



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

[REDACTED]

**Date of Birth: 11/20/2015**  
**Date of Incident: 03/21/2016**  
**Date of Report to ChildLine: 03/25/2016**  
**CWIS Referral ID: [REDACTED]**

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

Lancaster County Children and Youth Services (CYS)

**REPORT FINALIZED ON:**  
**9/9/16**

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 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.

Lancaster County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 04/27/2016.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	11/20/2015
██████████	Mother	Unknown
██████████	Father	Unknown
** ██████████	Babysitter	██████████ 1978

\*\*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 Near Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the ██████████ family. There was no previous involvement prior to this incident. CERO staff participated in the Act 33 meeting that occurred on 04/27/2016 in which medical professionals, agency staff, law enforcement and legal counsel were present and provided information regarding the incident, as well as historical information.

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

There was no previous involvement with Children and Youth.

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

Lancaster County CYC was notified on 03/25/2016 of the report regarding the victim child, ██████████, who was brought into Ephrata Hospital on 03/21/2016 after being found at the home of her babysitter not breathing. The child was transferred the same day from Ephrata Hospital to Children’s Hospital of Philadelphia (CHOP) for further assessment.

The day of the incident, the babysitter, who operates a home day care, had placed the victim child down for a nap on one of her older children’s beds. There were

pillows around the victim child as she lay on the bed. It is the belief that the child had rolled over onto her stomach but was not able to roll herself back over. The victim child was found face down on her stomach and was not breathing. The babysitter immediately called 911 and emergency personnel transported the child to Ephrata Hospital and then to CHOP.

At the time of incident, the babysitter also watched the victim child's 3-year old sister. The babysitter did have a Pack-N-Play in the home, but the victim child was not placed in there to take a nap. The door to the room that the victim child was placed in for a nap was closed due to the babysitter's family having dogs and also due to the other children of the babysitter being home from school for the day (there were 4 other children, ranging in age from 9-years old to 18-years old).

The family of the victim child believes that this was just a tragic accident and during the investigation continued to speak highly of the babysitter. There were no prior concerns regarding the babysitter before this incident. CHOP conducted all the necessary tests to determine any other injuries consistent with child abuse and none were found. The child was [REDACTED] around 05/05/2016 and would be [REDACTED] for the child due to the parent's both working. The victim child's injuries were very extensive due to her lack of oxygen and she will [REDACTED]. It is also likely that there will be extensive developmental delays but the extent is not known at this time.

Lancaster County CYC filed their investigation report with ChildLine on 05/25/2016 with a status of Unfounded. No charges were filed against the babysitter in this case.

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

- Strengths in compliance with statutes and regulations and services to children and families;
  - The county reports immediate and excellent collaboration with local law enforcement in conducting the investigation.
  - Law enforcement was also very appreciative of the working relationship that the county has with the police.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None noted
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Increased education for more public awareness in regard to safer sleeping environments for infants and children.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None Noted
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None Noted

**Department Review of County Internal Report:**

The CERO received the Lancaster County Child Fatality Team Report on 06/17/2016. CERO finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings is representative of what was discussed during the meeting on 04/27/2016.

**Department of Human Services Findings:**

- County Strengths:
  - The county demonstrated appropriate collaboration with law enforcement and medical professionals throughout the current investigation.
- County Weaknesses:
  - None Noted
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None Noted

**Department of Human Services Recommendations:**

DHS offers the following recommendations to practice as a result of the findings of this review:

- The agency should work with different community programs that serve children and families in order to educate on the proper and safe sleeping arrangements for infants and young children.