REPORT ON THE FATALITY OF:

Nhaima Camacho

Date of Birth: 03/18/2016
Date of Incident: 04/14/2016
Date of Report to ChildLine: 04/14/2016
CWIS Referral ID: [redacted]

FAMILY 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: 11/09/2016

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))

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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.

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:

First and Last Name:	Relationship:	Date of Birth:
Nhaima Camacho	victim child	03/18/2016
[redacted]	biological mother	[redacted] 1989
[redacted]	half sibling	[redacted] 2010
* [redacted]	biological father	

*[redacted] did not reside in the home of the reported incident. One additional note for reference the county agency was not able to obtain [redacted] demographics which would include date of birth.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records, law enforcement and emergency management services records pertaining to the Family. Follow up interviews were conducted with the county agency caseworker, supervisor, intake director, and agency administrator on 04/14/2016, 04/27/2016, 05/25/2016, 06/09/2016, 06/23/2016, 06/29/2016 and 06/30/2016.

Children and Youth Involvement prior to Incident:

The Lancaster County Children and Youth Agency did have prior history with the subject family. Lancaster County Children and Youth Agency received one prior referral, a [redacted] referral on 03/21/2016 regarding concerns as the mother gave birth on 03/18/2016 to the victim child referenced in this report, upon delivery the child tested positive for marijuana and

[REDACTED]. In addition, the mother tested positive for marijuana at the time of birth. The referral language referenced that the victim child did not appear to be going through withdraw symptoms and the child and mother appeared to be bonding or interacting appropriately with the baby while in the hospital. The referral [REDACTED] by the Lancaster County Children and Youth Agency.

Circumstances of Child Fatality and Related Case Activity:

On 04/14/2016 the victim child at three weeks of age was found unresponsive in the family's home of residence around 5:00 am. The victim child's mother reported she woke up around 1:00 am on the same date to feed her baby. The victim child presented to be awake and crying. The mother reported she carried the baby downstairs to the living room area of the home. The victim child was bottle fed by the mother. The mother referenced she took the victim child downstairs as the half sibling of the victim child is autistic and the mother did not want to disturb the half sibling who was sleeping. The review of the case materials provided reference that the half sibling slept in the mother's bedroom on a separate mattress. The victim child's mother mentioned she recalls feeding and then beginning to burp the child on the couch. According to the victim child's mother, she was lying on her back on the couch while the baby was resting on her chest area. The victim child's mother mentioned she fell asleep. Around 5:00 am the maternal grandmother woke up the mother and inquired about the location of the baby. The mother reported she found the baby lying face down in the couch between herself and the couch cushion. The review of case materials determined, that upon finding the victim child, that Emergency Management Services (EMS) were contacted immediately. The mother attempted to resuscitate the victim child by performing Cardio Pulmonary Resuscitation (CPR) by lying the victim child down on the living room floor. Upon arrival to the home by EMS, the victim child was provided resuscitation procedures and transported to Lancaster General Health Hospital. The subject victim child arrived at the hospital at 5:28 am. Additional CPR and treatment were attempted. Ultimately medical personnel were unable to resuscitate the victim child. The victim child was pronounced dead at the hospital. Asphyxiation would be the cause of death. [REDACTED] However, additional medical procedures performed on the victim child posthumously would find the victim child had received several depressed fractures of the victim child's skull along with retinal hemorrhaging.

Lancaster County Children and Youth Agency originally received a [REDACTED] referral on 04/14/2016 regarding this incident. After additional testing; [REDACTED] of the victim child's skull would find two depressed fractures and retinal hemorrhaging. The report was subsequently changed or reregistered to Lancaster County as [REDACTED] investigation. The county children and youth agency was notified of the change in status on the same date referenced in this report. Additionally, the incident was registered as a child fatality under the Act 33 guidelines. The county responded to the referral received. The county agency assessed the safety of the half sibling in the home. The half sibling is [REDACTED] and

