pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY

[redacted]

Date of Birth: 03/09/2018
Date of Incident: 07/14/2019
Date of Report to ChildLine: 07/14/2019
CWIS Referral ID: [redacted]

FAMILY UNKNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lancaster County Children and Youth Services

REPORT FINALIZED ON:

03/02/2020

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 07/24/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim child	03/09/2018
[redacted]	Biological Mother	[redacted]1993
[redacted]	Biological Father	[redacted]1991

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) reviewed all case records pertaining to the family. An initial discussion occurred with the assigned case worker on 07/15/2019. The CRO did attend the Act 33 meeting on 07/24/2019.

Children and Youth Involvement prior to Incident:

There is no known history with this family having any children and youth involvement prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

Lancaster County Children and Youth Services (LCCYS) received a report that the victim child was brought to the local hospital by his parents who were named as the alleged perpetrators. The parents reported that the mother put the victim child on the counter and walked away. It was reported that the parents heard the victim child hit the ground and immediately started to cry. The father held and rocked the victim child until he fell asleep. The parents reported that they then put the victim child down for a nap. When the parents checked on the victim child; they found the victim child unresponsive and noticed that the victim child had vomited. The parents put the victim child in the bath to try and clean and wake him however they were not successful. The parents then brought the victim child to the hospital at

which time the victim child was seizing. Hospital staff were able to stop the seizures and conducted a Computed Tomography (CT) scan which showed a skull fracture. The victim child was stable prior to being transferred to a specialty hospital.

LCCYS responded immediately to the specialty hospital along with [redacted] Police [redacted]. The victim child's maternal and paternal grandparents arrived at the hospital as well to be a support to the parents. Both parents were interviewed and shared the following account of what happened. They reported that it was a typical Sunday morning. They stated that they attended church where they always share a meal afterwards with the congregation. They reported that the victim child fell asleep during the meal so when they arrived home; the mother heated some food for the victim child. The victim child was sat on the kitchen countertop which was estimated to be 3 feet high. The father was sitting in the living room at this time. The mother took the father some coffee and left the victim child sitting on the countertop eating his lunch. The mother estimated that she was not gone longer than a "half minute" when she heard the victim child fall on the floor which they described as being vinyl. They reported that the father held the victim child to soothe him and nothing seemed abnormal at the time. The victim child fell asleep while the father rocked him. The victim child was then placed in his crib to sleep while the parents went to their room which is across the hall and took a nap. In about one hour, the mother went to check on the victim child and found the victim child unresponsive, eyes open and vomit on the victim child and in the crib. The father put the child in a warm bath hoping that would wake the child but once the father saw that the victim child had no control of his head; he knew something was not right. The father estimated that the child was only in the water for approximately 15 seconds before he realized that something was wrong. The father called the local hospital to inform them that he was bringing the victim child to be seen. The parents then took the child to the local hospital.

The victim child was admitted to the specialty hospital for observation. A skeletal survey was conducted on the victim child as part of their evaluation. The evaluation showed no previous injuries to the victim child. The specialty hospital ruled this incident as accidental due to the parents account of the incident matching the child's injuries. The victim child was discharged from the hospital on 07/16/2019 to his parents. LCCYS conducted a home visit on that same day and found the home to be safe. The family was provided with information regarding traumatic head injuries and appropriate supervision.

LCCYS unfounded the investigation on 08/02/2019 based on the information they gathered. The [redacted] were not filing charges against the parents as they felt it was accidental as well.

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

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

An Immediate response time was assigned and the agency met with the family the same day.

The agency assessed the child in his home to assure his safety.

The agency conveyed the seriousness of the report and discussed safety concerns.

The agency completed a Safety and Risk Assessment on the family to help guide their practice.

A very collaborative investigation has occurred for this case between the hospital, police and children and youth.

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

  No identified deficiencies.

- 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 family was informed on information regarding traumatic head injuries. The family also was made aware that if an incident of supervision happens again; the family will be assessed ongoing services.

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

  No recommendations identified.

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

  No recommendations identified.

Department Review of County Internal Report:

The Lancaster County Child Death Review Team held an Act 33 meeting on 07/24/2019, where case information was presented. The county report of the Act 33 meeting was received by the CRO on 01/24/2019. On 11/05/2019, the CRO sent correspondence to LCCYS Administrator, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:

The agency collaborated with Law Enforcement and communicated well with each other.

The agency's Act 33 meeting was well represented by county personnel, medical providers, and law enforcement. The meeting was very thorough and the agency implemented their Act 33 policies and procedures.

The agency provided the family with information on traumatic head injuries and safe supervision.

- County Weaknesses:

  None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

  After review of the file; the agency was found to be in compliance with statutory and regulatory requirements.

Department of Human Services Recommendations:

The department does not have any recommendations at this time.