



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## REPORT ON THE NEAR FATALITY OF



**Date of Birth: 10/16/2013**  
**Date of Near Death: 01/22/2014**  
**Date of Oral Report: 01/22/2014**

**FAMILY NOT KNOWN TO:**

York County CYF

**REPORT FINALIZED ON: 10/15/14**

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 did not convene a review team as a determination was made prior to 30 days.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	10/06/2013
[REDACTED]	Mother	[REDACTED] 1987
[REDACTED]	Father	[REDACTED] 1986
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2011

**Notification of Child Near Fatality:**

On January 22, 2014, the agency received a report of a child near fatality as the child was present at the York Hospital and had a [REDACTED] on the side of his head. It was alleged that this happened when he fell out of a swing. The child was certified to be in critical condition and was transferred to the Hershey Medical Center [REDACTED]. No perpetrator was named.

**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 his family. Medical records were also reviewed. Conversations and interviews were conducted with the Caseworker [REDACTED], CPS Supervisor [REDACTED], and Quality Specialist [REDACTED] throughout involvement but specifically on February 25, 2014 and September 9, 2014.

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

There was not any prior CYS involvement for this family.

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

The child was brought to the hospital by the mother because he had been fussy and not as active as normal. The hospital completed a scan and found a large [REDACTED]

██████████ on the right side of child's head. Child also had a small scratch on his face. Mother reported that the child fell out of a swing in the morning around 7:00 am. York Hospital ██████████ felt that the way the ██████████ looked; it was something that had been there more chronically. Mother denied that anything else happened but non-accidental trauma was suspected. Dr. ██████████ certified the child to be in critical condition. Dr. ██████████ stated that the child was expected to survive. The child was transferred to Hershey Medical Center.

When child was admitted to Hershey Medical Center several tests were conducted and it was determined that the child did not have a ██████████. The child had an ██████████ on his head that had been there since birth. ██████████ Hershey Medical Center on 1/24/14. Child was ██████████ to the mother.

Prior to ██████████, the agency and law enforcement spoke with the mother to assure safety of the other children. They remained with family members while the mother was at the hospital. Upon the findings at Hershey Medical Center that same day, it was determined that the children were safe with the mother. The worker then saw the other children with the mother on 2/04/14 during a home visit.

On 2/11/14, a physician from York Hospital called to say that he had reviewed the records and the ██████████ summary from Hershey Medical Center. He concurred that ██████████ York Hospital misread the scan and there was no evidence of trauma. However, as this physician was not the person that initially certified the child as a near fatality, this was not de-certified.

The agency filed their report with ChildLine on 2/18/14 with a status of Unfounded. The victim child remains with the mother and is receiving follow up medical care. No charges were filed during the case.

**Current Case Status:**

No relevant updates since the case was closed in February 2014. There has not been any further agency involvement.

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

Due to the case being unfounded before the 30 day time frame, an Act 33 Review team was not convened.

**Department Review of County Internal Report:**

York County CYF provided a report on the Near Fatality of the Victim Child to the Regional Office on February 25, 2014. The report contained all required information and a summary of agency findings. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on February 25, 2014.

**Department of Public Welfare Findings:**

- County Strengths:
  - County response to information received was urgent and thorough during the CPS investigation.
  - The CPS Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
  
- County Weaknesses:
  - Even though the agency was able to make a determination very quickly that abuse had not occurred, they did not see the other children in the home until a week after the report. Best practice standards would have the agency visiting with those children quickly after the report was received to assure continued safety.
  
- Statutory and Regulatory Areas of Non-Compliance:
  - None noted

**Department of Public Welfare Recommendations:**

The agency should continue to work with medical professionals to foster an understanding of Act 33 and certification and decertification.