



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: June 10, 2014**  
**Date of Incident: January 2, 2015**  
**Date of Oral Report: January 2, 2015**

### **FAMILY KNOWN TO:**

Dauphin County Social Services for Children and Youth

### **REPORT FINALIZED ON:**

September 30, 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. 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, DHS 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. Dauphin 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>
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Mother's paramour	[REDACTED] 1975
[REDACTED]	Victim child	06/10/2014
[REDACTED]	Victim child's brother	[REDACTED] 2010
* [REDACTED]	Maternal grandmother	unknown
* [REDACTED]	Maternal grandfather	unknown

\*These individual were not members of the household at the time of the incident but are relevant to the case.

**Notification of Child (Near) Fatality:**

On January 2, 2015 Dauphin County Social Services for Children and Youth (DCSSCY) was notified [REDACTED] of a child who was admitted to Harrisburg Hospital in cardiac arrest due to a seizure [REDACTED]. Harrisburg Hospital suspected abuse and certified that the child was in critical condition and was unsure if the child would survive.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Central Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Interviews were conducted with caseworkers [REDACTED], supervisors [REDACTED] and Director [REDACTED]. The regional office also participated in the County Internal Fatality/Near Fatality Review Team meeting on January 23, 2015.

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

The family's first involvement with DCSSCY was a general protective services referral received on November 18, 2014. The referral included concerns regarding domestic violence, lack of supervision, inappropriate physical discipline that resulted in an injury to the victim child's older brother and an allegation that the victim child was dropped by the mother's paramour that resulted in a bruise to the

child's head and no medical treatment was sought. Concerns were also expressed that the victim child's brother disclosed getting an injury after being hit by the mother's paramour but then recanted that information a week later while in the presence of his mother. The victim child's brother was seen at his daycare on the date of report and denied any abuse. [REDACTED] expressed concerns regarding the victim child's weight and increased defiant behaviors by the victim child's brother's within the last year. It was also reported that the victim child's brother had been absent from daycare the previous Friday and Monday. When the caseworker went to the mother's home, the mother's paramour told the caseworker that no one by that name lived there. The caseworker left her business card with the mother's paramour. The mother called the caseworker the next day and left a message that she received the caseworker's business card. On November 20, 2014, the caseworker spoke with the mother and arranged a visit to the mother's home on November 24, 2014. The mother denied allegations of domestic violence and lack of supervision. She reported that the victim child's brother was not hit by the paramour causing an injury, but that he fell into a stroller. [REDACTED] did not take the victim child's brother to the doctors but did keep him home from daycare for two days. No explanation was documented as to why he was kept home. [REDACTED] also denied that the victim child was dropped by the mother's paramour and had a bruise to his head.

[REDACTED] Police Department contacted the caseworker about this case as a police report was made regarding alleged abuse of the oldest child. The caseworker discussed her contact with the family with the officer and said a forensic interview would be scheduled for the child [REDACTED]; however, that referral was never made.

During this assessment, a criminal check was completed on the mother's paramour in [REDACTED] on November 18, 2014 which resulted in a long rap sheet of convictions which included child endangerment, child neglect, drugs and larceny convictions. This information was never addressed with the mother and the only service the agency provided to the family was a referral for [REDACTED]. The mother and children were visited again on December 1, 2014 and the mother again denied domestic violence and the mother's paramour stated that the child was never dropped. No other visits occurred with the family until January 2, 2015, the date of this near-fatality report.

**Circumstances of Child (Near) Fatality and Related Case Activity:**

On January 2, 2015, this report was received by DCSSCY [REDACTED]. According to the referral information, the victim child was admitted with cardiac arrest due to a seizure [REDACTED]. Harrisburg Hospital certified the victim child was in critical condition based on suspected abuse. At the time of the referral, it was unknown if he was expected to survive.

The victim child was then transferred from Harrisburg Hospital to Hershey Medical Center on the same date. Upon further examination, it was found that in addition to [REDACTED], he had [REDACTED], bruises all over his

body in various stages of healing and a possible [REDACTED]. Hershey Medical Center did not provide a prognosis for the victim child at the time.

