



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 11/29/2014
Date of Incident: 04/29/2015
Date of Report to ChildLine: 04/29/2015
CWIS Referral ID: [REDACTED]

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

REPORT FINALIZED ON: 11/12/15

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 not convened a review team in accordance with the Child Protective Services Law related to this report. Lancaster County Children and Youth Services Agency unfounded their investigation prior to the mandated 30 day timeframe, thus a county review was not required.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	biological mother	[REDACTED] 1989
[REDACTED]	biological father	[REDACTED] 1988
[REDACTED]	victim child	11/29/2014
[REDACTED]	sibling	[REDACTED] 2010
[REDACTED]	sibling	[REDACTED] 2012

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records and medical records pertaining to the Family. Follow up interviews were conducted with the county agency caseworker [REDACTED] supervisors, [REDACTED], intake director, [REDACTED] and agency administrator [REDACTED] on April 30, 2015, May 14, 27, 2015, and September 11, 2015.

Children and Youth Involvement prior to Incident:

Lancaster County Children and Youth Services Agency did not have prior involvement with the child and or family prior to the reported incident on 04/29/2015.

Circumstances of Child (Near) Fatality and Related Case Activity:

The subject child at the time of incident was a five month old girl. The family is a member of the Amish Community in Lancaster County. The child was taken to Ephrata Hospital [REDACTED] on the morning of April 29, 2015 as child presented to be in an altered mental state. The child's family reported the child was previously healthy and had no reported historical medical problems. The child's mother mentioned she was breastfeeding the child that morning. After the feeding the child was placed on the floor a few minutes later the child would slump over and appear as listless, lethargic. The mother made reference to medical staff that the child's eyes appeared like they wanted to close. The family called 911 as they had concern for the child. Emergency Management Services responders arrived at the home. The child was transported via ambulance to Ephrata Hospital. The medical staff at the hospital wanted to rule out of possible child abuse, as the child upon arrival had abnormal breathing and was not responding to medical care. Medical staff observed [REDACTED] the left eyelid and forehead. This was of concern as the petichae could be attributed to [REDACTED]. Medical staff did certify the child to be in critical condition. The child was transported on the same day to Penn State Hershey Medical Center (PSHMC) for further treatment and evaluation.

Lancaster County Children and Youth Services received a report of suspected abuse on April 29, 2015. The county agency responded immediately. Agency staff saw the child and family at PSHMC. Upon arrival at PSHMC, medical staff was somewhat confused as to why a representative from child and youth services were responding as they did not have any concern for the child to be in critical condition as a result of suspected abuse. However, PSHMC did not register the report. Further testing and treatment of the child would rule out any concern for child abuse or negligence of the child's parents. The medical staff conducted testing to ensure the child did not have [REDACTED] as at the time of admission thought the child might have [REDACTED]. This would be ruled out further testing determined the child did not have [REDACTED] and recommend the child be [REDACTED].

The child would [REDACTED] to her family [REDACTED] on April 30, 2015. Lancaster County Children and Youth Services chose not to follow up with Ephrata Hospital on the subject of decertification of the registered report. However such could have occurred due to the circumstances. The county children and youth agency staff were able to assess the family at the hospital. The family was cooperative with both children and youth services as well as area law enforcement. The county caseworker would complete an in home safety assessment of the home on April 30, 2015 which would determine the child and siblings to be safe in the home with the parents. The county would unfound their investigation for child abuse on May 12, 2015 which was prior to 30 days. Law enforcement would close the case as well there was no formal charges regarding the incident. The county agency would have discussion with the family regarding services available or if

linkage to services was of need, however the family was not interested in such services.

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

Lancaster County Children and Youth Services Agency did not complete a report as the county would unfound the investigation prior to 30 day timeframe.

Department Review of County Internal Report:

N/A, for this particular case a report was not required for reason referenced above.

Department of Human Services Findings:

Based on the information which ties into this report one could determine that there is still value on having ongoing dialogue, meetings or outreach with medical community on the subject of Act 33. One to ensure reports are not being missed and second that when a report is registered that the child's condition meets the criterion outlined in the statute.

Department of Human Services Recommendations:

The Department should review current collaborative outreach efforts with medical community on the subject of Act 33 to evaluate current processes or need for additional outreach at the state level. For local or county level enrichment, county children and youth administrators should be able to measure if enhancements are needed in collaborative efforts among the medical community.