



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 11/13/14
Date of Incident: 02/07/15
Date of Report to ChildLine: 02/10/15

[REDACTED]

FAMILY NOT KNOWN TO YORK COUNTY OFFICE OF CHILDREN, YOUTH AND FAMILIES AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS

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]	Victim Child	11/13/2014
[REDACTED]	Sibling	[REDACTED] 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 02/10/15, 02/12/15, 02/25/15, 03/03/15 and 05/13/15. The regional office also participated in the County Internal Fatality Review Team meeting on March 12, 2015.

Children and Youth Involvement prior to Incident:

The agency was not involved with the family prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

On Saturday, 02/07/2015 the mother was at work and the father was watching the children (twins). The father reported that the children were sleeping in the basinet in the living room and the victim child woke up and was fussy. The father carried the victim child upstairs in search of socks. According to the father, on the way down the stairs, the child was in father's left arm and the child's head was in the crook of the father's left arm. The dog ran down the stairs; hit the father's right knee and father's right knee buckled. The father's left arm and shoulder hit the wall and he believes the child's head hit the wall at that time. The father lost his balance and fell toward the right and felt the child move forward so he grabbed the child with his right hand and pulled the child toward him. The father thinks he may have grabbed the child's neck or shoulders. The child began to cry and went limp and lifeless. The father hit the child's face a few times, held him in the air, and bounced him a few times to try to get a reaction. He was unsure about whether or not the child was breathing so he put the child down on a chair and lifted the child's shirt to see if the child's chest was moving. The father held the child's nose and breathed into the child's mouth a few times and then pushed on the child's chest. The father then called 911. The mother arrived home from work at this time.

The mother reported that the child was lying on the chair upon her arrival and was "lifeless." The mother reported that the child's pupils were pin-point and the child would take a big breath and then would not breathe for a while. The EMS team arrived and the child was taken to York Hospital where he received a [REDACTED] and was observed until 9:00PM that evening. He was then discharged home. The father was told by police to expect the children and youth agency to contact him.

On 02/07/2015, [REDACTED] notified York County Office of Children, Youth and Families (CYF) of the incident described above. He reported that the ambulance crew did not note any injuries to the child upon arrival to the home, but that they did take the child to York Hospital by ambulance. [REDACTED] stated [REDACTED] would not be pursuing charges against anyone. CYF called York Hospital immediately upon receipt of the report from [REDACTED] at York Hospital reported to the agency that the child was [REDACTED] to the parents and there were no suspicions of child abuse. The agency screened this referral out and did not accept the case for investigation at that time.

On Sunday, 02/08/2015 the parents described that the child was fussy, would not eat, wanted to be held and vomited after eating. The mother reported that the child was, "spacey." According to the mother, the child was up a lot during the night of Sunday, 02/08/2015. Mother noted that overnight Sunday, 02/08/2015 into Monday, 02/09/2015 the child's arms were having jerking movements and would not stop, even when the child was touched and the child's pupils were fixed. The mother called the pediatrician and the child was taken back to York Hospital. The child was noted to be having seizures and was transported to Penn State Hershey Children's Hospital on Monday, 02/09/2015.

After admission to Penn State Hershey Children's Hospital, testing revealed that the child had [REDACTED] resulting from lack of oxygen to the brain which was most likely causing seizures. The skeletal survey was normal. The child was able to eat and breathe on his own.

On 02/10/2015 Dr. [REDACTED] of Penn State Hershey Children's Hospital certified the child to be in critical condition due to suspected child abuse. The report was assigned to CYF as suspected abuse and was assigned to the Central Region Office of Children, Youth and Families (OCYF) as a Near Fatality on that date. The father was listed as the alleged perpetrator.

CYF responded immediately upon receipt of the report to ensure the safety of the victim child's sibling. A safety plan was put into place in which the father was to have no unsupervised contact with either child. The maternal grandmother and paternal grandparents would supervise all contact between the father and the children.

As a result of the near fatality and child abuse report, the victim child's twin brother received a full pediatric exam, skeletal survey [REDACTED] on 02/13/2015. [REDACTED]

[REDACTED] The sibling was admitted to Penn State Hershey Children's Hospital. The parents were unable to provide an explanation for the injuries. [REDACTED] certified the sibling to be in critical condition as a result of suspected abuse. As a result of the sibling'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 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 was indicated against the father on 03/27/2015.

Detective [REDACTED] Police Department, charged the father with Aggravated Assault and Endangering the Welfare of a Child related to the victim child in this report. The father is in jail and awaiting trial.

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 ensured the safety of both 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 ensure 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.