pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Nicholas Lane

Date of Birth: 10/26/2016
Date of Incident: 01/12/2017
Report to Child Line: 05/02/2018
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 Services

REPORT FINALIZED ON:
10/19/2018

Department of Human Services/Office of Children, Youth and Families, Central Region
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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 Children and Youth submitted an unfounded report to ChildLine on 06/07/2018. Lancaster County Children and Youth convened a review team in accordance with the Child Protective Services Law related to this report. The County review team was convened on 05/23/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Nicholas Lane	Victim Child	10/26/2016
[redacted]	Father	[redacted]1982
	Mother	1988
	Maternal Half Sibling	2007
	Maternal Half Sibling	2009
	Maternal Half Sibling	2012
	Full Sibling	2014
	Maternal Grandmother	1958

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed the case records pertaining to the family, which included medical records, agency casework dictation, Coroner Report and Lancaster County Children's Alliance Report that outlined contact with the family. CRO also attended the Act 33 Meeting on 05/23/2018.

Children and Youth Involvement prior to Incident:

Lancaster County Children and Youth Services (LCCYS) was providing on-going services to this family since 08/19/2017. Prior to accepting the family for services, the agency received [redacted] The first [redacted] was in 2015 involving the victim child's [redacted] with regards to poor hygiene and truancy. This referral was addressed and the case was closed as the family left Lancaster County. The second [redacted] was the death of the victim child. This information is provided below in circumstances of child fatality and related case activity. The third [redacted] was on 02/14/2017 regarding poor

hygiene and truancy with regards to the victim child's [redacted]. LCCYS was addressing these concerns when the family relocated to Butler County at which time Butler County Children and Youth became involved. The family returned to Lancaster County in June of 2017 and LCCYS received a referral from Butler County on 06/23/2017 with the following concerns: ongoing head lice issues with the [redacted] The children were confirmed lice free on 05/26/2017; however, there were concerns that the children were re-infested. The children have no medical or dental exams. The one child has [redacted] and physical aggression. The family has "county hopped." The mother took six weeks to enroll the children in school and when the family resided in Butler County, the children had no toys or bedding - just a blow-up mattress. LCCYS accepted the family for services.

Circumstances of Child Fatality and Related Case Activity:

Lancaster County Children and Youth Services (LCCYS) received a [redacted] on 05/02/2018. The report stated that the victim child died when he was 1 or 2 months old which was over a year ago. The biological parents have severe domestic violence history. It was reported that the [redacted] was at the house and fell on the baby swing and the victim child died 2 days later. The alleged perpetrators listed are [redacted] ChildLine [redacted] and registered it as a fatality as the information provided now differed from [redacted] of child's death on 01/12/2017.

LLCYS received the [redacted] made on 01/12/2017 which stated that the victim child was deceased prior to arrival to the emergency department. The victim child is a two-month-old that was found at home unresponsive. Upon Emergency Medical Staff (EMS) arrival, the patient was in asystole, the most serious form of cardiac arrest that is usually irreversible. The [redacted] reported to medical providers that the child was last fed at 5:00 AM that morning. There were no reports of any recent illnesses, prenatal, and/or perinatal problems. After ChildLine review and consult with supervisor, [redacted] As it was unknown what caused the cardiac arrest, LCCYS was instructed that should they suspect that the cardiac arrest was caused by an abusive/neglectful act, [redacted]

LCCYS conducted a [redacted] of the referral received on 01/12/2017. Agency personnel completed home visits on 01/20/2017 and 02/15/2017. Interviews were also done at that time which the [redacted] stated that [redacted] fed the victim child earlier that morning around 3:00 AM and there wasn't anything wrong with the child at that time. The [redacted] reported that when [redacted] woke up later that morning and checked on the victim child, [redacted] noticed that he was not breathing. Agency personnel assured the safety of the other children. The agency received the Coroner's report which stated that after autopsy and forensic causation analysis, it is the opinion that the cause of death was Complications of Aspirations due to Meningitis and the manner of death was Natural.

Regarding this [redacted] LCCYS responded immediately as they have an open case with this family. The agency put a safety plan in place with the maternal aunt not allowing any unsupervised contact with the alleged perpetrators and [redacted] The agency made several home visits for continuing supportive services to the family during this investigation. The agency also scheduled two of the victim child's [redacted] to be interviewed at the Lancaster County Children's Alliance to inquire if additional information can be obtained. Neither [redacted] disclosed any concerns during their individual interviews.

LCCYS did contact the city police to report the [redacted] and shared what information they had. LCCYS communicated with the city police department throughout their investigation. The city police did not file charges against any of the alleged perpetrators and closed their case. The police accepted the coroner's report that the cause of death was natural.

LCCYS conducted the [redacted] investigation timely. The case was [redacted] The family is currently receiving on-going services through LCCYS and the victim child's [redacted] is continuing to receive [redacted] to address the death of this child. That [redacted] also continues to reside with her paternal grandmother.

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:

An immediate response tag was assigned to this case.

The agency was prompt with their investigation and no delays occurred during the assessment period.

The agency used the risk and safety assessment tool to guide their practice and decision making.

The agency was able to assess the other children in the home to assure safety.

The agency has provided the family with loss and grief resources.

A very collaborative investigation has occurred for this case.

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

The other children in the home were not interviewed by the Children's Alliance at the time of the Act 33 County Team Review. The children should be interviewed for additional information.

The family was accepted for services.

The victim child's [redacted] is receiving [redacted] services.

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 agency should continue to monitor [redacted] for the victim child's [redacted] to ensure that she is receiving the level of services that is needed.

The [redacted] treating the victim child's [redacted] should speak with the police regarding the victim child's autopsy so that the [redacted] can help the victim child's [redacted] separate the two incidents - the death due to Meningitis and the [redacted] falling on the child - to reduce feelings of guilt and responsibility.

The agency should always consider utilizing the Children's Alliance for all children, not just the identified victim child, affiliated with the family, who might be able to provide additional information regarding the investigation.

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:

None noted.

Department Review of County Internal Report:

Lancaster County Children and Youth Child Death Review Team held an Act 33 meeting on 05/23/2018 where medical information and the case were presented. The county report of the Act 33 meeting was received by the CRO on 08/10/2018. On 08/16/2018, 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 responded to the referral immediately by seeing the victim child's siblings and implementing a safety plan.

Agency personnel communicated well with law enforcement.

The agency completed their investigation and submitted the appropriate paperwork timely.

The agency did a full investigation despite having prior information on this incident.

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 has no recommendations at this time.