When the police and DCSSCY interviewed the mother's paramour on January 2, 2015, he stated that he awoke to the victim child crying and put him on the bed. He then went to the bathroom and when he returned, the child's eyes were rolled back and he was unresponsive. The mother's paramour stated that he hit the victim child to the back, stomach and face area to "bring him back." He explained that the victim child was like this about a month ago after his brother had choked him. The mother's paramour stated that he "brought the child back" after the choking incident but that it didn't work this time. The mother was at work at the time of the incident.

A Safety Plan was established naming the maternal grandparents as the caretakers for the child and his brother on January 2, 2015 [REDACTED]

On January 6, 2015, Dr. [REDACTED] from Hershey Medical Center provided additional information to DCSSCY about the extent of the victim child's injuries. He confirmed that the victim child did nearly die and required resuscitation. Dr. [REDACTED] explained that the victim child was [REDACTED]

[REDACTED] was classified as moderate to severe and there was [REDACTED] which may be indicative of shaking.

[REDACTED] A skeletal survey would date [REDACTED] more accurately but he was not stable enough to administer the skeletal survey at that time. [REDACTED]

[REDACTED] Based on the victim child's condition and injuries at the time of admission on January 2, 2015, Dr. [REDACTED] noted that he experienced repeated and acute inflicted physical abuse.

On January 7, 2015, a skeletal survey was completed and [REDACTED] [REDACTED] were confirmed that were approximately two weeks old.

The victim child's brother was seen at [REDACTED] on January 12, 2015 but provided no information regarding the incident or any disclosure of abuse.

On January 13, 2015, a registered report of suspected physical abuse was received [REDACTED] regarding the child's older brother listing the mother and the mother's paramour as the alleged perpetrators. The date of incidents for this report were unknown but would have happened prior to the January 2, 2015 near fatality report of the victim child. The outcome of this case was provided [REDACTED] on March 13, 2015 with a status of Unfounded.

On January 20, 2015, the victim child was moved to [REDACTED] so the maternal grandparents and mother could learn how to care for [REDACTED] and showed slow progress.

[REDACTED] His sibling remained in the care of his maternal grandparents who had begun the process to become a formal kinship resource and the victim child remained at [REDACTED]

On February 12, 2015, the victim child was [REDACTED] and placed with the maternal grandparents. The mother was allowed supervised visits with him and his brother but this didn't consistently occur due to conflict between the mother and the maternal grandparents. The mother also reported that she did not believe that the injuries to him were inflicted by someone but rather were the results of getting immunized.

On March 2, 2015, the outcome of this case was provided [REDACTED] with a status of Pending Criminal Investigation.

**Current Case Status:**

On April 2, 2015, the mother's paramour was arrested and charged with Endangering the Welfare of a Child, Aggravated Assault and Aggravated Assault of a Minor Child under the Age of 13. He was incarcerated at [REDACTED] Prison until April 29, 2015 when he posted bail.

The victim child and his brother remain with the maternal grandparents, who were approved as a formal kinship resource for the children on April 2, 2015. The mother continues to visit the children but still believes that the injuries were from immunization shots and were not inflicted by her paramour. The mother remains involved with her paramour and is currently pregnant with his child. The permanency goal for the child and his brother remains reunification with the mother.

On July 29, 2015, the Preliminary Court Hearing for the mother's paramour was held. All charges were bound over until the trial. The mother's paramour was also ordered to have no contact with any children.

[REDACTED]

[REDACTED]

The victim child is currently receiving [REDACTED] through the county's [REDACTED] and receives [REDACTED]. He continues to be followed by Hershey Medical Center for his [REDACTED]

[REDACTED]

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

- Strengths:
  - Case was reported to ChildLine
  - Maternal grandparents are involved.
  - Dauphin County Joint Investigation Team responded immediately.
  - The victim child's brother attends daycare.
  - A safety plan was initiated to assure for the safety of the victim child and his brother.
  - Dr. [REDACTED] was identified as the ongoing primary care physician.
  - A re-enactment was obtained by law enforcement.
  
