggested

that the children go with the father [redacted] as he had full custody of [redacted] and the deceased victim child. The mother stated they could, but that she would rather the children go with her paramour/ex-fiancé, [redacted]. At this point, the mother contacted her paramour/ex-fiancé, who stated he would be willing to watch the children; however he was not available on this evening for a home check to be completed.

The Jefferson County caseworker again stated that it may be best for the children to be with their father, as it was important for them to have somewhere to go that evening, and due to the circumstances, that their father would be the best option, as they would be able to be together as a family and support one another. The mother would not agree to the children going to the father, so the Pennsylvania State Police took protective custody of the surviving children, and worked in conjunction with Jefferson County Children and Youth Services to ensure the father was contacted and explored as a suitable home for the children to be released.

The Jefferson County caseworker contacted Butler County Children and Youth Services on-call, after hours caseworker, and requested a safety and home check be completed for the father's residence. [redacted] clearances were checked, with no prior background noted. Butler County Children and Youth Services was let into the home by the father's landlord since the father was at the Pennsylvania State Police barracks with his children, completed a check of the home and found it to be safe, with bedrooms for each of the children.

After the surviving children were interviewed by the PA State Trooper investigating the case, the biological child, [redacted] was released to the care and custody of the his father. It should be noted that the victim child's sibling, [redacted], was not visiting with his mother when the fatality occurred, therefore, it was the victim child's sibling [redacted] who had been [redacted], and subsequently released to his father.

[redacted], who are not biological children of the father, were [redacted]. Subsequently, on May 25, 2011, the mother signed [redacted] to ensure the children receive the necessary services regarding the loss of their sibling.

During the course of the [redacted] investigation, it was learned that the mother had a substantial number of prescription [redacted] medications prescribed to her, all of which included drowsiness as a side effect. During the internal Child Fatality Review team meeting, it was discovered that the

mother has an extensive history of [redacted] as well as a number of [redacted], each of which did not know the mother was under [redacted] elsewhere. It appears that the mother, and her boyfriends, had [redacted] in Clearfield and Jefferson Counties, [redacted] medic [redacted]. According to information gathered from the children during the investigation, the mother used the cocktail of prescription drugs daily. It was a regular occurrence for the mother to sleep all day, and for the older children to be responsible for the younger children, including making meals and supervising them throughout the day.

Jefferson County Children and Youth Services made collateral contacts with [redacted] professionals and the children's school district to gather information related to their investigation. The school district reported that the children missed numerous days of school. The guidance counselor reported that she spoke to one of the siblings, who stated that the children did not want to come to school, because they had to take care of their mother. Another sibling reported that he did not want to attend school because he was afraid that his mother would die when he was at school, and that he would not be able to care for her. At no time did the school district make a referral to Clearfield County Children and Youth Services regarding the children's truancy, or the lack of parental control that was present in the home.

Jefferson County Children and Youth Services completed their investigation on June 19, 2011, determining the status of the investigation to be [redacted] against the mother for [redacted] resulting in the death of a child. To date, no criminal charges have been filed in relationship to this case.

Current Case Status

There are no family members residing in Jefferson County at this time, therefore no active case is open in that County.

The case remains open with Clearfield County Children and Youth Services, who monitor the kinship placement of the victim child's two half-siblings. The children continue to reside with the victim child's father, who reports that members of his community and church have been very gracious in donating food, clothing and personal items for the children. The father reached out to Butler County Children and Youth Services for assistance in securing [redacted] for all of the children. This agency assisted the father in securing the necessary services for him and the children.

Butler County Children and Youth Services does not have any direct service activity with the family, but have provided the father with assistance in securing services for the children when needed.

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. Jefferson County has convened a review team in accordance with Act 33 of 2008 related to this report. Clearfield County participated in that review.

- Strengths
  There were no strengths identified by the County.

- Deficiencies:
  There were no deficiencies identified by the County.

- Recommendations for Change at the Local Level:
  The County discussed strategies to identify the abuse of [redacted] medications, and a way for medical professionals to better track where patients are being treated, and what medications are being filled and used by patients.

- Recommendations for Change at the State Level:
  There were no recommendations for change at the State level identified by the County.

Department Review of County Internal Report

The Department was in receipt of the County Internal Report. While it did not identify any strengths or deficiencies, there were several strengths noted by the Department in this case. This feedback was provided to the County verbally on June 22, 2011.

Department of Public Welfare Findings:

- County Strengths:
  There were several strengths identified in the review of this child fatality. Jefferson County was diligent in their investigation, and worked collaboratively with law enforcement, medical professionals and neighboring County children and youth agencies. The case documentation completed by the Jefferson County caseworker was exceptional, being very detailed and well organized. Safety and risk assessments were completed at the correct intervals, and the established safety plans for the surviving child were thorough, detailed, and tailored to suit the safety and well-being of the child.

- County Weaknesses:
  The Department did not identify any weaknesses in the review of this case.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no statutory or regulations violations related to this case.

Department of Public Welfare Recommendations:
The Department recommends better collaboration with area school districts, which may include education around signs of [redacted] and reporting procedures. It is recommended that the Counties work with school districts to establish in-service presentations related to child protective services. In this case specifically, it was reported after the child fatality that the home school district had information related to the children and their living conditions, however failed to notify the child welfare agency of those concerns.

The counties may consider adopting County-wide truancy policies to be used by each of the school districts within their individual counties. In this case specifically, this would have lead to the information related to the family dynamics being brought to light before the child fatality had occurred, and would have allowed for an assessment of the safety and well-being of the children in the mother's care.

Additionally, the Department recommends that the County engage discussion with county [redacted] offices concerning what appears was patient prescription shopping by the parents in this case and its impact.