pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Gideon Enoch Ladd

Date of Birth: 5/6/2016
Date of Death: 8/5/2016
Date of Report to ChildLine: 8/5/2016
CWIS Referral ID: [redacted]

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

York County Children & Youth Services

REPORT FINALIZED ON:
01/11/2017

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.

York 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 08/25/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Gideon Ladd	Victim Child	05/06/2016
[redacted]	Sibling	[redacted]2016
[redacted]	Father	[redacted]1988
[redacted]	Mother	[redacted]1985
*[redacted]	Babysitter	[redacted]1988

* 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 obtained and reviewed all current case records pertaining to the [redacted] family. Follow up interviews were conducted with the Caseworker, and the Supervisor on 08/25/2016. The regional office also participated in the County Internal Fatality Review Team meeting on 08/25/2016.

Children and Youth Involvement prior to Incident:

The family was not known to York County Children & Youth Services prior to the incident on 08/05/2016.

Circumstances of Child Fatality and Related Case Activity:

Victim child was in the care of [redacted] at the time the incident occurred. [redacted] alleged that she placed the twins face down on her pillow top mattress with comforters and blankets around them. Thirty minutes later she went into the room to wake them up. When she rolled Gideon over he was gray and she

observed blood. Police were called to the residence on 08/05/2016. When they arrived the child was in cardiac arrest. [redacted] performed CPR on the child. Gideon was transported to the York Hospital where he later died as a result of negligence of safe sleep habits in an unlicensed daycare facility. The perpetrator runs a daycare facility in her home with no more than 3 children. The daycare is not required to be licensed with that number of children.

Safety of twin brother, [redacted] was assured by no contact with the AP. The AP's children are currently under a no un-supervised contact safety plan. Her children are ages 2, 6, and 10 years. The AP is the only identified caretaker in her home. She does have a husband but he was not home during this emergency.

York County Children and Youth services [redacted] as the perpetrator on 10/04/2016. The [redacted] status is supported by the fact that [redacted] acknowledged that she laid the baby on his belly on a soft mattress to sleep. She is a Certified Nursing Assistant and acknowledges that this was not an appropriate method given the age and prematurity but did it knowingly despite the risks.

The child was born 31 weeks premature [redacted] The autopsy report was completed and revealed the cause of death to be Sudden Unexplained Infant Death. There were no traumatic injuries or congenital abnormalities. The criminal investigation has been completed and no charges will be filed.

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

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

- All parties worked together collaboratively
- [redacted] was appropriately referred at birth. Services were in place and will continue to be in place for the sibling.
- Services were in place to educate parties on safe sleep.

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

- None identified

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

- None identified

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

- None identified

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

- None identified

Department Review of County Internal Report:

Central Region received the York County Internal Fatality Review Team report on 11/07/2016. Verbal feedback was provided to the County on 11/07/2016
The Department concurs with the county report's findings and recommendations.

Department of Human Services Findings:

County Strengths:

- York County Children, Youth and Family Services conducted a timely investigation in conjunction with the law enforcement officials.

County Weaknesses: and

- None

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

- None

Department of Human Services Recommendations:

- Information should be provided to the community to educate them about safe sleep.