



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 06/17/2014
Date of Incident: 01/01/2017
Date of Report to ChildLine: 01/01/2017
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 Agency

REPORT FINALIZED ON:
06/04/2017

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 01/25/2017.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	06/17/2014
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Sibling	[REDACTED] 2000
[REDACTED]	Biological Mother	[REDACTED] 1983
[REDACTED]	Biological Father	[REDACTED] 2008
[REDACTED]*	Maternal Grandmother	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 Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [REDACTED] family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff attended the agency Act 33 meeting on 01/25/2017 and discussed the case with agency staff at that time.

Summary of circumstances prior to Incident:

There was no prior involvement with this family by Lancaster County Children and Youth Agency (CYA) or other children and youth agencies.

Circumstances of Child Near Fatality and Related Case Activity:

On 01/01/2017, the maternal grandmother was providing care to the victim child when he fell and injured his head. The report stated that the victim child fell four

feet off of a concrete slab, hitting his face onto the concrete below. The grandmother and child were at [REDACTED] Park in [REDACTED] when this occurred. The grandmother called the mother immediately and she drove to the park and transported the child to the hospital. The child was transported to Lancaster General Hospital [REDACTED]. He also had a concussion. The child was transferred to Children's Hospital of Philadelphia, where a physician certified him to be in serious condition due to suspected neglect, as it was unknown if the grandmother had been supervising him. The child did not lose consciousness. He was reported to be walking and talking and drinking juice at the hospital.

The agency spoke with the mother of the child who had been at home during the incident. The mother stated that the grandmother told her that the child had jumped on the steps while she was holding on to him. He then tried to jump again when she was not holding onto him and he fell, causing the fracture. The child stayed in the Children's Hospital of Philadelphia one night and then [REDACTED] when no other concerns were found on his skeletal survey. The child was seen by a [REDACTED] after the incident and it was recommended that he be seen for a check-up in one year; however, the mother has stated that she is taking extra precautions and will be scheduling an appointment for her child in 6 months instead. [REDACTED]

[REDACTED] Police interviewed the maternal grandmother and determined this incident to be an accident as she was present when the child fell.

There is no documentation that the agency interviewed the maternal grandmother, or made attempts to interview her regarding the report, beyond a phone message left for her on the second day of the investigation.

Lancaster County CYA filed their investigation report with ChildLine on 02/24/2017 with a status of Unfounded. The agency investigation deemed this to be an accident as the maternal grandmother was present when the child jumped suddenly. There were no charges filed in this case. The case was closed with no additional services.

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 assigned an immediate response tag to the report and the investigation was initiated and completed within the required timeframes.
 - Agency initiated immediate contact with the family and the hospital.
 - The Agency interviewed all appropriate individuals.
 - The child was referred [REDACTED] as per CAPTA regulation.

- The Agency remained involved with the family during the investigation as assisted with referrals to community resources.
- 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;
 - None noted.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
 - 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 Central Region Office received the Lancaster County Child Near Fatality Team Report on 05/19/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 01/25/2017. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. The County report was not submitted within the 90 day time frame. However, the agency was in the process of implementing a new template and was conferring with DHS during this time. DHS will continue to work with the agency to assure that time frames are met in regarding to the Act 33 process. Written feedback was provided to Lancaster County Administration on 05/19/2017.

Department of Human Services Findings:

- County Strengths:
 - The agency responded immediately to the hospital and was in constant communication with medical professionals, and with each other, coordinating to see the child and the family.
- County Weaknesses:
 - The agency did not interview the maternal grandmother (alleged perpetrator), nor did they document attempts to interview her beyond a phone message on the second day of the investigation. She was also not provided notification of the report, even though the agency had been provided her address by police on 01/03/2017.
 - Beyond interviewing the alleged perpetrator, the agency had information early during the investigation to make a determination on

the case, and a conclusion safety assessment was even completed, however the agency did not make a determination on the case until 02/23/2017.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
Lancaster County was found to be out of compliance in the following areas:
 - 3130.21(b) – The agency saw the children 01/09/2017 and completed a “Conclusion of Investigation” Safety Assessment Worksheet on 01/10/2017. The children were seen again on 02/15/2017, but the case was then closed on 02/24/2017 without a Safety Assessment Worksheet being completed.
 - 3490.55(d) – The agency did not interview the alleged perpetrator or document attempts to interview the alleged perpetrator, beyond one phone message.
 - 3490.58(b) – The agency did not provide written notification of the investigation to the alleged perpetrator. The agency did not initially have the alleged perpetrator’s address but was provided the address on 01/03/2017.
 - 3490.67(a) – The agency did not submit the Child Protective Service Investigation Report (CY-48) to ChildLine within 30-days of the receipt of the report. There was no documentation found as to why the case extended beyond the 30-day time frame.

Department of Human Services Recommendations:

County specific recommendation: It is recommended when conducting a Child Protective Services investigation to ensure to interview all individuals who have been identified as the alleged perpetrator and as the victim child.