pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Brooklyn March

Date of Birth: 06/12/2014
Date of Death: 05/20/2017
Date of Report to ChildLine: 05/17/2017
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:
11/07/2017

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))

Department of Human Services/ Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dhs.state.pa.us

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 review team meeting was convened on 05/24/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Brooklyn March	Victim Child	06/12/2014
[redacted]	Mother	[redacted]1983
	Father	1984
	Sibling	2015
	Caregiver	1980
	Caregiver	1977
	Cousin	2001
	Cousin	

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) attended the Act 33 meeting on 05/24/2017 and obtained and reviewed all current case records pertaining to the family. CERO staff spoke with Lancaster County Children and Youth Agency (LCCYA) staff involved with this case.

Children and Youth Involvement prior to Incident:
LCCYA had no prior involvement with the child's family as the family resided and continues to reside in Georgia. LCCYA requested information regarding the family's history with the children and youth agency in Georgia and were informed that the family had no history with their agency.

LCCYA also had no prior involvement with the caregiver's family.

Circumstances of Child Fatality and Related Case Activity:
The victim child was brought into a local hospital on 05/16/2017, after reportedly vomiting and seizing. The victim child was found to be in critical condition with multiple bruises to her back, butt and shoulders in various stages of healing. She

was airlifted to a local trauma center where a CT scan and additional medical testing were completed. The victim child was found to have a bi-lateral subdural hemorrhage, retinal hemorrhaging in both eyes, and possible swelling of the brain, in addition to the extensive bruising. The victim child remained at the local trauma center until she passed away from her injuries on 05/20/2017.

The victim child and her sibling had been residing with [redacted] since January 2017, while [redacted] were residing in Georgia. [redacted] had come upon some difficult times and reached out to [redacted] for the children for a little while. The biological father was incarcerated at the time. When questioned regarding the injuries, [redacted] reported that the victim child had fallen off the bed earlier in the day, but was acting fine. No one had seen the victim child fall off the bed, but [redacted] heard a loud boom and then the victim child jumped up and exclaimed that she was fine. [redacted] had then left to go to [redacted] baseball game. [redacted] reported that the victim child seemed fine until later that evening, after [redacted] had returned home from the game, and she began seizing and vomiting. The victim child became unresponsive and [redacted] contacted 911 and began performing CPR until emergency medical personnel arrived and transported the victim child to the hospital. [redacted] also provided an additional account of events that they felt could have caused the injuries to the victim child. They reported that the weekend prior to the victim child being admitted to the hospital, [redacted] had gone through a door and when [redacted] swung it open, it had hit the victim child on the head causing a bruise under her eye. [redacted] that the child's injuries did not match up with the stories being provided and evidence from the investigation indicates that [redacted] was the only individual caring for the victim child at the time of the incident as [redacted] was staying out of town for [redacted] job. LCCYA completed their investigation on 07/14/2017, [redacted] for causing bodily injury to the victim child.

LCCYA assured safety of [redacted] LCCYA referred the family to their local children and youth agency to assess the safety of [redacted] LCCYA also completed a safety assessment for these children and a safety plan was put in place stating that [redacted] Ongoing [redacted] are being provided to [redacted] in order to assure the [redacted] The criminal investigation is still ongoing and no charges have yet been filed related to this incident.

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 the case.
  - The CPS caseworker went immediately to the hospital to start the investigative process.
  - [redacted] worked collaboratively with the Agency in conducting an evaluation of [redacted] to rule out any signs of abuse for that child.
  - The Agency was prompt with their investigation and no delays occurred during the assessment period.
  - [redacted]
  - The Caseworker contacted the state of Georgia to determine past child welfare involvement with the family.
  - The family was accepted for services on 5/17/17.
  - The Agency will continue to provide supportive services to the family until case closure.
  - [redacted] acted appropriately in triaging Brooklyn and transferring her to [redacted] for additional medical treatment.
  - [redacted] was supportive of the biological parents and provided the family the opportunity to spend time with Brooklyn before she was taken off of life support.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:
  - None identified

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Lancaster County Children and Youth Agency should continue to identify opportunities to educate the community on the importance of reporting suspected child abuse.
  - Provide literature in the lobby of the Children and Youth Agency on where and how to report suspected child abuse.
  - A follow up conversation with the [redacted]

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

  No recommendations for changes at the state and local levels on monitoring and inspection of county agencies were brought to light at the meeting.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  No recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse were brought to light at the meeting.

Department Review of County Internal Report:
The County submitted their report in a timely manner within the required 90-day timeframe. The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
  - The agency immediately began the investigation, cooperated with medical personal and assured the safety of the children involved.
  - The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.
  - The agency is continuing to offer services to the caregiver's family and to monitor the safety of the children in her home.

- County Weaknesses:
  - None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - There were no areas of regulatory non-compliance observed.

Department of Human Services Recommendations:
The Department has no recommendations.