



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth:** 8/20/14  
**Date of Near Fatality:** 3/19/15  
**Date of Report to ChildLine:** 3/19/15  
**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

### **REPORT FINALIZED ON:**

July 1, 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 has convened a review team in accordance with the Child Protective Services Law related to this report. However the review team meeting was not held until June 22, 2016. This was due to the fact that it was not identified that this report should have been registered as a near fatality until June 3, 2016.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	victim child	8/20/2014
[REDACTED]	mother	[REDACTED] 1990
* [REDACTED]	father	[REDACTED] 1990

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

**Summary of OCYF Child Fatality Review Activities:**

The Central Region Office of Children, Youth and Families obtained and reviewed all case records pertaining to the family. The Central Region had ongoing contact with Lancaster County Supervisor and assigned Caseworker. The Central Region ensured the Initial Notification was posted and that the Child Fatality Data Collection Form was sent to ChildLine within 60 days of the report being registered as a near fatality. Central Region attended the Act 33 review team meeting held on June 22, 2016 and confirmed ChildLine received the CY 48 within 60 days and that the investigation was indicated.

**Children and Youth Involvement prior to Incident:**

The family was known to Lancaster County Children and Youth (LCCY). On August 18, 2014, LCCY received a General Protective Services report with concerns regarding mother's [REDACTED], income, housing, and her ability to parent. She also had pending criminal charges for stabbing the child's father with a kitchen knife.

On August 20, 2014, the family was opened for ongoing services. The mother was not cooperative with services [REDACTED]

### **Circumstances of Child Near Fatality and Related Case Activity:**

On March 19, 2015 LCCY received a Child Protective Services investigation due to the child overdosing on cocaine. Both of the child's parents were listed as alleged perpetrators. According to the referral source, the child was taken to Lancaster General Hospital by both parents due to a fever and seizure like symptoms. Upon examination the child had extremely high blood pressure and sodium levels. Urine tests were completed twice and the child tested positive for cocaine on both tests. The child was life flighted to Penn State Hershey Medical Center. It was believed that the child ingested cocaine either from the mother leaving him unattended or the mother deliberately giving him cocaine. The mother denied both of these scenarios. The attending physician stated the child had ingested a significant amount of cocaine, not just residue.

[REDACTED] Police Department obtained a search warrant and while searching mother's home they found a piece of a baggie in which cocaine would be packaged. The mother had stated she was the only caregiver, she denied knowing how the child ingested the cocaine and she also denied that she had cocaine in her home. She admitted to using heroin one year ago.

[REDACTED] On March 22, 2015 the child [REDACTED] with no lasting concerns from the overdose. The child was placed in an agency approved foster home. On April 1, 2015 the mother was incarcerated at [REDACTED] Prison. The mother was charged with aggravated assault, endangering the welfare of a child, corruption of minors and possession of a controlled substance. LCCY completed evaluations on the father and his residence and on April 21, 2015 the child was placed with his father. Neither parent has any other children. On April 24, 2015 LCCY indicated the mother as the perpetrator of the abuse. The agency had the father and child open for services until October 1, 2015, at which time the case was closed.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:** (Please note that as of the writing of this report, the county has not yet submitted their written report. The information below is being identified from the Act 33 meeting that was held on June 22, 2016.)

- Strengths in compliance with statutes, regulations and services to children and families;

Lancaster County Children and Youth conducted a thorough and comprehensive investigation of this case. The case file was well documented.

There was also collaboration between law enforcement and the county agency during this investigation of suspected child abuse.

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

Lancaster County Children and Youth received a Child Protective Services report on March 19, 2015. On June 3, 2016 Childline had discovered that this report should have been registered as a near fatality. Therefore all of the near fatality requirements (Initial Notification, Child Data Collection Form, Act 33 meeting and the final report) were not completed within the mandated time frame.

- 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 at this time.

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

None at this time.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None at this time.

### **Department Review of County Internal Report:**

Lancaster County conducted an Act 33 Review Team Meeting on June 22, 2016, at this time the written report has not been submitted to the Central Region Office.

### **Department of Human Services Findings:**

- County Strengths:

Central Region determined that Lancaster County Children and Youth conducted a thorough and comprehensive investigation of this case. The case file was well documented.

There was also collaboration between law enforcement and the county agency during this investigation of suspected child abuse.

At the time of the near fatality Lancaster County [REDACTED] had been closely monitoring this family. They had taken appropriate actions due to the mother's non-compliance with services.

County Weaknesses:

Lancaster County Children and Youth should ensure their staff are knowledgeable on what constitutes a near fatality so that future identification does not get overlooked.

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

Lancaster County Children and Youth received a Child Protective Services report on March 19, 2015. On June 3, 2016 Childline had discovered that this report should have been registered as a near fatality. Therefore all of the near fatality requirements (Initial Notification, Child Data Collection Form, Act 33 meeting and the final report) were not completed within the mandated time frame.

**Department of Human Services Recommendations:**

Central Region Office of Children, Youth and Families recognized the quality and procedural mechanisms currently in place within Lancaster County as they relate to the assessment and investigation of Child Protective Services cases and recommends their continuation.

Central Region Office of Children, Youth and Families recommends that LCCY ensure their staff are trained on what constitutes a near fatality in accordance with the statute so that future reports are not missed or identified untimely. It is also recommended that ChildLine staff are trained on this same issue.

Central Region Office of Children, Youth and Families also commends Lancaster County Children and Youth in its collaborative relationship with this office in compiling case specific data and evaluating the overall process of the Fatality/Near Fatality in an effort to promote consistent, quality services to children, youth and families.