



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Benjamin R. Lightcap

BORN: January 9, 2012

DIED: January 9, 2012

FAMILY UNKNOWN TO: Berks County

REPORT FINALIZED ON: August 23, 2013

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Act 33 of 2008 also requires that County children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated, or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Berks County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Maternal grandmother	[REDACTED] 1963
[REDACTED]	Maternal grandfather	[REDACTED] 1966
[REDACTED]	Maternal uncle	[REDACTED] 1988
[REDACTED]	Maternal aunt	[REDACTED] 2008
[REDACTED] s	Father	[REDACTED] 1992
[REDACTED]	Mother	[REDACTED] 1995
Benjamin Lightcap	Victim Child	01/09/2012

Notification of Fatality/Near Fatality:

Berks county Children and Youth was notified on 01/10/2012 that the parent [REDACTED] [REDACTED] who lives with her parents, gave birth to a baby boy on 01/09/2012, and allegedly threw the infant into the trash container in her bedroom. Later in the evening, she was taken to Lehigh Valley Hospital [REDACTED]. Her family was unaware of her pregnancy.

Summary of DPW Child Fatality Review Activities:

The Department of Public Welfare conducted a review of the file and interviewed several Berks County employees associated with the case. The supervisor for Child Protective Services was interviewed as well as the caseworker conducting the investigation. The Manager for Intake Services was also interviewed regarding the agency's response to the report, the plan for investigation and the case review. The regional office reviewed the [REDACTED]

Summary of Services to the Family:

Children and Youth involvement prior to Incident:

The family was active at the intake level for a short period of time in 1992 when there were some custody issues reported on [REDACTED]. Also in 2005 the family was homeless, and lived

in a motel for a brief period of time. Subsequently, the grandmother did find a place to live and she was gainfully employed. The case was opened for intake services but was not referred for in-home services as there were no other issues presented by the family.

Circumstances of child's near fatality and related case activity:

██████████ concealed her pregnancy from her family and from those who knew her, including the school she attended. She stayed home from school on ██████████, telling her parents she did not feel well. As the day progressed, ██████████ noted she was spending long periods of time in the bathroom and was concerned. ██████████

██████████ called their mother at work around 1 p.m. because he noticed a large amount of blood. The mother of ██████████ came home around 5p.m. and noticed that ██████████ and immediately called 911. ██████████ to Lehigh Valley Hospital via ambulance, due to the fact that she was bleeding and a minor child. At the hospital, ██████████ still denied the pregnancy, but later admitted around ██████████ while at the hospital to ██████████ that she had given birth to a child and had tried to flush him down the toilet. ██████████. While in the hospital she required ██████████. She did admit to giving birth and discarding the infant in a trash can after placing him in a sheet and a white ██████████ bag on top of the sheet. The autopsy revealed that the baby, Benjamin, was full term, born alive, took a breath and weighed 7.5 pounds, 21 inches. ██████████ admitted to ██████████ that she had at first attempted to flush the baby down the toilet. ██████████ also stated she had discussed the pregnancy with someone, ██████████

██████████ was interviewed ██████████ on 1/12/2012, and told ██████████ that ██████████ told him not to worry, she would take care of the baby. ██████████

Berks County made the first contact with the family on 01/10/2012 and developed ██████████ on that date indicating that ██████████ contact with her ██████████

██████████ An autopsy was performed on 1/10/2012. The cause of death was drowning, with a contributing factor of positional asphyxia, due to being placed completely wrapped inside a sheet in a head down position in the trash can. The Coroner's Office ruled the manner of death as a homicide. The mother ██████████ was arrested and placed into a Juvenile facility.

Current/most recent status of case:

██████████ placed at the Berks County Detention Facility. She was being offered supportive counseling services. The family remained cooperative throughout the investigation; however, did obtain the services of an attorney. The case is presently closed. ██████████ was sent to a residential program after her discharge from detention. ██████████ was incarcerated without bail. ██████████

County strengths and deficiencies as identified by the County's fatality report:

County Strengths:

Berks County Children and Youth Services responded promptly to the report. There was no open case at the time of the report. The agency conducted all interviews promptly and gathered

as much information as possible, despite the belief of law enforcement that the agency did not have a role in this investigation. The family was cooperative with the agency and law enforcement.

County Weaknesses:

The pregnancy was not suspected by school, family or those in contact with [REDACTED]. There was a demonstrated [REDACTED].

County recommendations for changes at the local, County or State levels as identified in County's near fatality report:

The working relationship between law enforcement and the agency is critical to good investigation process and subsequent outcomes. Good communication is essential and sharing contacts and interviews, when appropriate should occur.

Safe Haven information should be made available in schools.

Department of Public Welfare Findings:

County Strengths:

Berks County Children and Youth Services responded promptly to the report and conducted all interviews as appropriate. Due to the serious nature of the circumstances and the fact that the mother was facing homicide charges, law enforcement did not [REDACTED]. [REDACTED] Berks County Children and Youth Services. Berks County Children and Youth Services did offer to law enforcement to allow them to proceed [REDACTED] while they gathered [REDACTED] the allegations and render [REDACTED] on the case.

County Weaknesses:

The difficulty in the communication between law enforcement and the agency posed a problem for the agency. The mother was facing homicide charges and the law enforcement agency needed to [REDACTED], believing that Berks County Children and Youth Services did not necessarily have a role as integral as theirs. The county did attempt to help adjust this position. The caseworker and the agency solicitor obtained necessary information [REDACTED]. Police did not notify the agency of the arrest of the mother.

Statutory and Regulatory Compliance Issues:

The status determination on the [REDACTED] went to the 60 day mark due to waiting for the final autopsy report. The Act 33 meeting was not held in a timely manner and the County report to Regional Office was not submitted in a timely manner. All other documentation was timely and complete.