pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/09/2014
Date of Incident: 05/19/2017
Date of Report to ChildLine: 05/19/2017
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:
11/02/2017

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))

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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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/14/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	04/09/2014
	Sibling	[redacted]2016
	Sibling	2012
	Sibling	2009
	Sibling	2007
	Sibling	2005
	Sibling	2003
	Sibling	2002
	Sibling	2000
	Biological Mother	1979
	Biological Father	1976

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff attended the agency Act 33 meeting on 06/14/2017 and discussed the case with agency staff at that time and on 07/24/2017.

Summary of circumstances prior to Incident:

The family was not known to Lancaster County CYA prior to this involvement.

Circumstances of Child Near Fatality and Related Case Activity:

Lancaster County CYA received a report on 05/19/2017 that a 3-year-old Amish child had been stepped on by a mule in the family barn. The father was allegedly in the barn but was not present when the incident occurred. The child was determined be in critical condition at Lancaster General Hospital and was transferred by helicopter to Hershey Medical Center. The case was not initially determined to be a near fatality as the status of the child was not known. Upon further review of the child's condition by the physician, the incident was determined to be a near fatality on 05/24/2017, as there was suspected neglect leading to the injuries.

The father explained that he and another child were in the barn cleaning out the mule pens. He was not aware that the victim child or his 7-year-old sibling were in the barn. The mules were hitched to the plow. He stated that he did not hear any crying, but his older son saw the victim child on the ground. He was told that the 7-year-old sibling grabbed the bridle of the mule and this caused the mule to step down on the victim child. The child was initially unconscious, but upon some chest compressions from the father, he vomited and cried.

The agency coordinated with law enforcement and observed the child and spoke with the father at Hershey Medical Center on 05/20/2017. The child had [redacted] from the incident. [redacted] to repair his pancreas. As a result of this, the distal pancreas was removed. The victim child [redacted] on 05/26/2017, with future medical follow-up scheduled.

Lancaster County CYA filed their investigation report with ChildLine on 06/20/2017 with a status of Unfounded for serious physical neglect. It was determined that the incident was accidental as the father of the child was in the next room of the barn and the incident occurred when a sibling of the victim child pulled on the bridle of the mule. No charges were filed by police.

The agency closed their case at the conclusion of the investigation as the parents were following up on the medical needs of the child and there were no additional areas of concern.

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;
    - No additional concerns were noted for the other siblings in the home. The family has cooperated with the Agency during the investigation. The parents were receptive to any recommendations made by the Agency and the Agency was culturally sensitive and remained professional and courteous towards the family during the investigation. The child's injuries were considered accidental.

- An immediate response tag was assigned to the case.
- The Agency was prompt in starting the investigation.
- The Agency remained involved with the family for 60 days.
- Visits were conducted at the hospital and in the home to meet with the family to assess the home environment and evaluate parenting capacity.
- The case was reviewed and the child's injuries were considered accidental.
- The Agency was persistent with its efforts to interview all family members.
- The Agency will continue to provide supportive services to the family until case closure and will explore community resources available that may be useful to the parents.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None noted.

- 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 parents were encouraged to participate in Farm Safety Classes.
  - The parents plan to install rope blocks in the barn stalls to assist with animal management.

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - The Agency Director of Intake Services continues to meet quarterly with the Amish Elders to discuss topics that impact the Amish community including farm safety and awareness.

Department Review of County Internal Report:

The Central Region Office received the Lancaster County Child Fatality Team Report on 07/24/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 06/14/2017. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Lancaster County Administration on 07/24/2017.

Department of Human Services Findings:

- County Strengths:
  - The agency responded within 24 hours to see the child, coordinate with law enforcement, and consult with medical staff regarding the child's condition.
  - The agency coordinated with the elders in the Amish community to assure that the family was receiving support.

- County Weaknesses:
  - While the agency did make home visits and see the other children in the family, it does not appear that any of the children were interviewed, even though some of them were involved with the incident.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - 3130.21(b) - In the Preliminary Safety Assessment (5/20/17), only the father and the victim child were seen at the hospital. The other individuals that were not seen, but potentially would have been a part of the safety assessment, were not documented in the appropriate section.
  - 3130.21(b) - The New Information Safety Assessment (5/25/17), lists all of the children seen for the assessment except for the two that were not seen. These two children were not documented as not being seen in the appropriate section.
  - 3130.21(b) - The contact associated with this safety assessment (5/25/17) only states that the children were either in a wagon or running around. There is not any description of any interaction to assess safety. This is also more than 72 hours after the initial contact, with no documented attempts to see the children prior to this date.
  - 3130.21(b) - The mother of the child was not seen or assessed until 6/12/17 at the closing visit.
  - 3130.21(b) - Two children were never seen during the investigation.
  - 3490.55(d)(5) - There is no documentation that the caseworker interviewed the 7 year old sibling that pulled the bridle of the mule, or the 15 year old sibling that had been working in the barn with the father and interacted with the child after the incident. While the caseworker has verbally indicated that the father did not permit her to interview the children, the agency should have considered further action to conduct these interviews as they would have been pertinent to the investigation.

The agency will be issuing a Licensing Inspection Summary with these findings and the County will be expected to provide a Plan of Correction to the Department.

Department of Human Services Recommendations:

The agency needs to continue to review their practices around child abuse investigations, and reinforce these practices in the caseworkers conducting the investigations. There were key pieces missed in this investigation, and while it was ultimately ruled an accident, key interviews needed to be completed to assure there were no further concerns.