pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: 10/01/2012
Date of Near Death: 02/19/2013
Date of Oral Report: 02/19/2013

FAMILY NOT KNOWN TO:

York County CYF

REPORT FINALIZED ON:

10/01/2013

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))

Department of Public Welfare/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dpw.state.pa.us

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:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/01/2012
	Mother	[redacted]1992
	Father	[redacted]1989
	Sibling	[redacted]2011
	Maternal Grandmother	[redacted]1965
	Maternal Great Aunt	[redacted]1967

Notification of Child Near Fatality:

On February 19, 2013, the Victim Child was brought into the Hanover Hospital Emergency Room with complaints of vomiting and not eating. The child has [redacted] and was [redacted] to the hospital. The Pediatrician completed a [redacted] on the Victim Child and noticed a few bruises on the child's back. The child's [redacted]. The child also had [redacted] According to the [redacted], one of the [redacted] looks older than the other. The injuries could not be explained so the [redacted] contacted [redacted], certifying the child to be in Serious Condition. This was then relayed to York County CYF as an [redacted] investigation and child near 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 were also reviewed. Conversations and interviews were conducted with the Caseworker Kevin [redacted] Supervisor [redacted], and Quality Manager [redacted] throughout involvement but specifically on February 19, 2013 and when the CPS Decision was made on April 15, 2013. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on February 28, 2013.

Children and Youth Involvement prior to Incident:
There was no prior Children and Youth involvement with this family.

Circumstances of Child Fatality and Related Case Activity:
On February 19, 2013, the Victim Child was brought into the Hanover Hospital Emergency Room with complaints of vomiting and not eating. The child has [redacted] and was [redacted] to the hospital. The Pediatrician completed a [redacted] on the Victim Child and noticed a few bruises on the child's back. The child's [redacted]. The child also had [redacted]. According to the [redacted], one of the [redacted] looks older than the other.

The Mother was visibly upset and shocked at the injuries and stated she is almost always home with the child. The [redacted] was suspicious of non-accidental trauma. The child was certified to be in serious but stable condition. Child was taken to Johns Hopkins [redacted]. There were no explanations provided for the injuries. The child was expected to survive. There was found to be another child in the home. This sibling was put on a Safety Plan with the Maternal Grandmother and Maternal Great Aunt providing supervision to the plan.

On February 20, 2013, the child was [redacted] at Johns Hopkins. The family members were all present at the hospital. The Maternal Grandmother and Maternal Great Aunt were also present in the home at the time of the report. This was the Grandmother's home. The family had only moved there a month ago.

The Victim Child was [redacted] on February 22, 2013. On this day the Father confessed to shaking the child and was arrested. He stated that on February 14, 2013, he was alone with the children while the Mother and Grandmother had gone grocery shopping. The Victim Child woke up at 9 am and he attempted to give her a bottle, but she just wanted to play with it, rather than eat it. He stated that he became agitated due to a lack of sleep and he shook the Victim Child stating, "Why are you doing this?" He reported that she began to cry, but he calmed her back down. The family then noticed that the Victim Child had less of an appetite and was sleeping more. Prior to being hospitalized she had been dry heaving and spitting up mucus, and there was [redacted].

As there were no further concerns with the family home, the child was released to the mother. She remained in the home with the two children and family supports. The family was not open for agency services.

The Victim Child had shown full recovery before the agency case was closed. She received one follow up visit to check her [redacted] which did not yield any further concerns. A [redacted] was done on the Sibling, and no concerns were noted.

The agency completed an investigation, filing the CY48 with ChildLine on 04/15/2013. The case was INDICATED for the Father as a Perpetrator of physical abuse. He was incarcerated at the [redacted] Prison and charged Endangering the Welfare of a Child, Aggravated Assault, and Simple Assault.

Current Case Status:
The Father remained incarcerated at the [redacted] Prison. On September 20, 2013 he was sentenced to 4 to 9 years for Aggravated Assault.

The agency has not had further contact with the Victim Child or her family since the report.

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 28, 2013 at the York Hospital. The team was comprised of local CYS professionals, medical professionals, and regional staff.

- Strengths:
  The team felt that the agency handled the current CPS 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.

- 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 CYF provided a report on the Near Fatality of the Victim Child to the Regional Office on March 11, 2013 at the completion after the Act 33 meeting was complete. 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 October 1, 2013.

Department of Public Welfare Findings:

- County Strengths:
  - County response to information received was urgent and thorough during the CPS investigation, including appropriate safety planning.

- The CPS 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 work with the community and local medical professionals to educate families on the effects of shaking babies, to include positive non-physical techniques in handling frustration with children.