



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Sheri Horning

Date of Birth: 04/09/2014
Date of Death: 11/14/2015
Date of Report to ChildLine: 11/15/2015
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 Services Agency

**REPORT FINALIZED ON:
05/12/2016**

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 Services Agency has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/18/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Sheri Horning	Victim Child	04/09/2014
[REDACTED]	Biological Mother	[REDACTED] 1990
[REDACTED]	Biological Father	[REDACTED] 1989
[REDACTED]	Sibling	[REDACTED] 2011

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records, law enforcement and emergency management services records pertaining to the Family. Follow up interviews were conducted with the county agency caseworker [REDACTED], supervisor, [REDACTED], supervisor [REDACTED], intake director, [REDACTED] and agency administrator [REDACTED] on 11/15, 11/16 and 11/18/2015, 12/11/2015 and 02/05/2016.

Children and Youth Involvement prior to Incident:

Lancaster County Children and Youth Services Agency did not have prior involvement with the child or family prior to the reported incident on 11/15/2015.

Circumstances of Child Fatality and Related Case Activity:

On 11/14/2015 emergency management services, fire personnel and local area law enforcement responded to an emergency 911 call, on the property of the victim child's family farm. Emergency personnel arrived at the scene around 5:00 pm. The response was pertaining to the parent's 18-month old child who was struck and backed over by a skid loader operated by the child's father. The victim child was

observed to be lying on the ground by the left rear of the skid loader. The child was pronounced dead at the scene. According to the report [REDACTED] the victim child was with the mother and a sibling towards the front side of the barn area feeding livestock. The victim child's father was towards the back area of the barn. He was preparing to operate a farm implement to haul away manure from the barn. The child's mother lost track of the child briefly and asked the sibling where the child was. The sibling mentioned she went to "go see Daddy." At that moment the mother heard the sound of the skid loader being operated. The mother immediately ran toward the location of the machine. The sound of the mechanized equipment was far too great to hear the cries of the mother or notice the young child in the vicinity. It was reported the father, while backing up the skid loader, accidentally ran over the victim child. The mother, in running towards the area of the barn, witnessed the horrible sight of the child being crushed by the loader. The mother informed personnel that she immediately ran to call 911. Both parents were devastated by the horrific incident. The victim child's father was under the impression the children were not in the operating vicinity but rather in another area of the barn or property with their mother. The child's death was ruled accidental via Coroner's Office and the body was released to the selected funeral home on 11/14/2015.

Lancaster County Children and Youth Services Agency received the [REDACTED] report on 11/15/2015. [REDACTED]

[REDACTED] The county responded with an unannounced home visit conducted on 11/16/2015. The victim child's family was cooperative with Lancaster County Children and Youth Services Agency as well as local area law enforcement. At the time of the visit to the family home the victim child's sibling was seen and safety was assessed by the county agency worker. The sibling was determined to be safe and after interviews with family members and review and consultation with law enforcement the incident was determined to be accidental.

Law enforcement determined the incident accidental and no charges were pursued by the Lancaster County District Attorney's Office. Lancaster County Children and Youth Services [REDACTED] investigation [REDACTED] on 12/11/2015. The county did provide the family reference materials and linkage for services primarily in the area of [REDACTED] as well as additional supports. The family did not wish to receive agency services. The victim child's family are members of the local Mennonite Community; thus they have community support during such times of hardship:

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;
The county report referenced as a strength that the assigned caseworker provided (offered) services for the family however the family did not wish to

accept agency services as the family has a solid support system in place between family, community and their church.

- 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;

None noted.

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

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.

It should be noted that the Lancaster County's Review Team Report does not highlight a wealth of substance in the areas identified above based on the circumstances of this incident. The county children and youth agency ultimately ██████ the investigation. A review team did not need to be convened due to the time period for the investigation outcome, however one was convened, which in turn resulted in requiring a county report. The majority of the strengths, deficiencies and recommendations for change identified in the report were detailed as not applicable, again based on the circumstances.

Department Review of County Internal Report:

The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case on 02/8/2016. Due to the circumstances of this particular case there are no areas to dispute with the identified report. The county was provided written feedback via correspondence on 03/29/2016 regarding receipt and review of the content of their report.

Department of Human Services Findings:

- County Strengths:

The Departmental review found Lancaster County Children and Youth Services Agency responded appropriately to the referral received. The review of incident circumstances, case files, medical and emergency response records did not find areas for dispute. The County of Lancaster is

geographically large and has a significant population size. The population is very diverse for such reason Agency Administration is aware and focuses staff training on diversity, community and (or) cultural outreach. The review found the agency was culturally sensitive regarding the circumstances of this case. The county agency staffs were empathetic in conducting their investigation into this matter with the family. The county is proactive in their efforts to continue for example to have community outreach with both the Amish and Mennonite Community which is done through ongoing quarterly meetings.

- County Weaknesses:

None noted.

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

██████ investigation was handled appropriately per regulation. The review found no areas of noncompliance via Lancaster County Children and Youth Services Agency.

Department of Human Services Recommendations:

The event on 11/14/2015 truly was a horrific tragedy which members of the victim child's family will carry such hardship for the rest of their lives. The entire family and their community have been impacted the loss of said child. This report sheds light on the subject of trauma and the importance of county agency staff receiving appropriate support and follow up when having experienced post traumatic events. One could imagine the difficulty of the assigned caseworker and supervisor utilizing skills in area of engagement with the family post incident, the discussion of events, and information gathering to assure safety and measure need for ongoing agency or community services. The result can weigh heavily on the assigned caseworker. This was observed during discussion with the caseworker during the review process. County Children and Youth Administrators should evaluate internal processes existing (or needed) to ensure their labor force is in receipt of appropriate services.

The Department should review current collaborative outreach efforts with county children and youth agency administrators in attempts to highlight the subject of mental trauma incurred to agency caseworkers while performing job duties. In doing so one may be able to increase caseworker retention. For local or county level enrichment, county children and youth administrators should be able to measure if enhancements are needed in this subject area. Ongoing collaboration with the child welfare training center as well as additional state and community stakeholders on this topic can provide caseworkers with better ability to handle such hardship, resulting in better outcomes for the children and families served.