pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Carter Craig

Date of Birth: 04/12/2017
Date of Incident: 03/07/2018
Date of Report to ChildLine: 03/07/2018
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
New Jersey Department of Children and Families

REPORT FINALIZED ON:
01/29/19

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 03/28/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Carter Craig	Victim Child	04/12/2017
[redacted]	Paternal Step-Sibling	Unknown
	Mother	[redacted]/1986
	Father	[redacted]/1986
	Step-Mother	Unknown

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 [redacted] Family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff discussed the case with the county on 03/28/2018, 06/28/2018, and 07/26/2018.

Summary of circumstances prior to Incident:
On 04/12/2018, the agency received a referral regarding the [redacted] and the victim child due to the [redacted] testing positive for marijuana when the child was born. The agency made the decision to screen this case out as there were no other concerns beyond the marijuana use. The agency did not have a phone number for the [redacted], so a letter was sent. The [redacted] called after receiving this letter and stated that she had used marijuana before delivery but denied current use. The agency worker explained that if any further concerns were received, the case would be opened for assessment.

On 07/10/2017, the agency received a referral that the [redacted] continued to use marijuana while breastfeeding. When the caseworker arrived at the home on 07/12/2017, it was determined that the [redacted] had moved to New Jersey. The agency made a referral to New Jersey and closed the case.

The Lancaster County Children and Youth (LCCYA) received records from New Jersey Department of Children and Families. The referral from LCCYA was received on 07/13/2017. The [redacted] agreed to be opened for services through the agency in New Jersey due to her past drug use. She was residing with her sister in New Jersey. The [redacted] completed [redacted] in December 2017 and New Jersey closed her case on 01/16/2018.

Circumstances of Child Fatality and Related Case Activity:

The agency received a referral on 03/07/2018 when the victim child was found unresponsive in his crib at the [redacted] home. The [redacted] of the victim child performed cardiopulmonary resuscitation until emergency medical services arrived. The child was transported to [redacted] and was in cardiac arrest. The victim child was pronounced dead at 3:17 pm. The coroner completed an exam. The victim child was found to have head bruising and a flat skull which is indicative of rough handling over a period of time. There was no alleged perpetrator named. The victim child spends two weeks in New Jersey with his [redacted] and had just come back four days prior. There were numerous individuals that had cared for the victim child. There was no explanation provided as to how the victim child obtained the injuries. The coroner will complete a further investigation to determine a timeline for the bruising.

Prior to making a determination on the case, the agency made one attempt to speak with the [redacted] and conducted a visit to the [redacted] home. The police completed interviews with the [redacted] and [redacted] as well.

LCCYA filed their investigation report with ChildLine on 05/04/2018 with a status of [redacted] The agency has indicated that a determination 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.

The case is closed with the agency as there were no concerns with the [redacted] in the [redacted] 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;
    - The Agency collaborated with hospital staff, local police, coroner's office, and New Jersey DHS.
    - The Agency was proactive after receiving the report, collaborated with police, and had the report registered as a fatality.
    - In 2017 the Agency completed their assessment and referred the family to New Jersey DHS when learning the [redacted] and child moved out of state.
    - The agency did not provide services to the family as the child is deceased.

- 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;
    - The Act 33 team was unable to come up with any recommendations due to limited information provided to the team as the criminal investigation and autopsy report is still pending.

- 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.
    - It was recommended that the caseworker provide information to the family on grief and loss resources.

Department Review of County Internal Report:

The Central Region Office received the Lancaster County Child Fatality Team Report on 06/28/2018. 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 03/28/2018. 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 DHS findings. Written feedback was provided to Lancaster County Administration on 06/28/2018.

Department of Human Services Findings:

- County Strengths:
    - The agency immediately reached out to New Jersey and gathered all case information on the [redacted] case.
- County Weaknesses:
    - The agency only made one attempt to interview the [redacted] in New Jersey and no attempts to interview any other caregivers for the child while he resided in New Jersey.
    - Detailed interviews were not obtained with the [redacted], [redacted], or any other household members in the Pennsylvania home prior to making the case pending.
    - The agency did not document the safety assessment of the [redacted] child in the home.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - 3130.21(b): The safety assessment of the [redacted] child in the home was not documented on the safety assessment worksheet.

Department of Human Services Recommendations:

LCCYA should continue to assess and update their documentation of all items pertaining to investigations to assure that detailed accounts of interviews and assessments are included in the agency record.