pennsylvania
DEPARTMENT OF PUBLIC WELFARE

# REPORT ON THE FATALITY:

Carter Good

**Date of Birth:** 11/30/12
**Date of Death:** 9/15/13
**Date of Oral Report:** 9/16/13

## FAMILY KNOWN TO:

Lancaster County Children and Youth Agency

## REPORT FINALIZED ON:

8/13/14

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. 6349 (b))

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

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. Lancaster County has not convened a review team in accordance with Act 33 of 2008 related to this report. The county agency was not required to convene a review team as the agency completed their investigation and [redacted] the report prior to the 30 required time period.

**Family Constellation:**

| Name: | Relationship: | Date of Birth: |
|---|---|---|
| Carter Good | Victim Child | 11/30/12 |
| [redacted] | Mother | [redacted]/92 |
| | Father | [redacted]/86 |

**Notification of Child (Near) Fatality:**

On September 13th 2013 the victim child's mother contacted emergency management services when she found the victim child lying face down in the child's bedroom. The child was transported via ambulance to Hershey Medical Center (HMC). Cardio pulmonary resuscitation (CPR) was performed on the child for approximately two hours. The child was [redacted] The child expired at 6:20 pm on September 15th 2013. Medical staff had concern regarding the circumstances described attributing to the child's death. The medical staff initially determined that the explanation of death by natural causes was not adequate and current medical conditions do not explain this event. The report was registered as a child fatality by Dr. [redacted] of HMC on September 16th 2013. Lancaster County Children and Youth Agency received [redacted] report on the same date. The victim child was the only child of the parents. The county agency did not need to provide immediate response to assure safety of any additional children. The county did follow [redacted] protocol regarding their investigation.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Central Region Office of Children, Youth and Families obtained and reviewed all cases records pertaining to the [redacted]. The county agency obtained and provided

medical records to the Regional Office. Follow up interviews were conducted with the county agency supervisor [redacted], intake director, [redacted] and agency administrator [redacted] on September 16th, 17th, 30th, October 10th 2013 and April 3, 2014. As referenced prior, a County Internal Fatality Review Team was not convened as it would not be required due to the completion of the county's investigation would occur prior to the 30 day requirement. Further medical evaluation and testing along with the performed autopsy would determine the victim child's death was of natural causes and was not a result of child abuse and or neglect.

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

The family was known to the county children and youth agency. On March 29th 2013, Lancaster County Children and Youth Services received [redacted] on the family. The referral had concerns for the victim child in this report. [redacted] The biological parents according to the referral were not overly cooperative with the providers. Disputes referenced that mother would not notify [redacted] regarding the child's care, issues with the child's mother not following the recommended [redacted] for the child as well as the mother becoming easily frustrated with the child during observed care.

The child was receiving approximately [redacted] The child has a [redacted] In addition the referral had mention of past history of parents regarding substance abuse however [redacted] The parents referenced they have been sober for over a year from the date of this referral and have [redacted] for their substance abuse.

The child was born at 36 weeks gestation at HMC. Due to aforementioned [redacted] at birth the child had a [redacted]. The child required [redacted]. The family was linked up with an in [redacted] provider to help monitor and support the child's [redacted]. Lancaster County Children and Youth Services Agency opened the referral for agency assessment on April 1st 2013. The child and family were seen by agency worker on April 3rd 2013. The county agency completed in home safety assessment worksheet and determined the child to be safe in the home. The child's parents were cooperative with the agency. The review of the agency record determined that the county agency was able to follow up with various professionals such as child's primary care physician, various [redacted], and [redacted] whom the child and family have association. The county agency closed their assessment on April 22, 2013. The family was not opened for agency services. The assessment determined no concern for the parents care of the child, no discovered child welfare issues in the home; in addition services for the child were already in place. There was no need for the county agency to assist in linking the family up with any additional services. This was the only prior agency involvement with the family.

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

On the evening of September 13th 2013 the victim child's mother placed her child down in the child's bedroom for a [redacted]. As referenced the victim child had a [redacted] which required the child to be [redacted] The victim child's mother reported that she placed the child lying down on his back in the crib with head resting on a circular pillow. [redacted] The child and his mother were the only two individuals in the home at the time. The child's mother left the room, she returned to the room between 9:15 or 9:20 pm as [redacted] Upon entry into the room the mother witnessed the child to be lying face down next to the pillow with vomit on the child's face. The child's mother attempted CPR for approximately 30 to 40 seconds and then called Emergency Management Services (EMS). EMS arrived at the home around two minutes later. The victim child was transported to HMC. CPR was performed for approximately two hours. The child was [redacted]. The victim child's family and medical staff had discussions regarding the child's prognosis. A decision was made to [redacted]. The child expired at 6:20 pm on September 15th 2013.

Medical staff had concern due to the circumstances of the child fatality. Dr. [redacted] HMC registered the child fatality. The doctor had concern with the explanation of natural death as not adequate; the child had an unwitnessed event in the home which resulted in the child's death. One concern was the child and his functioning, he was not able to roll over, was only starting to develop the ability to lift his head and look around which conflicts with the mother's account of placing the child lying down flat on his back and then finding the child [redacted] lying face down with vomit on the child's face. The report was registered as a fatality on September 16th 2013. Lancaster County Children and Youth Agency began their investigation on said date.

The county children and youth agency and law enforcement conducted a joint investigation. The victim child's parents were cooperative with the investigation. Both law enforcement and the county children and youth agency interviewed the parents. Lancaster County Children and Youth Agency was able to obtain medical history for the child as well as medical documents associated with the child along with the reported incident. Further medical testing of the deceased child, the autopsy, review of the child's medical history determined that the mother's account of events was indeed probable and the child had [redacted] which caused the child to roll over. The child did have historical episodes of [redacted]. The autopsy determined the child passed away due to asphyxiation with a secondary cause of pneumonia. The review of medical records showed the child was seen on September 3th 2013 at HMC as he [redacted] in his home in the morning. The child [redacted] via the hospital. The investigation determined that both parents were aware of the medical needs of the child and both did ensure follow up with medical care. The child had ongoing [redacted] follow up [redacted] via HMC such as [redacted]. Both law enforcement and children and youth services found the mother's account of the circumstances of the incident to be credible.

Law enforcement closed their case and did not pursue charges for this case. Lancaster County Children and Youth Services did complete their investigation on 10/8/13. [redacted] The county did not open the family for services as the victim child was the only child of the biological parents.

**Current Case Status:**

N/A.

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

Lancaster County Children and Youth Service did not convene a County Act 33 review as the county agency was not required to do so. The county agency completed their investigation prior to 30 days from the date of oral report. The investigation was [redacted] as further inquiry of medical testing and evaluation confirmed the victim child's mother's account and determined the death of the child was of natural causes and not a result of child abuse or neglect.

**Department Review of County Internal Report:**

N/A.

**Department of Public Welfare Findings:**

The Departmental review of the county involvement prior to incident and the county's investigation did not find any areas of regulatory noncompliance.

**Department of Public Welfare Recommendations:**

No recommendations.