REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/10/2017
Date of Incident: 10/01/2017
Date of Report to ChildLine: 10/01/2017
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:
03/22/2018

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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/25/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	08/10/2017
[redacted]	Mother	Unknown

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 discussed the case with the county on 10/25/2017 and 01/09/2018.

Summary of circumstances prior to Incident:
Lancaster County Children and Youth Agency (LCCYA) has not experienced prior involvement with the victim child or his family.

Circumstances of Child Near Fatality and Related Case Activity:
On 10/01/17, Lancaster County Children and Youth Agency (LCCYA) received a report of suspected physical abuse involving the victim child. The child had been brought to Ephrata Hospital with [redacted] respiratory distress, and vomiting on 9/29/2017. [redacted] The child was certified to be in critical condition by a physician and non-accidental trauma could not be ruled out. The child was transferred to Hershey Medical Center. The report was registered as a near fatality.

The agency and law enforcement went to Hershey Medical Center on 10/02/17 to see the child and meet with the mother. The mother is from Uganda and was brought to the United States less than 2 years ago by [redacted],

who continued to provide services to the family. A translator was needed to communicate with the mother as she speaks Swahili.

The agency worker met with a physician [redacted] It was possible he would need [redacted] and the mother would need to be trained to care for the child. The skeletal survey was returned [redacted] for the child.

The agency met with members of the mother's family that had also been brought to the United States and they described her as caring appropriately for the child. The mother was also interviewed and denied doing anything to harm the child. He had been nursing normally and then stopped and was exhibiting the respiratory distress and vomiting, so she had taken him to the hospital.

Lancaster County CYA filed their investigation report [redacted] on 11/30/2017 with a status of Unfounded. Medical professionals could not determine that the medical conditions of the child were a result of physical abuse. Law enforcement is not filing charges against the mother.

The agency closed their case with the family after the investigation was completed. The child remained at Hershey Medical Center. [redacted] will continue to provide services to the mother and support her in the care of the child [redacted] The agency has indicated that Hershey Medical Center will contact them [redacted] if there are any concerns for the mother's ability to provide ongoing medical care to the child.

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;
  - An appropriate response tag was assigned to the case and the Agency started the investigation immediately.
  - The Agency was prompt with their investigation and no delays occurred during the assessment period.
  - The caseworker conducted a home visit to assess the living conditions and determine if the family needed additional services or resources.
  - The caseworker requested all medical records [redacted]
  - The Agency completed risk and safety assessments on the family to help guide the decision making.

- A very collaborative investigation has occurred for this case.
- Translation services were provided to the family due to the limited English proficiency needs.
- The child will be referred [redacted]
- The agency continued to provide supportive services to the family until case closure.
- Hershey Medical Center was supportive of the biological mother and her family and provided the family many opportunities to visit with the child.
- Hershey Medical Center [redacted] worked collaboratively with the Agency in conducting an evaluation of the child to rule out any additional signs of child abuse.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The mother's concerns for her baby were initially dismissed by medical staff. The language barrier may have contributed to the minimization of the mother's expressed concerns.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Additional education for the community on cultural awareness and sensitivity to the needs of a family where English is their second language.
  - Explore ways to increase transportation for families where distance creates challenges for the family to travel out of the country to see their child.

- 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 Fatality Team Report on 01/09/2018. 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 10/25/2017. 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. Written feedback was provided to Lancaster County Administration on 01/11/2018.

Department of Human Services Findings:

- County Strengths:
  - The agency showed excellent collaboration with law enforcement and medical professionals while investigating the case.
  - The agency reached out to interpretation services for verbal communication with the mother.
- County Weaknesses:
  - After the investigation was unfounded, the agency closed the case while the child was still admitted to the hospital with [REDACTED] This was discussed extensively with the agency and it was explained that there were supportive services from [REDACTED], no concerns with the mother's care of the child, and the assurance that the hospital would contact them with any concerns. While the risk factors may not have been present, it is still concerning that there were so many unknowns regarding the child's medical conditions when the agency case was closed.
  - The agency worker on the case had to be prompted to provide more detailed information in her documentation regarding agency visits with the child and family. While this information did exist, it was not immediately available for review.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - No areas of regulatory non-compliance found.

Department of Human Services Recommendations:

There are no recommendations as a result of this review.