pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF

Nazareth LaSanta

Date of Birth: 09/15/2012

Date of Death: 01/16/2013

Date of Oral Report: 01/15/2013

FAMILY KNOWN TO:

Lancaster County Children and Youth Agency
Father is known to Chester County CYS

REPORT FINALIZED ON: 09/04/2013

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 convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
LaSanta, Nazareth	Victim Child	09/15/2012
[redacted]	Mother	[redacted]1992
[redacted]	Father	[redacted]1985
[redacted]	Maternal Grandfather	[redacted]1949

Notification of Child Fatality:

On January 15, 2013, Lancaster County CYA was contacted by [redacted] regarding a Child Near Fatality. According to the report, the Victim Child was brought to Ephrata Hospital in Lancaster County on January 13, 2013 with [redacted] and [redacted] The child was then transferred to Hershey Medical Center where he was declared to be in [redacted] and was certified as a Near Fatality due to the suspicious nature of his injuries. On January 16, 2013, the Victim Child was declared brain dead and was taken off of life support. The Victim Child passed away. This report was then certified to be a Fatality.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth, and Families obtained and reviewed all current and past case records pertaining to the Victim Child and her family. Medical records and the police report were also reviewed. Conversations and interviews were conducted with the Caseworker [redacted], [redacted] Supervisor [redacted], and Intake Director [redacted] throughout involvement but specifically on the date of the report January 15, 2013 and when the [redacted] Decision was made on March 15, 2013. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on February 13, 2013.

Children and Youth Involvement prior to Incident:
The agency received truancy referrals on the Mother as a child in 2008 and 2009. In September 2009, it was learned that the Mother was not attending school because she was taking care of her paraplegic father. The agency opened the family for in-home services in the Adolescent Response Unit. Supportive services were provided and the case was closed on March 10, 2010 when the presenting concerns were addressed. The agency did not have interaction with the Mother again until this report.

The Father has previous agency involvement from December 2009 when the mother of his child gave birth and tested positive for marijuana. When the agency responded to the referral at the hospital, the Father was present, but was not present for any subsequent home visits. The case was closed when the mother and child moved out of the county. It was also reported that the Father has two children to another mother that are currently in custody in Chester County. The agency requested records but they were never forwarded. The Chester County worker did state that the children were in care due to their mother's drug use and prostitution. The Father could not provide care for them, so they were placed in CYS custody.

Circumstances of Child Fatality and Related Case Activity:
On January 15, 2013, Lancaster County CYA was contacted by [redacted] regarding a Child Near Fatality. According to the report, the Victim Child was brought to Ephrata Hospital in Lancaster County on January 13, 2013 with [redacted] and [redacted]. The parents reported that the child had been taking a nap. They heard the child fussing and checked on him. They found that the Victim Child had thrown up and gone limp. The Father began to perform CPR on the child. According to Lancaster CYA, the police videotaped a demonstration of this and the father was doing full chest compressions, not infant CPR. The child was transported to the hospital by ambulance.

After being evaluated at Ephrata Hospital, the child was transferred to Hershey Medical Center. At Hershey Medical Center, the child was certified to be in critical condition, had some [redacted], and [redacted]. There was no accidental explanation for these injuries, and the parents could not explain the injuries. Abuse was suspected by the medical staff. The child was not expected to live.

On January 16, 2013, the child was declared brain dead and his body was turned over to the Dauphin County Coroner for autopsy. This case was then upgraded to a Child Fatality.

The Father reported that on January 4, 2013, the child was brought to the Emergency Room after the father stated that he had tripped and fallen on top of the child. The child was scanned and released with no concerns. These scans were sent to Hershey Medical Center for review, as there were some [redacted] found in the Victim Child. It was determined by Hershey Medical Center that these [redacted] had been healing for approximately three to eight weeks.

On January 23, 2013, during a subsequent police interview, the Father admitted to removing the child from his bouncy seat, slamming the child's head into his chest and then slamming him down violently onto the bed. The child then vomited and became unresponsive. The Father performed CPR until the paramedics arrived. He was arrested and placed in [redacted] Prison on January 23, 2013.

[redacted] the Mother stated that she did know that the Father had harmed the child, despite originally stating that she had no knowledge of the events. She did not act to protect the child despite this knowledge.

[redacted], filing [redacted] on March 15, 2013. The case was [redacted] for the Father as a [redacted] and the Mother as a [redacted]. The Father was charged with Endangering the Welfare of a Child and Criminal Homicide, and was incarcerated at [redacted] Prison. The Mother was charged with two counts of Endangering the Welfare of a Child.

Current Case Status:
The Father of the child remains incarcerated [redacted] Prison. Both the Father and the Mother are awaiting trials for their charges.

The autopsy of the Victim Child remains pending with the Dauphin County Coroner.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:
A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on February 13, 2013 at the Lancaster County Children and Youth Agency. The team was comprised of local CYS professionals, medical professionals, law enforcement, and other community members. The Team discussed Lancaster County CYA's handling of the [redacted] Investigation and found it to be appropriate.

- Strengths:
  The team felt that the agency handled the current [redacted] investigation well and provided information to all parties involved. The agency maintained consistent communication with the hospitals and medical professionals throughout the case.

- Deficiencies:
  None were noted by the team in regards to the handling of the case by the agency. It was felt that the parents would have benefited from some form of educational component in regards to parenting, perhaps at the hospital at the time of birth.

- Recommendations for Change at the Local Level:
  It was discussed by the team that there needed to be more effort placed on communication between hospitals. This was noted by the team to be a great concern. It was felt by the team, that if accurate scans had been completed on

the incident which happened January 4, 2013, and the healing fractures had been found, this could have been communicated to CYA to assess the family for services. It was also discussed that EMS/First Responders should be trained in mandated reporting and recognizing the possible signs of child abuse.

- Recommendations for Change at the State Level:
  None noted.

Department Review of County Internal Report:
Lancaster County CYA provided a report on the Fatality of the Victim Child to the Regional Office on March 13, 2013 at the completion of the [redacted] investigation. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on July 22, 2013.

It should be noted that Lancaster County CYA did request records from Chester County to confirm the Father's involvement, but did not receive this information despite the request. While the Victim Child had not been involved with Chester County, it would have been important for agency discussion and planning to have received some written information.

Department of Public Welfare Findings:

- County Strengths:
  - County response to information received was urgent and thorough during the [redacted] investigation.
  - The [redacted] Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
  - The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
  - The agency took a very active role in maintaining communication between all members of the team including law enforcement and medical professionals.

- County Weaknesses:
  - None Noted.

- Statutory and Regulatory Areas of Non-Compliance:
  None Noted

Department of Public Welfare Recommendations:
The agency should continue to assess all referrals for potential safety threats and appropriate response. As there was an identified need for education and hospital communication, the agency should continue to provide information to these services and look into ways to support accurate identification of abuse by these agencies.