pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ridley Toomey

Date of Birth: 01/28/2019
Date of Death: 06/14/2019
Date of Report to ChildLine: 05/29/2019
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:
12/12/2019

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))

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 06/19/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Ridley Toomey	Victim child	01/28/2019
[redacted]	Biological Father	[redacted] 1980
	Biological Mother	[redacted] 1983
	Household Member	[redacted] 1963
	Household Member	[redacted] 1979
	Babysitter	[redacted] 1984
	Babysitter	[redacted] 1970
	Babysitter	[redacted] 1984

* 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) obtained and reviewed all case records pertaining to the family. CERO staff attended the Act 33 meeting held by Lancaster County and spoke with Lancaster County Children and Youth Agency (LCCYA) staff involved with this case.

Summary of circumstances prior to Incident:
The family was previously known to LCCYA. A [redacted] referral was received on 05/06/2019 regarding concerns that [redacted] was conducting [redacted] in a way that placed the child at risk; the family did not have inadequate housing; and the child's basic needs were not being met. LCCYA was still in the process of assessing these concerns when the fatality report was received.

Circumstances of Child Fatality and Related Case Activity:
On 05/29/2019, emergency personnel were called to the child's [redacted] home due to the child going into cardiopulmonary arrest after being placed on tummy

time. The child was being cared for [redacted] at [redacted] home next door, at the time of the incident because the mother was at work during this time period. When emergency personnel arrived at the home, they found the child on his back on a blanket with one of his [redacted] providing CPR. Emergency personnel took over providing CPR. The child's body was still warm, but his lips were blue. There was a cream-colored liquid coming from his mouth and small amounts of blood coming from his nose and mouth. The child was initially transported by ambulance to the local hospital where they were able to get to resuscitate him. He was then transported by helicopter to a local specialty hospital to be treated due to concerns for a hypoxic brain injury. Several brain functioning tests were administered to the child and he was found to have no brain activity. The child remained in the hospital until his death on 06/14/2019.

While [redacted] has no additional children, one of the [redacted] LCCYA immediately assessed the safety of these children and a safety plan was put in place to ensure that these would remain safe until the investigation was completed.

On the day of the incident, the child was dropped off at the [redacted] home in the early afternoon by the [redacted] The child was reported to be in good health and spirits when he was dropped off. His diaper was immediately changed and then one of the [redacted] spent time engaging him in play. He ate without any difficulty that day and consumed two 8-ounce bottles during his time with the [redacted] took the child and [redacted] on a trip to the local library for a time period and returned to the home around 5:30 PM. The child was then given a bath. Following his bath, the child was placed on a blanket on a hard floor for tummy time. The child was noted to be laying with the left side of his face up. While the child was on tummy time, [redacted] were getting dinner together and then feeding the other children. [redacted] stopped over to the home during this time period as well and checked on the child prior to going outside to smoke a cigarette with [redacted] After smoking, [redacted] returned back to [redacted] home and [redacted] came back into the home and spoke to the [redacted] who were in the kitchen. The [redacted] decided to go out and smoke again prior to finishing dinner. Before heading outside, the [redacted] went to check on the child. [redacted] placed [redacted] hand on the child's back after the moving the blanket around a bit to reposition the child's head. At this point, the child's head was noted to be down. [redacted] then flipped over the child after noticing that he was unresponsive and immediately began CPR while emergency personnel was contacted for assistance.

An autopsy was completed following the child's death and no evidence was found of blunt force trauma or concerning injuries. The child's death was ruled to be caused by complications for asphyxia in an accidental manner. LCCYA [redacted] the case on 07/03/2019 and the case was closed with no further services being provided. No criminal charges have 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;
  - At the end of the investigation the Agency reached out to the family to provide them with information on [redacted]
  - An appropriate response time was assigned, and the Agency met with the mother and child within 24 hours.
  - The Agency completed Safety and Risk Assessments on the family to help guide their practice.
  - A collaborative investigation has occurred for this case between the hospital, police and Children and Youth Agency.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  - 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;
  - The Act 33 committee discussed the importance of having supervised tummy time and for parents and caregivers to be educated on the need for supervised tummy time.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None identified.

Department Review of County Internal Report:

Lancaster 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 and worked cooperatively with local law enforcement to ensure a thorough investigation was completed.
  - 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 does not have any recommendations at this time.