pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/07/2017
Date of Incident: 05/14/2018
Date of Report to ChildLine: 05/17/2018
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH OFFICE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lancaster County Children and Youth

REPORT FINALIZED ON:
05/13/19

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 Children and Youth (LCCYS) has not convened a review team meeting because they received the report on 05/17/2018 and determined the status of the investigation to be unfounded and submitted the CY48 to ChildLine on 06/14/18. Since the determination was made within 30 days of the report to ChildLine, an Act 33 review team meeting was not required.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	07/07/2017
	Biological Mother	[redacted]/1996
	Biological Father	[redacted]/1996

Summary of OCYF Child (Near) Fatality Review Activities:
The Central Region Office of Children, Youth and Families obtained and reviewed the entire family file. The Central Region reviewed all of the structured case notes, safety and risk assessments, medical records, and other case specific information provided by LCCYS. Central Region staff also had ongoing telephone communications with LCCYS regarding this case.

Summary of circumstances prior to Incident:
The family had no prior involvement with LCCYS.

Circumstances of Child (Near) Fatality and Related Case Activity:
[redacted] was in the custody of his [redacted] the evening of 05/14/2018. [redacted] dropped [redacted] off at his maternal grandmother's home for her to babysit while they went to the gym. It is reported by the parents that [redacted] had a fever periodically on 05/13/2018 and earlier in the day on 05/14/2018 and that is why they asked maternal grandmother to babysit rather

than taking [redacted] to the daycare at the gym as they usually do. After the gym, [redacted] picked up [redacted] and drove to their home. Around 9:20 p.m. [redacted] dropped [redacted] off at their home and [redacted] then drove to [redacted] maternal grandfather's home for a visit. While at grandfather's home, grandfather observed that [redacted] body was very hot, but his hands and feet were very cold, and mother observed that the child appeared droopy and tired. [redacted] then put [redacted] in his car seat to drive home. [redacted] indicates that [redacted] got quiet about 5 minutes into their drive home so she assumed that he fell asleep. When they arrived home at approximately 10:00 pm, as [redacted] was getting [redacted] out of his car seat, she observed him to be unresponsive with no pulse and his head slumped forward. [redacted] called [redacted] from her cell phone to come outside while a passerby called EMS.

[redacted] was transported to [redacted] Hospital via ambulance then to [redacted] around midnight via [redacted].

It has been determined by [redacted] that [redacted] condition was caused by a virus and is not child abuse or neglect. [redacted] remains in the Intensive Care Unit at [redacted]

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

An Act 33 team meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine. The report was received by ChildLine on 05/17/2018 and the [redacted] was filed unfounded on 06/14/2018.

Department Review of County Internal Report:

An Act 33 Team meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine.

Department of Human Services Findings:

- County Strengths:
  LCCYS responded to [redacted] and conducted interviews in a timely manner.

  LCCYS worked collaboratively with the hospital and obtained all medical records pertaining to the incident.

  LCCYS submitted all documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses:
  No areas of weakness were noted regarding this near fatality.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  There were no regulatory violations regarding this near fatality.

Department of Human Services Recommendations:

The Central Region Office recommends that LCCYS continue to meet all regulatory guidelines regarding the Child Protective Service Law and child fatalities and near fatalities. The Central Region Office also recommends that LCCYS continue their efforts in working collaboratively with all medical personnel, law enforcement agencies and community partners within Lancaster County.