REPORT ON THE NEAR FATALITY

Date of Birth: 03/14/2016
Date of Incident: 07/11/2017
Report to Child Line: 07/11/2017
CWIS Referral ID:

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:
01/02/2018

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))

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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 Children and Youth submitted an unfounded report to ChildLine on 09/07/2017. 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 07/26/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	03/14/2016
[redacted]	Father	[redacted]1981
[redacted]	Mother	[redacted]1982
[redacted]	Sibling	[redacted]2003
[redacted]	Sibling	[redacted]2006
[redacted]	Sibling	[redacted]2005
[redacted]	Sibling	[redacted]2014
[redacted]	Sibling	[redacted]2012

Summary of OCYF Child 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:

There wasn't any children and youth involvement 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 07/11/2017. The report stated that the victim child fell twice in the past 24 hours [redacted] The first fall was from a height of 2 stairs and the victim child struck his head and had a large bruise to his forehead. The second fall was that same day from the cellar stairs from about 5 to 6 feet onto concrete. The

father reported that the child was coming up the basement wooden stairs approximately 5 feet high off side and fell onto the cement floor. This incident was unwitnessed. The victim child's sister heard the victim child grunt and then immediately heard the victim child cry. The father reported that the victim child walked unsteady and was pale in color. The father also reported that the child became lethargic and vomited on the way to the hospital.

As per the mother, the victim child, along with two of his siblings ages 5 and 3, were in the basement playing. The mother said that she called the victim child's sibling upstairs and didn't know that both siblings came upstairs leaving the victim child in the basement by himself. It was reported that the victim child tried climbing the basement steps and fell off and hit his head on a cement floor. The parents immediately called the family doctor who said to take the victim child to Lancaster General Hospital. At Lancaster General Hospital, the victim child [redacted] which is the reason that Lancaster General transferred the victim child to Hershey Medical Center [redacted] The victim child was at Hershey Medical Center until discharged on 07/13/2017. The victim child was then seen again at Hershey Medical Center on 08/10/2017 [redacted] It was explained to both parents that there would not need to be any further testing or evaluation and that the victim child [redacted]

LCCYS was aware that there were siblings in the home at the time of the incident. The agency learned that the parents were staying at Hershey Medical Center with the victim child and the victim child's siblings were with their paternal aunt and uncle. The agency did a preliminary safety assessment of the children and found them to be safe with the paternal aunt and uncle.

LCCYS notified the [redacted] Police Department the same day they received the numbered incident. Arrangements were made for the agency caseworker and the detective to conduct interviews the next day at the hospital. Both the mother and father were interviewed separately. Both of the parents were consistent with what happened. The mother explained that there is a play room area which is carpeted in the basement. The mother talked about the first fall which she stated that she was in the basement giving [redacted] to another one of the children when the victim child crawled up to the second step and fell. The mother stated that the victim child's leg was stuck in the step and the child fell head first and hit the floor at the bottom of the steps. The mother stated that she didn't see the victim child at the steps until he was already falling. The mother stated she gave the victim child Motrin and he seemed fine the rest of the day. The mother also stated that her husband was at work when that fall occurred and found out when he came home for supper.

The mother then explained the second incident. The mother said that the three youngest children were playing in the basement in the play room. The mother said that she called the victim child's one sibling upstairs. The mother said that both of

the victim child's siblings came up stairs and forgot that the victim child was still down stairs. The mother stated that her oldest child heard the victim child crying and she is the one who found the victim child laying on the floor. The mother stated that her oldest child carried the victim child upstairs. The mother stated that the victim child was not bleeding and didn't seem to steady to walk. The mother indicated that is when she and her husband called the doctor and was instructed to take the victim child the hospital.

The father was also interviewed by the detective and agency personnel. The father's account of what happened was the same as the mother's account. The detective was satisfied that the incident was accidental and did not file charges against either of the parents.

Agency personnel met with the family upon the victim child to discuss supervision. A safety plan was put into place that the victim child would be supervised by any person over the age of fourteen at all times. Both of the parents agreed to the plan. Agency personnel also discussed safety measures with regards to the basement. The parents agreed to put up another railing on the other side of the steps and to utilize safety gates and the top and bottom of the steps.

LCCYS conducted the CPS investigation timely. The parents installed a railing on the other side of the steps in the basement. The family also has safety gates that they are using at the bottom and top of the steps. The parents were also in the process of having the entire basement carpeted. The family followed through with medical care for the victim child and it appears as if there is not any lasting effects from the fall. The case was marked unfounded on 09/07/17 and 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 communicated well with law enforcement and medical providers.
    The caseworker put a Safety Plan into place to assure the safety of the children.

- 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; 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 talks about safety procedures.

Department Review of County Internal Report:

Lancaster County Children and Youth Child Death Review Team held an Act 33 meeting on 07/26/2017 where medical information and the case were presented. The county report of the Act 33 meeting was received by the CRO on 11/28/2017. On 11/28/2017, 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 by seeing the victim child and the victim child's siblings.
  Agency personnel communicated well with law enforcement.
  The agency worked with the family and provided suggestions regarding child proofing their basement which is a common play area for the children.
  The agency works well with the Amish community.

- County Weaknesses: and
  None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  During the review of the file, the agency structured case notes reveal that agency saw the victim child's siblings to assure safety but failed to document that the children were seen on the Safety Assessment Worksheet. This issue was addressed in previous licensing inspection summary and has since been rectified by the Agency through their plan of correction and monitored by their CRO program representative.

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 safety procedures and supervision.