pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Zoe Holmstrom

Date of Birth: 10/19/2000
Date of Death: 1/19/2016
Date of Report to ChildLine: 1/19/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Cumberland County Children and Youth

REPORT FINALIZED ON:

06/23/2016

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))

Department of Human Services/Office of Children, Youth and Families, Central Region
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Reason for Review:

Pursuant to the Child Protective Services Law, 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.

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 not convened a review team in accordance with the Child Protective Services Law related to this report. Cumberland County was not required to convene a review team because the investigation was [redacted] [redacted] submitted to Childline on 02/16/2016 (28th day).

Family Constellation:

Name:	Relationship:	Date of Birth
Zoe R. Holmstrom	Victim Child	10/19/2000
[redacted]	Mother	[redacted]1967
*[redacted]	Father	Unknown

Father resides in [redacted] his address and information is unknown.

* 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 obtained and reviewed all case records pertaining to the family. The Central Region had ongoing contact with Cumberland County Supervisor [redacted] and assigned Caseworker [redacted] [redacted] The Central Region ensured the Child Fatality Data Collection Form was sent to Childline within 60 days of the report. Central Region also confirmed Childline received [redacted] within 30 days and confirmed that the investigation was [redacted]

Children and Youth Involvement prior to Incident:

On 11/10/2015 Cumberland County Children and Youth received a [redacted] [redacted] referral due to concerns that mother was leaving the victim child home alone from 7:00pm to 7:00am multiple times a week due to the mother's work schedule. Cumberland County Children and Youth worked with mother and developed a plan of resources and supports, at the end of the [redacted]

assessment (01/08/2016); mother had adequate care and supervision of the child while she worked. Mother was also working with [redacted] to have a [redacted] available to be with victim child while she worked.

Circumstances of Child Fatality and Related Case Activity:

On 01/18/2016 at 7:00am victim child was taken by ambulance to Hershey Medical Center. During the ambulance transport the child went into Cardiac Arrest. Child [redacted] and the prognosis was poor. Mother had informed Hershey Medical Center that the victim child started [redacted] at 5:00am [redacted] A toxicology screen was done and the child tested positive for [redacted] The child was not [redacted] and she did not take her medication independently. At that time it could not be ruled out as to whether or not mother gave the child the medication or somehow the child obtained the [redacted] on her own and took it. [redacted] report was called in [redacted] Police Department was also contacted [redacted] Mother was at the hospital the entire time along with two adult siblings. On 01/19/2016 the child was taken off life support and at 7:25am and the child passed away.

Mother was interviewed on 01/19/2016 at Hershey Medical Center [redacted] Mother had stated she has three adult children; none of them live in the home with her and victim child. Mother adamantly denied giving the victim child any other medication besides what she was [redacted] The mother denied that she [redacted] any medications. [redacted] also searched the home and did not find [redacted] in the home. Cumberland County Caseworker [redacted] interviewed mother again on 01/21/2016. Her paramour [redacted] was also interviewed on this date. The mother had stated child started [redacted] at age one and was hospitalized at Geisinger Medical Center in Danville. The child also lived with her father, [redacted] for about four years (approximately ages four to eight) and according to mother child was not receiving [redacted] at that time. Regarding the incident, the mother stated that on 01/18/2016 at around 5:00am she heard a grunting noise coming from child's room and when she entered child's room she found the child was [redacted] and tried to talk to child. The child's eyes rolled back in her head and mother called 911. On the way to the hospital child went into cardiac arrest. Mother's paramour was not in the home during the incident and does not live in the home. He did state he was in the home on 01/17/2016 and child appeared normal.

On 01/26/2016 [redacted] contacted Cumberland County Caseworker [redacted] He informed her that he had spoken to Hershey Medical Center on 01/25/2016 and they did a

repeat toxicology screen on victim child 12 hours after the first toxicology screen and it did not show any signs of ████████ in her system. Dr. ████ explained that the quantification for the ████████ on the initial toxicology screen reported that ████████ was "not detectable." In short the ████████ was either a false positive or it showed up as a cross reaction from one of the other medications ██ ████████ Dr. ████████ at the Dauphin County Forensic Center completed the autopsy and stated child passed away as a result of her seizure disorder. The ████████ Police Department closed their investigation with no charges.

On 02/16/2016 Cumberland County Children and Youth ████████ the case.

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

Cumberland County did not conduct an Act 33 meeting because the report was ████████ within 30 days.

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

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

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

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

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

Department Review of County Internal Report:

Cumberland County did not conduct an Act 33 meeting because the report was ████████ within 30 days.

Department of Human Services Findings:

- County Strengths:

Central Region determined that Cumberland County Children and Youth conducted a thorough and comprehensive investigation of this case. The case file was well documented.

Central Region determined that Cumberland County Children and Youth was in full compliance with all applicable statutes, regulations and services to children and families.

There was also collaboration between law enforcement and the county agency during this investigation [redacted]

- County Weaknesses:

  The only area concern was not in regards to Cumberland County's investigation. The concern identified was that Hershey Medical Center did a second toxicology screen on victim child twelve hours after the initial screen and discovered the first screen was a false positive or the [redacted] showed up as a cross reaction from one of the other medications [redacted] Hershey Medical Center did not notify Cumberland County Children and Youth nor did they notify the investigating police department. [redacted] Police Department had contacted the hospital during the course of his investigation and he was given this information.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  No areas were identified.

Department of Human Services Recommendations:

Central Region Office of Children, Youth and Families recognized the quality and procedural mechanisms currently in place within Cumberland County as they relate to the assessment and investigation of Child Protective Services cases and recommends their continuation.

Central Region Office of Children, Youth and Families also commends Cumberland County Children and Youth in its collaborative relationship with this office in compiling case specific data and evaluating the overall process of the Fatality/Near Fatality in an effort to promote consistent, quality services to children, youth and families.