



REPORT ON THE NEAR FATALITY

[REDACTED]

Date of Birth: 06/26/2015
Date of Incident: 11/11/2016
Report to Child Line: 11/11/2016
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

REPORT FINALIZED ON:
04/24/2017

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.

Lancaster County Children and Youth submitted an unfounded report to child line on 01/10/2017. Lancaster County Children and Youth convened a review team in accordance with the Child Protective Services Law related to this report. The County review team was convened on 11/23/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	[REDACTED] 2015
[REDACTED]	Father	[REDACTED]
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Sibling	[REDACTED] 2012
[REDACTED]	Sibling	[REDACTED] 2013

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed the case records pertaining to the family, which included medical records, agency casework dictation and safety assessment worksheets that outlined contact with the family. A discussion occurred with the agency intake supervisor several times throughout this process.

Children and Youth Involvement Prior to Incident:

The family was not known to Lancaster County Children and Youth prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

Lancaster County Children and Youth Services (LCCYS) received a [REDACTED] CPS report [REDACTED] on 11/11/2016. The report stated that the victim child fell through a hay hole approximately 10 feet onto a concrete surface and lost consciousness. [REDACTED]

As per the parents, the victim child was playing on the second floor of the barn with his two siblings when the victim child fell through one of the floor boards. The

father admitted that he was not present when the injury occurred. The victim child was transported to Lancaster General Hospital by ambulance. It was reported [REDACTED] that the victim child was crying and irritable upon their arrival. The child was initially evaluated at Lancaster General Hospital before being transported to Hershey Medical Center. The victim child was not in critical condition at the time; however, Dr. [REDACTED] certified the child to be in serious condition.

On 11/11/2016, Hershey Medical Center reported that the victim child had [REDACTED]

[REDACTED] On 11/11/2016, LCCYS personnel made an unannounced home visit to the family's home to see the victim child's siblings and to assure their safety. It was learned that the family resides with the paternal grandparents in their home and no safety plan was needed. It was also learned that the state police were dispatched to the home at the time of the incident.

On 11/12/2016, agency personnel went to Hershey Medical Center to see the victim child and meet with his mother and maternal grandmother. The caseworker observed the child to be playing and acting normal. The caseworker learned that the child did not fall through a hay hole but did fall through a loose floor board. A discussion about supervision was held and the mother agreed that she would supervise the children and not rely on the older siblings to supervise the younger children.

The victim child was released to his parents on 11/12/2016 with a follow up appointment [REDACTED]

On 11/18/2016, agency personnel met with the family at their home with the paternal grandparents. The victim child was being held by his mother and appeared to be alert. He had yellowish brown bruising on the right side of his ear and face and black and blue bruising under his right eye. It was reported that the victim child was doing fine; he was eating, walking and sleeping well. The father reported that he fixed the floor board in the barn. The father also stated that he was watching the children in the barn on the day the incident occurred. He said the boys were playing near him and he only left them unattended for a few minutes when the accident happened. The parents reported that the victim child [REDACTED] and is doing well.

LCCYS did contact the [REDACTED] Police Department on 11/11/2016 to report the numbered abuse and learned that they were already aware of the incident. LCCYS communicated with the [REDACTED] police throughout their investigation. The [REDACTED] police did not file charges against the father and closed their case.

LCCYS conducted the CPS investigation timely. The father fixed the loose floor board in the barn which agency personnel verified was done. The family followed through with medical care for the victim child and it appears as if there are no permanent effects from the fall. The case was marked unfounded on 01/10/17 and

it was determined that the family was not in need of services at the completion of the investigation.

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;
The agency is working well with the Amish community.
The agency followed through with the family and the family is following through with doctor's appointments.
- Deficiencies in compliance with statutes, regulations and services to children and families;
The family allowed the caseworker to look at the house and no concerns were 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;
None noted.
- 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.
Acknowledge the Amish communities and recommend to thoroughly check their barns for any missing/damaged floor boards in their barns. And to increase supervision of children when near/in the barn.

Department Review of County Internal Report:

Lancaster County Children and Youth Child Death Review Team held an Act 33 meeting on 11/23/2016 where medical information and the case were presented. The county report of the Act 33 meeting was received by the CRO on 03/22/2017. On 03/27/2017, the CRO sent correspondence to LCCYS Administrator, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:
The agency responded to the referral immediately by seeing the victim child and the victim child's siblings.
Agency personnel communicated well with law enforcement.

The agency completed their investigation and submitted the appropriate paperwork timely.

The agency works well with the Amish community.

- County Weaknesses: and
None noted
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
After review of the file, the agency was found to be in compliance with statutory and regulatory requirements.

Department of Human Services Recommendations:

The investigation was completed in a timely manner by Lancaster County Children and Youth Services. Lancaster County Children and Youth Services has a good working relationship with their Amish community. The recommendation would be for the agency to work in partnership with the community to do an outreach on the importance of barn safety checks.