has a very structured daily routine, but was determined to be safe. The half sibling's biological father lives in close proximity and is involved with his care, although he is not in an ongoing relationship with the victim child's mother. Lancaster County Children and Youth Agency never received any prior referrals pertaining to the half sibling and there are [redacted] providers who come in contact on a regular basis to assist in the half sibling's [redacted] needs. The review of the case file provided documentation that the county agency submitted a referral on 04/15/2016 to local area law enforcement. The county agency has collaborated with investigation efforts. During the investigation, the mother's account remained consistent and it could be plausible that the victim child did slide off of the mother's chest and into the couch when the mother fell asleep. The one area of uncertainty pertains to the depressed skull fractures and retinal hemorrhage, the autopsy was unable to rule out accidental or intentional as the mechanism for injury. There was some discussion at the county's Act 33 review on this subject as an attending doctor presented various mechanisms for how such an injury could occur, along with the development of a child's skull at such age. In addition the victim child's mother has admitted during the investigation to substance abuse more specifically admission to the use of marijuana. She was drug tested by law enforcement and her toxicology report was positive for marijuana.

Ultimately, Lancaster County Children and Youth Agency would [redacted] the CPS investigation on 06/08/2016. The biological mother was offered county agency services, which she refused. The county agency did provide linkage to community services [redacted] The county, during their investigation, followed up with service providers who were involved with the older half sibling as referenced prior in this report. No concerns were found regarding that child's care. Law enforcement still has an open case and follow up with the Lancaster County District Attorney's Office they are still awaiting the toxicology results to come back on the victim child before finalizing their investigation. At the time of this report the results of such evaluation has not been completed or obtained.

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 county report provided reference that Lancaster County Children and Youth Agency did respond as required to the [redacted] referral when received. In addition the county requested medical records and had collaboration with medical professionals and law enforcement to help assist in the investigation. The report had additional reference as a strength was the ability of the first responders at the scene to provide documentation of circumstances observed in the home at time of arrival. The report had reference that the county agency will provide support and follow up for county agency caseworkers during difficult or traumatic situations.

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

  N/A, the county report did not provide specific reference in this area.

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

  The county report provided reference that hospitals should make (call) referral to county children and youth services agencies if a mother, infant is testing positive for drugs in their system, [redacted] [redacted] The report has some question if further outreach is needed as unsure if there are situations in which referrals are not occurring. The county report referenced the need to have additional outreach with community hospitals to see if the subject of safe sleeping or co-sleeping is discussed with parents at time of birth.

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

  N/A, the county report did not provide reference in this area.

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

  The county report highlighted the same areas in this section as referenced in the recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse section.

Department Review of County Internal Report:

The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case on 06/23/2016. The review determined there are no areas of major dispute with the identified report. The county was provided written feedback via correspondence on 06/30/2016 regarding receipt and review of the content of the report.

Department of Human Services Findings:

- County Strengths:

  The Departmental review found that the county did respond appropriately upon receipt of the registered CPS investigation. The review found that there was sound collaboration between the county children and youth agency and assigned law enforcement. In addition the county utilized collateral contacts to help in the assessment if services would be needed for the surviving half sibling. In addition

the county was willing to offer and or provide additional services to the family however such services were not reciprocated.

- County Weaknesses: and

In review of the circumstances pertaining to this case and review of historical materials one could question if the county should have had follow up contact upon receipt of [redacted] referral on 03/21/2016. Agency follow up would not have prevented this horrible tragedy based on the circumstances however, conducting an assessment may have had value as the agency might have been able to provide services or linkage to additional community supports if needed.

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

The Departmental review found no areas of regulatory noncompliance pertaining to this report.

Department of Human Services Recommendations:

The Department should both evaluate and provide assistance with County Children and Youth Services Administrators to ensure their agency has documented procedures in place regarding the determination to screen out GPS referrals. These procedures should specifically address decisions to screen out the referral when there is no contact with the child and family. In addition this report should take a moment to highlight the subject of trauma which impact county children and youth agency staff. It would be a benefit for agency administrators to evaluate internal processes in place to help caseworkers and/or supervisor when they have dealt or need to respond to a highly stressful or traumatic episode. In doing so one may be able to increase caseworker retention as well as their overall job performance.