



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

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

**Anthony Debruin**

**Date of Birth: 10/27/08**  
**Date of Death: 8/12/14**  
**Date of Oral Report: 8/12/14**

### **FAMILY KNOWN:**

**Lancaster County Children and Youth Service Agency**

### **REPORT FINALIZED ON:**

**March 23, 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. Lancaster County did convene 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>
Anthony Debruin	victim child	10/27/08
[REDACTED]	mother	[REDACTED]/73
[REDACTED]	father	[REDACTED]/73
[REDACTED]	sibling	[REDACTED]/96
[REDACTED]	sibling	[REDACTED]/97
[REDACTED]	sibling	[REDACTED]/00
[REDACTED]	sibling	[REDACTED]/01
[REDACTED]	sibling	[REDACTED]/01

**Notification of Child Fatality:**

On Sunday afternoon August 10, 2014 area Emergency Medical Services (EMS) and local law enforcement were called to the family home. The victim child wandered off the property. At the time of incident the child's father was watching the child and briefly lost sight of the child. Family members searched for the child both in the house and around the property. The child was found lying in a creek adjacent to the property of the family home by his father. Upon arrival EMS found the victim child's father attempting CPR on the child. The child was taken via ambulance to Lancaster General Hospital (LGH). The child then transferred to Penn State Hershey Medical Center (HMC) the same day at approximately 6:00 pm. The child was [REDACTED]

[REDACTED] and his condition did not improve. The child was taken off life support on August 12, 2014. The child was pronounced dead at 10:15 pm. The incident was [REDACTED] on August 12, 2014 [REDACTED]

[REDACTED] The Department of Public Welfare, Office of Children Youth and Families, Central Region Office [REDACTED] as it was determined a conflict of interest for Lancaster County Children and Youth Services Agency [REDACTED] as the child was [REDACTED] through the county agency and the county was providing an [REDACTED]

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

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records and medical records pertaining to the Family. Follow up interviews were conducted with the county agency supervisor, intake director, and agency administrator on

August 12, 13 and 26, 2014, September 5 and 9, 2014. The Regional Office did participate in a Fatality Review Team meeting on September 9, 2014.

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

The family [REDACTED] the victim child in May 2011. The child was in care of Lancaster County Children and Youth Service Agency prior [REDACTED]. The county agency was providing an [REDACTED]. The family had no additional involvement with Lancaster County Children and Youth Services.

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

On Sunday afternoon August 10, 2014 at approximately 2:46 pm EMS responded to the family home. EMS received a call regarding a drowning of a five year old child. Upon arrival emergency response personnel found the child's father performing CPR techniques along a bank of a creek adjacent to the property. The review of law enforcement, medical records and family member's testimony; the sequence of events that afternoon mirrored such. The victim child went outside the home with his father. The child did have some limitations; the child had a [REDACTED] [REDACTED]. The child also had developmental and intellectual delays, [REDACTED]. The child's [REDACTED] [REDACTED] did impact him however it should be referenced the child was able to maneuver in and outside the home by himself. It was difficult to determine the exact amount of sight the child actually had due to some of his other disabilities.

The child wanted to go outside to play. The child's father went outside with him. The child wanted to go for a car ride which according to the father meant the child would play in the back seat of the van as if he was driving. The van was parked in the driveway of the property. The passenger doors were open. The child was sitting in his car seat unstrapped. The child's father was sitting down on the ground of the driveway resting up against the family home approximately 20 feet from the parked van. The father mentioned he lost track of the child for approximately 2 or 3 minutes. He looked for the child in the van and around the van. Upon not being able to locate the child, the father yelled into the home calling for the child. Additional family members began attempting to locate the child both in the home and outside. The victim child's father ran down the bank of the property and looked on the road for the child. According to the child's father, the road and the creek were more of the dangerous areas the child could have wandered. After not observing the child on the road, the father ran down towards the creek. There is a stone bridge and the road crosses the creek. On the left side of the bridge the father did not notice the child. The father would mention that the child did like to go down to the creek. The left side of the creek was a place where the family would spend time. The victim child's father returned back to the property to continue to locate the child. Additional family members were outside attempting to locate the child. The child's father did return back to the creek several minutes later upon his return he went to the other (right) side of the bridge which intersects the creek. At this position the father noticed the victim child lying face up in the water. The child was immediately taken out of the water and the father began resuscitation techniques on the bank of the creek. An additional family member called 911. EMS arrived within minutes of the call and law enforcement arrived on the scene shortly past ambulance arrival.

The child was transported to LGH and then transported the same day to HMC. The victim child arrived at HMC at approximately 6:00 pm. The child was [REDACTED]. The child would undergo [REDACTED] and after discussion between medical staff and the family it was decided on August 12, 2014 to remove the child from life support care. The child did expire at 10:15 pm August 12, 2014.

The OCYF Central Region Office investigated the report as it was a conflict for the county children and youth agency to complete the investigation. A request was made for Dauphin County Children and Youth Services to see the victim child at HMC on August 12, 2014. In addition Lancaster County Children and Youth Services did assess the safety of the other children in the home. The other children in the home were determined to be safe. [REDACTED] Police Department investigated the circumstances of the incident. The family was cooperative with law enforcement, medical staff and the Regional Office. Law enforcement closed their investigation and no charges were pursued by the County District Attorney's Office. The father was interviewed twice by law enforcement personnel. The Regional Office interviewed both the victim child's father and mother. The father's account of incident was consistent. The approximate distance from the van to the creek is 200 yards. The entire time period from initial loss of the child to finding was approximately ten minutes. The child did not present with any prior trauma or suspicious injuries. The cause of death was determined to be accidental drowning. The Regional Office [REDACTED] on September 15, 2014.

**Current Case Status:**

The family was [REDACTED] by Lancaster County Children and Youth Services Agency. The family did [REDACTED].

**Strengths and Deficiencies and Recommendations for Change as Identified by the Child Fatality Report:**

**Strengths:**

Referenced at the review was quick response from EMS and local law enforcement. Also referenced was the collaboration between LGH and HMC.

**Deficiencies:**

The report did not specifically reference any deficiencies.

**Recommendations for Change at the Local / State Level:**

The report referenced for continued avocation for clear communication between caseworkers, law enforcement, and hospitals for specific cases which can cross various jurisdictions. For example in this specific case, the coroner was from one jurisdiction, two hospitals were involved, the District Attorney's Office and law enforcement were from another county. In addition the Department conducted the [REDACTED].

**Department Review of County Internal Report:**

The Department reviewed the submission of Lancaster County Children and Youth Services report regarding this fatality on September 22, 2014. The Department concurred with the report,

and verbal feedback was provided same date. The county was provided written correspondence on February 26, 2015 regarding receipt and review of the report.

**Department of Public Welfare Findings:**

**County Strengths:**

The county children and youth agency responded appropriately once the report was received. The OCYF Regional Office was notified and conducted the investigation as it was conflict for the county. Both law enforcement and the Regional Office had good collaboration conducting the investigation. The county agency was able to help facilitate a review for the Regional Office. The Regional Office was able to request and obtain prior medical history and care sought for the victim child.

**County Weaknesses:**

N/A

**Statutory and Regulatory Areas of Non-Compliance:**

The Departmental review did not find any specific areas of regulatory noncompliance.

**Department of Public Welfare Recommendations:**

N/A