pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY

[redacted]

Date of Birth: 05/11/2018
Date of Incident: 08/10/2019
Date of Report to ChildLine: 08/10/2019
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 Social Service Agency

REPORT FINALIZED ON:

01/27/2020

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 08/28/2019.

Family Constellation:

First and Last Name	Relationship	Date of Birth
[redacted]	Victim child	05/11/2018
[redacted]	Biological Mother	[redacted]1987
[redacted]	Biological Father	[redacted]1988
[redacted]	Sibling	[redacted]2014
[redacted]	Sibling	[redacted]2013
[redacted]	Sibling	[redacted]2019
[redacted]	Sibling	[redacted]2009

Summary of OCYF Child 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 a few days after the incident occurred. The CRO did not attend the Act 33 meeting on 08/28/2019. CRO was invited to attend the Act 33 meeting and had intentions of attending. However, there was an accident in route to the meeting and CRO was not able to attend due to sitting in traffic for 2 hours.

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 Fatality and Related Case Activity:
Lancaster County Children and Youth Social Service Agency (LCCYSSA) received a report that the victim child was brought to the local hospital by Emergency Medical Staff (EMS) after being in cardiac arrest. It was reported that the victim child was unsupervised and drowned in the family's inflatable pool. The victim child's father was outside mowing the grass and the victim child was following his older siblings

who were also outside doing chores. The victim child's mother was inside making dinner during this time. The victim child's siblings went inside to ask where the victim child was. The victim child's mother went outside and found the victim child in the pool. The victim child's parents contacted EMS who responded to the home. The victim child did not have a heartbeat for 30 minutes and cardiopulmonary resuscitation (CPR) was performed for 25 minutes. The victim child was transported to the local hospital where he was intubated and then transferred to a specialty hospital. The victim child was on life support and his prognosis was poor.

LCCYSSA responded immediately to the specialty hospital and met with the entire family. The victim child's mother reported that she was in the home making dinner while her husband was outside mowing the yard. It was reported that the older siblings were also outside doing chores and the victim child was following along with them as that is something he normally did. The older siblings came inside and asked the mother where the victim child was. The victim child's mother said that she went outside to look for him since that is the last place he was and that is when she found him in the pool. It was reported that the pool gate had a lock on it however; the victim child learned how to unlock the pool gate. It was reported that both parents told the victim child that he was not permitted to go to the pool by himself.

LCCYSSA did an informal safety plan with the victim child's parents that all the children must be supervised by someone fourteen years or older. The victim child's parents agreed to the plan and agreed to supervise the children at all times.

[redacted] Police [redacted] were involved with this case as well. [redacted] toured the property and took photographs of the pool and the surroundings. This was done prior to 08/16/2019 at which time LCCYSSA did an unannounced home visit to the residence but no one was home. LCCYSSA personnel did note that there was not a pool at the residence at that time. LCCYSSA did another home visit four days later and the victim child's father gave the worker a tour of the property to show that he took the pool down. The inflatable pool had been surrounded by chicken wire with a makeshift gate that latched with a bungee cord and spring release hook. While the agency saw that the pool was taken down; the victim child's father was reminded of the importance of supervising his children at all times. The victim child's father agreed and said he wanted to take more precaution.

On 09/06/2019, the victim child was discharged to his parents from the rehabilitation facility to his parent's home. The victim child was sent home on a feeding tube and both parents were provided with information on [redacted] as well as home health care.

LCCYSSA personnel made several unannounced home visits and learned that the family has in home services in place [redacted] and a local home health care who comes to the home twice a week. There were no concerns noted that any of the children were not being supervised.

LCCYSSA unfounded the investigation on 10/09/2019. LCCYSSA believed this particular incident did not meet CPSL for lack of supervision. The [redacted] informed the agency that the District Attorney's Office is reviewing the case for possible charges.

On 12/23/2019, [redacted] stated that they received approval to charge the parents with endangering the welfare of children. [redacted] stated that the parents are aware and the charges will be filed soon.

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

- Strengths in compliance with statutes, regulations and services to children and families:
    - An appropriate response time was assigned. The Agency started the investigation immediately and all the children were seen and their safety assessed.
    - 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.
    - The agency caseworker visited the home multiple times during the investigation.
- Deficiencies in compliance with statutes, regulations and services to children and families:
    - The agency provided the family with information regarding [redacted] and resources.
    - The agency discussed the role the parents play in providing an appropriate level of supervision for their children.
- 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 supervision practices within the Amish community, as the agency continues to receive reports where children are injured due to lack of supervision or inadequate supervision.

- The committee discussed the realization that the agency continues to receive reports that involve lack of parental supervision within the Amish community resulting in a child being injured. While much work has been done in the Amish community, providing education and increasing awareness regarding proper supervision, the agency will continue to review with the parents the importance of providing an appropriate level of supervision for the children and will explore opportunities to provide education regarding supervision.

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 08/28/2019 where case information was presented. The county report of the Act 33 meeting was received by the CRO on 11/25/2019. On 12/18/2019, the CRO sent correspondence to LCCYSSA 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 the hospital and communicated well with each other.

  - The agency assessed safety of all the children in the home.

- The agency provided the family with information on [redacted] and made several home visits to assist the family both before the victim child was discharged from the hospital as well as after.

- The agency provided education to the family on the importance of appropriate supervision.

- <u>County Weaknesses:</u>

  - None noted.

- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency:</u>

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

<u>Department of Human Services Recommendations:</u>

The department recommends that county agencies continue to work with their Amish communities to provide education with regards to appropriate supervision of the children.