pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/26/12
Date of of Incident: 07/24/13
Date of Oral Report: 08/04/13

FAMILY KNOWN KNOWN TO:

Lebanon County Children and Youth

REPORT FINALIZED ON:
03/14/14

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))

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

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	father	[redacted]/1987
	mother	[redacted]/1990
	brother	[redacted]/2009
	sister	[redacted]/2007
	sister	[redacted]/2010
	sister	[redacted]/2008
	uncle	[redacted]/1981
	aunt	[redacted]/1975
	victim child	10/26/2012

Notification of Child (Near) Fatality:

The incident occurred on 07/24/2013 which was the same date it was reported.
On 8/3/13 an unknown mandated reporter contacted medical staff at the hospital stating that an unknown family member was with the AP, [redacted], and the AP had left the child alone in the AP's van for 4 to 5 hours. Dr. [redacted], certified that the child was in critical condition but would survive. Dr. [redacted] did confirm that the child's condition could have been the result of being left unattended in a hot car for that extended period of time. Hershey Medical Center contacted Lebanon County with the information received.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records pertaining to the [redacted] family. Follow up interviews were conducted with the county agency caseworkers: [redacted], Agency administrator [redacted] on August 13, 2013. The Regional Office participated in the County Internal Fatality Review Team meeting on September 3, 2013.

Children and Youth Involvement prior to Incident:
April 11, 2012, the agency received a report regarding [redacted], 6 year old sibling of victim child due to the child having an injury to her arm as a result of her father hitting her with a stick. The injury was not serious and the family was not opened for services. Both father and mother denied that the child was hit by the father.

Circumstances of Child Near Fatality and Related Case Activity:
On 7/24/13 the child was taken to [redacted] by the AP due to child having a 107 temperature and seizures. The child was immediately taken to Hershey Medical Center. On 8/3/13 an unknown mandated reporter contacted medical staff at the hospital stating that an unknown family member was with the AP and the AP had left the child alone in the AP's van for 4 to 5 hours. Dr. [redacted], certified that the child was in critical condition but would survive. Dr. [redacted] did confirm that the child's condition could have been the result of being left unattended in a hot car for that extended period of time. The medical condition of the child is not expected to improve much as he is [redacted]
The AP was given guardianship of all the children by the mother [redacted] and father while the couple was looking for appropriate housing. The couple became estranged and the father then moved into the home of the AP (his sister) where the children were already residing and continue to reside.
The AP reported that she had the child in the van with her while traveling from her home to run some errands for approximately an hour and a half before proceeding to the [redacted] to drop off two children. She then drove to her relative's home where she visited for 15-20 minutes. She reported that the child was in the van with the driver's side window down and was within eyesight for the duration of the visit. She reported noticing the child "jumping" in his car seat and was found to be unresponsive. Child's grandmother then provided CPR to the child to no avail. The child was then taken to the GSH ER by his uncle, arriving there at 4:35pm and was later [redacted] to the Hershey Medical Center (HMC).
The near death case review was conducted on Sept. 3, 2013 and the team voted unanimously to indicate the AP.

Current Case Status:
In August, the child was [redacted] and transferred to [redacted] a residential facility focused on the [redacted] he requires. Once [redacted], he will remain in placement under the custody of Lebanon CYS. The family was opened for protective services on August 14, 2013. The remaining 4 children remained with their father until November 1, 2013 when, based on tips received by the agency, it was reported that the father was allowing the AP access to the children. The father had signed a safety plan stating that he would not allow the AP unsupervised access to the children while he and the children remained in the AP's home. The children were removed and placed with their mother. The current family service plan (FSP) services are young child parenting skills, and budgeting for the mother.
The CY 48 was completed on September 3, 2013 and indicated the AP for physical neglect. Lebanon County DA filed Aggravated Assault criminal charges and the AP is currently incarcerated.

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

Strengths:
The county agency investigation complied with regulations and response times as required.

Deficiencies:
The county agency's report did not reference any specific identified deficiencies.

Recommendations for Change at the Local Level:
The county agency's report did not reference any specific changes for recommendation at the state or county level.

Recommendations for Change at the State Level:
The county agency's report did not reference any specific changes for recommendation at the state or county level.

Department Review of County Internal Report:

The Department reviewed the submission of Lebanon County Children and youth report regarding this case. The report was received on 9/3/13. There were no areas to dispute or concern with identified in the report.

Department of Public Welfare Findings:
County Strengths:
Upon review of the documents associated with this particular case it would appear there is a positive working collaboration between law enforcement and the county agency.

County Weaknesses:
The circumstances of this incident and review of the county's case did not identify any systemic weakness.

Statutory and Regulatory Areas of Non-Compliance:
The review of the county case file notes and medical records did not find any areas of non-compliance.

Department of Public Welfare Recommendations:
It would appear there is a positive working collaboration between law enforcement and the county agency along with other agencies that are part of the multi-disciplinary team (MDT) process.