REPORT ON THE FATALITY OF:

Amelia Howard

Date of Birth: 11/16/2017
Date of Incident: 12/15/2017
Date of Report to ChildLine: 12/15/2017
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:
5/21/2018

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 12/20/2017. A follow-up meeting was held on 01/24/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Amelia Howard	Victim Child	11/16/2017
		1990
		1989

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff discussed the case with the county on 12/20/2017 and 01/24/2018.

Summary of circumstances prior to Incident:

The agency received a referral on 11/16/2017 after the child was and the hospital expressed concerns that had previous throughout for . The agency began and found home appropriate for the child. The caseworker was in the process of scheduling follow-up visits with at the time the fatality occurred.

Circumstances of Child Fatality and Related Case Activity:

The agency received a referral on 12/15/2017 that the child was deceased after she was brought to the hospital unresponsive. stated that the child was fed around 3:30am and went back to sleep, laying on her own belly on the couch When of the child came home at 7:00am the child was cold to the touch and not breathing. was sleeping on the couch beside her. stated that tried to perform CPR as had been taught at the hospital. The

child was pronounced dead at 7:45am at the hospital. The hospital conducted skeletal and CT scans but they were returned negative. [redacted] denied [redacted]

The caseworker and supervisor interviewed [redacted] about the incident. [redacted] stated that the child had been eating well and [redacted] had put some cereal in her bottle that night. [redacted] confirmed that the child had been sleeping on her belly and [redacted] was next to her but not directly beside her.

[redacted] of the child was not living in the home after the incident occurred, and could not be reached for an interview. [redacted] was not returning calls to police as well. The police were waiting on autopsy results prior to interviewing [redacted]

Lancaster County CYA filed [redacted] with ChildLine on 02/08/2018 with [redacted]. The agency has indicated that [redacted] cannot be made until the coroner's report is received. At that time, the police will determine any charges and the agency report can be updated.

[redacted] agency as there are no other children in the home.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  - An immediate response tag was assigned to this case.
  - The agency was prompt with their investigation and no delays occurred during the assessment period.
  - The agency used the risk and safety assessment tool to guide their practice.
  - A very collaborative investigation has occurred for this case between [redacted], local police and hospital personnel.
  - The caseworker requested all medical records for [redacted].
  - The agency provided supportive services to [redacted] until [redacted]
  - Information was provided to [redacted] on loss and [redacted]

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The agency could have made additional attempts to see the child in the home, given the infant's age and [redacted]. [redacted] may have been deliberately avoiding the caseworker and not allowing a thorough [redacted] to occur.

- 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 agency had minimal involvement with [redacted], with only prior [redacted] received on [redacted]. In hindsight, the agency could have offered [redacted] additional [redacted].
- The agency is now addressing the high-risk nature of [redacted] [redacted] with a new policy, allowing for additional monitoring of the case and more thorough [redacted] of [redacted] needs.
- The agency will explore additional training opportunities for staff on early childhood development.

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;</u>
  - None noted.

- <u>Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.</u>
  - None noted.

<u>Department Review of County Internal Report:</u>

The Central Region Office received the Lancaster County Child Fatality Team Report on 04/11/2018. There was a delay in the report being submitted as the initial Act 33 was held 5 days after the incident and an additional meeting was held on 01/24/2018, when more information was known. The Department 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 12/20/2017 and 01/24/2018. 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 Department's findings. Written feedback was provided to Lancaster County Administration on 04/19/2018.

<u>Department of Human Services Findings:</u>

- <u>County Strengths:</u>
  - The agency showed excellent collaboration with law enforcement and medical professionals while investigating the case.
  - As this fatality incident occurred on a [redacted] case and the caseworker did not have expertise in child abuse investigations, the [redacted] supervisor aided the caseworker in home visits.
- <u>County Weaknesses:</u>
  - The Department concurs with the agency's discussion of the deficiency around attempts for home visits. The caseworker did make some attempts to see [redacted] and child, but could have made more attempts or attempted unannounced visits. There were also no [redacted] [redacted] that occurred during the time leading up to the fatality incident. They were discussed but had not yet been put in place.
- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>
  - No areas of regulatory non-compliance found.

Department of Human Services Recommendations:

The Department concurs with the agency recommendations from the County Act 33 report as noted above.