- Deficiencies:
  - There was no follow through with a [REDACTED] referral from the November 2014 General Protective Services (GPS) assessment.
  - Lack of follow through from the November 2014 GPS assessment regarding allegations of domestic violence in the home.
  - Continuity of seeing the children throughout the GPS assessment in November 2014.
  
- Recommendations for Change at the Local Level:
  - Medical providers should be consulted when there are concerns regarding an injury, either in person or with photographs.
  - Medical should be consulted to determine whether a child [REDACTED]
  - Additional follow-up is needed with referral sources.
  - Follow-up regarding CRC referrals.
  - Communication between law enforcement and the CCYA needs to improve.
  
- Recommendations for Change at the State Level:
  - None noted

**Department Review of County Internal Report:**

DCSSCY provided a report on the Near Fatality of the victim child to the Regional Office on March 20, 2015. The report contained all required information and a summary of the findings of the agency's Act 33 review team meeting. Written approval was sent to the agency on July 7, 2015.

**Department of Human Services Findings:**

- County Strengths:
  - The near-fatality investigation was completed within required timeframes.
  - The joint investigation team responded to the hospital immediately.
  - Kinship resources were identified immediately to care for the child and his brother.
  
- County Weaknesses:
  - A prior GPS referral should have been assessed as a Child Protective Services (CPS) referral.
  - Collaboration with law enforcement needs to improve.
  - Supervisory reviews of cases were not completed regularly.
  - Missing Risk and Safety Assessments.
  
- Statutory and Regulatory Areas of Non-Compliance:

Two CPS and one GPS case were reviewed for compliance:

  - 6311 (a) & 6313 (a) - For one case reviewed, the agency did not report alleged child abuse to ChildLine after they received the report.
  - 3490.55 (b, d, e) - In 1 of 2 CPS cases reviewed, the county agency did not begin the investigation immediately and did not interview appropriate parties
  - 3490.235 (e) - In 3 of 3 cases reviewed, supervisory reviews of the case were not completed within the required timeframe.
  - 3490.234 (b) (1-2) - In the GPS case reviewed, written notice to the family regarding the date of their acceptance or date they were not accepted for ongoing services was provided.
  - 3490.321 - In the GPS case reviewed, there was no documentation that a Risk Assessment was completed at the conclusion of the assessment period.
  - 3490.322 (d) - In 1 of 2 CPS cases reviewed, the supervisor signed a completed Risk Assessment untimely.
  - 3130.21 (b) - In the GPS case reviewed, a Safety Assessment was not completed at the conclusion of the assessment period prior to the family being accepted for ongoing services.
  - 3130.21 (b) - In the GPS case reviewed, the preliminary Safety Assessment was not completed within the required timeframe.
  - 3130.21 (b) - In the GPS case reviewed, the preliminary Safety Assessment was signed by the supervisor outside of the required timeframe.
  - 3130.21 (b) - In 1 of 2 CPS cases reviewed, the child was determined to be "unsafe" however there was a Safety Plan found in the file that

was effective until the date of [REDACTED]  
[REDACTED]

**Department of Human Services Recommendations:**

DCSSCY should continue to successfully collaborate with local law enforcement and medical professionals regarding all appropriate cases, complete investigations timely, obtain all relevant collateral information in a timely manner and continue to hold quality Act 33 meetings within the required timeframe.

DCSSCY should continue to monitor and enforce their new protocol regarding supervisory oversight and documentation of cases. This would include the review and approval of all Safety and Risk Assessments within the required timeframes; supervisory reviews at least every ten days and documented recommendations regarding cases.

DCSSCY should review, amend as appropriate and monitor their policy/protocols regarding CPS investigations. This should include assurances that: all staff members understand their roles as mandated reporters and when to make a referral to ChildLine; investigations are begun immediately; and all allegations are addressed and documented during interviews with appropriate parties.