pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/29/2019
Date of Incident: 02/28/2019
Date of Report to ChildLine: 02/28/2019
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 Agency

REPORT FINALIZED ON:

09/16/2019

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 completed their investigation and filed the report with ChildLine as unfounded on 03/21/2019 which is before the 30th day of the investigation. A review team did not need to be convened.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim child	01/29/2019
	Mother	[redacted]/2002
	Father	[redacted]/1999
	Maternal Grandmother	[redacted]/1969
	Maternal Grandfather	[redacted]/1967
	Maternal Aunt	[redacted]/2004

* 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 Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all 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:

The family was previously known to LCCYA. A general protective services referral was received on 01/30/2019, with concerns that the mother was a teenage mother who had [redacted] for marijuana. The Agency was still assessing these concerns at the time of the incident. On 3/21/19, the concerns were found to be invalid and the case was closed out.

Circumstances of Child Near Fatality and Related Case Activity:

The child was taken by her parents to the emergency room at a local hospital on 02/28/2019 due to a head injury from reportedly falling off the bed. The child was found to have a brain bleed which was reported to be minor. The medical team completed a full skeletal survey on the child and the results were normal. The child was behaving normally and no concerns were noted for the parents care or interactions with her while in the hospital. She was treated and released to the care of her parents the next day. The child was scheduled to follow up with her doctor and to have a follow up brain scan to ensure that bleed heals without complication.

The mother still resides with her parents. She and her younger sibling were the only other minors in the home at the time of the incident. LCCYA immediately responded and assessed their safety, but there were no concerns for the safety of either of the teenagers. The father still resides at home with his parents, but visits the mother's home and occasionally stays overnight with her and the child.

The parents maintained that the child had fallen off the bed causing the injuries, but initially were not truthful about how the child had fallen from the bed, blaming a dog for jumping on the bed and causing the child to fall. The mother eventually came forward and admitted that the child had been up all evening crying and when she had finally fallen asleep, the mother placed the child on the bed beside her. The mother then fell asleep next to the child. While sleeping the mother rolled over and accidentally knocked the child off the bed, onto the floor, resulting in the injuries sustained by the child.

The medical team determined that the child's injuries were consistent with a child that would have fallen off a 2-foot bed. The case was determined to be unfounded on 03/21/2019. Local law enforcement also determined, during their investigation, that the incident was an accident and no charges were filed. The Agency provided the mother and father with comprehensive information regarding safe sleeping arrangements for infants. The parents have articulated a plan to ensure that the child is always put to sleep in her bassinet rather than with other individuals. LCCYA determined that no additional services were needed for the family and the case was closed.

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;
    - LCCYA did not convene a review team as the report was unfounded before the 30th day. As such, a County Child Fatality report was not completed.

- Deficiencies in compliance with statutes, regulations and services to children and families:

    - LCCYA did not convene a review team as the report was unfounded before the 30th day. As such, a County Child Fatality report was not completed.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

    - LCCYA did not convene a review team as the report was unfounded before the 30th day. As such, a County Child Fatality report was not completed.

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

    - LCCYA did not convene a review team as the report was unfounded before the 30th day. As such, a County Child Fatality report was not completed.

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

    - LCCYA did not convene a review team as the report was unfounded before the 30th day. As such, a County Child Fatality report was not completed.

Department Review of County Internal Report:

Lancaster County was not required to provide a County Internal Report due to the case being unfounded before the 30th day.

Department of Human Services Findings:

- County Strengths:

    - The agency immediately began the investigation and worked cooperatively with local law enforcement to ensure the safety of the children involved.

    - The agency consulted with medical professionals.

- County Weaknesses:

    - None identified

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - None identified

Department of Human Services Recommendations:

The Department recommends that medical providers and social service agencies continue to provide information regarding “safe sleep” to parents with newborns and young children.