



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 11/13/2014
Date of Incident: 02/13/2015
Date of Report to ChildLine: 02/13/2015
CWIS Referral ID: [REDACTED]

**FAMILY KNOWN TO YORK COUNTY OFFICE OF CHILDREN, YOUTH AND
FAMILIES AT TIME OF INCIDENT**

REPORT FINALIZED ON:
08/11/2015

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.

York County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on March 12, 2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1977
[REDACTED]	Father	[REDACTED] 1973
[REDACTED]	Sibling	[REDACTED] 2014
[REDACTED]	Victim Child	11/13/2014
* [REDACTED]	Maternal Grandmother	[REDACTED] 1955
* [REDACTED]	Paternal Grandmother	[REDACTED] 1948
* [REDACTED]	Paternal Grandfather	[REDACTED] 1945

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the agency Quality Assurance Program Specialist, [REDACTED], the Supervisor, [REDACTED] and the Caseworker, [REDACTED] on 02/13/2015, 02/25/2015, 03/03/2015 and 05/13/2015. The regional office also participated in the County Internal Fatality Review Team meeting on 03/12/ 2015.

Children and Youth Involvement prior to Incident:

The agency's initial involvement with the family was on 02/10/2015 when they received a report of suspected child abuse concerning the victim child's twin brother which listed the father as the alleged perpetrator. Upon receipt of the report from [REDACTED] on 02/10/2015, stating the condition of the victim child's sibling was critical due to suspected child

abuse, the agency immediately ensured the safety of both children. A safety plan was put into place in which the father, who was listed as the alleged perpetrator on the report related to the sibling, was to have no unsupervised contact with either child. The maternal grandmother and paternal grandparents were to supervise all contact between the father and the children.

Circumstances of Child Near Fatality and Related Case Activity:

A child abuse and near fatality report was received for this child's twin brother on 02/10/2015, in which the father was listed as the alleged perpetrator. At the time of those reports related to the victim child's sibling, the mother was not considered an alleged perpetrator. As a result of the sibling's critical condition due to suspected child abuse, the treating physician recommended that the victim child receive a full pediatric exam, skeletal survey and [REDACTED] which were conducted on 02/13/2015. [REDACTED]

[REDACTED] The victim child was admitted to Penn State Hershey Children's Hospital. The parents were unable to provide an explanation for the injuries to this child. On 02/13/2015, Dr. [REDACTED], certified this child to also be in critical condition as a result of suspected abuse. The report was listed as an abuse report for CYF and a Near Fatality for the Central Region OCYF. As a result of the victim child's injuries, the mother was no longer able to be ruled out as an alleged perpetrator of child abuse. [REDACTED]

[REDACTED] The children [REDACTED] Hershey Medical Center on 02/15/2015/2015 and were placed together in a foster home. [REDACTED]

Following police interviews, during which CYF was present, the mother was ruled out as an alleged perpetrator. [REDACTED] the agency [REDACTED] recommended that the children return home with the mother. A safety plan was not put into place. The children's mother was fully cooperative and filed a Protection From Abuse Order against the father as soon as the children were placed back in her care and custody. She secured her own housing, was employed and had a support system in place. As such, CYF closed the case. The child abuse report on the sibling was indicated against the father on 03/27/2015. The report related to the victim child was indicated with unknown perpetrator on 03/27/2015 as the time of the injury could not be determined.

Detective [REDACTED] Police Department, charged the father with Aggravated Assault and Endangering the Welfare of a Child related to the sibling of this victim child. The father is in jail and awaiting trial. Charges were not brought against anyone related to this child as it was not possible to date the injuries sustained by this child.

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

- Strengths in compliance with statutes, regulations and services to children and families; The Hershey Medical Team provided excellent documentation and communication throughout the investigation. The MDT team worked collaboratively to complete the investigation.
- The Detective and Caseworker completed joint interviews. The victim child and his sibling are safe in the care of their mother.
- Deficiencies in compliance with statutes, regulations and services to children and families; None identified.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; It is recommended that Emergency Departments at local hospitals consult with medical experts in child abuse regarding suspicious injuries to children.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None identified.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. It is recommended that local Victim Witness Office provide outreach to families involved with the criminal justice system in order to provide support as families navigate the criminal proceedings.

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 April 6, 2015. 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, 2015.

Department of Human Services Findings:

- County Strengths: The County began the investigation and assured safety of all children immediately upon receipt of the report. The county worked cooperatively with law enforcement and has remained involved until they were sure that mother could protect her children absent agency intervention.
- County Weaknesses: None identified.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None noted.

Department of Human Services Recommendations:

The Department concurs with the findings and recommendations of York County CYF's Act 33 meeting. The Department suggests that the agency should continue to assess and assure safety immediately on all child abuse reports and should continue to seek input from local specialists as appropriate and as related to child abuse reports.