



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE FATALITY OF**

**Liliana Lunsford**

**Date of Birth: 01/31/2013**  
**Date of Death: 03/16/2014**  
**Date of Oral Report: 03/16/2014**

### **FAMILY KNOWN TO:**

York County Children, Youth & Families

### **REPORT FINALIZED ON:**

11/25/14

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. York 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> |
|-------------------|---------------------------------|-----------------------|
| Lunsford, Liliana | Victim Child                    | 01/31/2013            |
| [REDACTED]        | Mother                          | [REDACTED]            |
| [REDACTED]        | Sibling                         | [REDACTED]            |
| [REDACTED]        | Paternal Grandmother of Sibling | [REDACTED]            |
| [REDACTED]        | Paternal Uncle of Sibling       | [REDACTED]            |

\*The Father of the Victim Child is Unknown

**Notification of Child Near Fatality:**

On March 16, 2014, the York County Children, Youth & Families(CYF) Emergency Duty Worker was contacted by the [REDACTED] with a suspicious child death. The child was found unresponsive after having spent the night in the bedroom of the paternal uncle of the Victim Child's sibling. [REDACTED] then contacted ChildLine and this was registered as suspected child abuse and a child 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. Conversations and interviews were conducted with the Caseworker [REDACTED] Supervisor [REDACTED], and Quality Specialist [REDACTED] throughout involvement but specifically on March 19, 2014, April 14, 2014, and May 28, 2014. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on April 14, 2014.

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

The agency received a referral regarding the Mother and the sibling of the victim child on November 13, 2011. According to the report, the Mother was having suicidal thoughts and had taken a 30 day supply of [REDACTED] in 14 days and was around the child.

She was [REDACTED] and the child was with the maternal grandparents. The agency was able to immediately meet with the mother who had been experiencing some stress, but denied trying to overdose. The agency completed an assessment, finding the mother to be appropriate and the allegations to be unsubstantiated. The mother had appropriate income and supports. She reported that she was going through a custody battle with the father of the child. The case was closed with no additional services needed.

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

The child was staying overnight in the home of the paternal grandparents of her half-sibling. The paternal uncle of the half-sibling also resided in that home. The child was to be sleeping in a youth bed which is kept beside the grandmother's bed. The grandmother reported that the paternal uncle came into the room and asked for the child to sleep on his chest. It was reported by the grandmother and the paternal uncle that he had been married to a woman and helped her raise her daughter for three years as if she was his own. The woman then left him and he was unable to have contact with the child since she was not his biological child. This sent him into a [REDACTED] and he had been [REDACTED] for these concerns. Spending time with the victim child helped him to deal with some of the sadness that he felt at not being able to see this other young child. She told him that he could not have the child come to his room and he left. Later he came into her room after she was sleeping and brought the child to his bedroom. The uncle reported that he fell asleep with the child on his chest. In the morning, the grandmother called to the uncle to wake the child up while she went outside to get the paper. When she came back inside, the uncle was holding the child, crying and screaming hysterically when it was discovered that she was not breathing. The grandmother called 911 and even though she thought the child had died, she still attempted CPR. The paternal uncle later told police that he could have smothered the child while she was sleeping in his bed. He was [REDACTED] to a [REDACTED] after he attempted to hang himself. He reports that he made two attempts to hang himself in his room. In both attempts, he went unconscious, but then the rope must have given out and he came to. The grandmother reported that he had been [REDACTED] but in February was getting back to his old self.

The child was brought to York Hospital by emergency personnel. The child was pronounced dead at the hospital.

An autopsy was completed on March 17, 2014. The cause of death was ruled undetermined, suspicious. The child had a .04% ethanol level in her system. The individual completing the autopsy also stated that this would have to be ingested to register at this amount. The uncle had initially stated that he drank vodka after he found the child deceased. In [REDACTED], he stated that he had been drinking the vodka over a span of time. He had taken a half gallon bottle of vodka into the room when he was with the child. He drank approximately four inches of the bottle and reports that the child was already sleeping at this point.

The agency filed their report with ChildLine on May 12, 2014 with a status of [REDACTED]. No charges were filed at that time.

On May 28, 2014, a team meeting was held with a forensic pathologist, York Assistant District Attorney, [REDACTED] City Detectives, and the Agency Caseworker. It was determined that additional testing would be completed on the liquid found in the child's stomach. In an addendum filed on June 9, 2014, it was noted that there was a 0.24% level of ethanol in the child's gastric contents indicating recent ingestion.

On June 27, 2014, the agency filed an updated report with ChildLine with a status of [REDACTED].

**Current Case Status:**

On August 8, 2014, the paternal uncle of the sibling was arrested and placed in [REDACTED] Prison. He was charged with Murder of the Third Degree, Involuntary Manslaughter, Endangering the Welfare of Children, and Tampering with Evidence. The Trial for this case is pending. As of November 20, 2014, the paternal uncle remains incarcerated with bail set at \$300,000.

The agency closed the case as the sibling remained safe with the mother. The mother indicated that she was already pursuing [REDACTED] for the sibling of the victim child to address any current or future concerns with grief and loss.

On August 8, 2014, a section of an indoor playground at a church in Gettysburg was dedicated to the victim child.

**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 April 13, 2014 at the York Hospital. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff.

- **Strengths:**  
The team felt that there was a quick response to the situation by all members of the team including law enforcement, the agency, and medical personnel. Information was shared freely and the team worked well together on this case.
- **Deficiencies:**  
None were noted by the team in regards to the handling of the case by the agency.
- **Recommendations for Change at the Local Level:**  
No recommendations were made.
- **Recommendations for Change at the State Level:**  
None noted.

**Department Review of County Internal Report:**

York County CYC provided a report on the Near Fatality of the Victim Child to the Regional Office on June 23, 2014. 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 June 23, 2014.

**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.
  
- County Weaknesses:
  - None noted.
  
- Statutory and Regulatory Areas of Non-Compliance:
  - None noted.

**Department of Public Welfare Recommendations:**

None at this time.