REPORT ON THE FATALITY OF:

Ro Lian

Date of Birth: 01/08/2019
Date of Incident: 05/22/2019
Date of Report to ChildLine: 05/22/2019
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 Social Services Agency

REPORT FINALIZED ON:
12/13/2019

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 Social Services Agency (LCCYSSA) did not convene a review team for this case.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Ro Lian	Victim Child	01/08/2019
	Sibling	2017
	Sibling	2015
	Sibling	2013
	Biological Mother	1992
	Biological Father	1983

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 family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff discussed the case with the county on 05/23/2019 and 07/05/2019.

Summary of circumstances prior to Incident:

On 09/06/2018, LCCYSSA received a report on the family. There were concerns that were wandering the streets and police officers responded. were home and there was a communication barrier due to the language of (Burmese). A referral was made to the agency for follow up. The agency worker was able to meet with the family and determine that they were involved with services for transportation to appointments and As the family had demonstrated supports, the case was due to the one-time supervision incident but closed with no additional services provided by the agency.

Circumstances of Child Near Fatality and Related Case Activity:

On 05/20/2019 the victim child was brought to [redacted] Hospital by his [redacted] on the advice of his primary care physician. The child had yellow eyes and skin and he was not feeding well. The victim child was transported from [redacted] Hospital to [redacted] The victim child was in respiratory failure and liver failure and was intubated on route to the medical center. Upon examination the child was found to have bilateral head bleeds and retinal hemorrhages. There were concerns for non-accidental trauma. LCCYSSA received a [redacted] report on 05/22/2019 with this information for investigation. The agency immediately engaged law enforcement and worked together with them throughout the investigation.

The caseworker and officer observed the victim child at the hospital. Medial staff were conducting brain death tests on the victim child. [redacted] were not present, so the caseworker and officer went to [redacted] home. Through the use of church interpreters, they were able to confirm a safety plan that [redacted] could not be alone around [redacted] while the investigation was active. On 05/23/2019 the child was pronounced dead and the investigation was upgraded to a child fatality.

Further medical testing determined that the child had cytomegalovirus (CMV) which would have caused the retinal hemorrhaging and head bleeds. The child's liver was also enlarged. It was determined that the child's medical conditions were not caused by abusive actions or neglect. There were no concerns with [redacted] care of the child as he had been attending regular medical appointments.

Law enforcement was involved throughout case but closed their case once the cause of death was determined to not be suspicious.

LCCYSSA filed their investigation report with ChildLine on 06/19/2019 [redacted] It was determined that the child's injuries and subsequent death were a result of a medical condition and infection. No additional services were requested or needed, so the agency closed the case at the conclusion of the investigation.

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

Lancaster County Children and Youth Social Services Agency [redacted] As such, a County Child Fatality report was not completed.

Department Review of County Internal Report:

Lancaster County Children and Youth Social Services Agency did not provide a County Internal Report [redacted]

Department of Human Services Findings:

- County Strengths:
  - Collaboration between LCCYA, law enforcement, and hospital staff was observed throughout case involvement. Law enforcement was present with the agency at hospital and home visits.
  - The agency used multiple language resources that were available to them due to the growing refugee population in the county.
  - The caseworker continuously offered supportive services to the family throughout the case. The caseworker took great care to assure that the family understood what was available to them to process the death of their child.

- County Weaknesses:
  - None noted with the investigation.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - 3130.21(b) – (September 2018 [redacted]) The children were seen by the caseworker on 09/07/2018 but an initial safety assessment worksheet was not completed until 11/05/2018.
  - 3130.21(b) – (September 2018 [redacted]) The children were seen on 09/07/2018 and then again on 11/02/2018. More than 30 days passed during the assessment period and the children were not seen.

  These items will not be issued on a Licensing Inspection Summary to the agency as they were previously cited on the 2019 Annual Inspection Summary and an approved plan of correction has been provided by the agency.

Department of Human Services Recommendations:

No recommendations are being noted by the Department at this time.