



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Eric Clapper Jr.

BORN: 09/01/2011

DIED: 11/12/2011

FAMILY KNOWN TO:

The Family Was Known to York County Children and Youth

May 7, 2012

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed by Former Pennsylvania Governor Edward G. Rendell on July 3, 2008 and went into effect 180 days from that date December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.¹

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Clapper, Jr., Eric	Victim Child	09/01/2011
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father	[REDACTED]
[REDACTED]	Sibling	[REDACTED]

Notification of Fatality/Near Fatality

On November 2, 2011, York County Children and Youth Services received a report from [REDACTED] regarding a suspicious child fatality of a 2 month old infant. According to the report, the now deceased infant had [REDACTED] since [REDACTED] on October 8, 2011. The child had been born [REDACTED] and spent a month in the [REDACTED] prior to [REDACTED]. It was also reported that the child had not received medical care since his [REDACTED]. The child was also on a [REDACTED].

The report was registered as a child fatality due to alleged Medical Neglect with both the Father and Mother listed as alleged perpetrators. An autopsy was scheduled for November 14, 2011.

2. Documents Reviewed and Individuals Interviewed:

- Complete York County Children and Youth Services (YCCYS) case record of child abuse investigation, and service planning record
- Child medical records from York Hospital and [REDACTED]
- Child Autopsy report completed by [REDACTED]
- Interviews with [REDACTED] Supervisor, and [REDACTED] Investigator

Case Chronology:

Previous CYS involvement:

On February 12, 2007, YCCYS received a referral from [REDACTED] regarding the Mother and Father, and an 8 day old female child. According to the referral, the child was currently [REDACTED], since her birth, with [REDACTED]. There were concerns regarding [REDACTED] of the parents and their ability to provide the level of care needed for this child. There were also concerns that there were many animals in the home and home was not in sanitary condition. The child was [REDACTED]. YCCYS made initial contacts, but before they could complete a full assessment, the child passed away [REDACTED]. As the parents had no other children, the agency closed the case at intake. No additional referrals were received on the family until the current involvement.

Circumstances of child's near fatality:

The Victim Child was born [REDACTED] at York Hospital on September 1, 2011. The child

¹ 23 Pa, C,S, § 6343(c)1,2.

was placed in the [REDACTED] due to [REDACTED] and was also placed on a [REDACTED]. The child was [REDACTED] on October 8, 2011 weighing [REDACTED].

When the victim child was [REDACTED], it was reported that the parents would be living with the father's family while they cared for the child. The child was also to have [REDACTED]. The mother denied [REDACTED]. [REDACTED] reports that they contacted mother three days after [REDACTED] and she stated that the child had been to the [REDACTED]. An appointment had been made at [REDACTED] for October 14, 2011, but was cancelled by the mother. Two additional appointments were also cancelled. The child was not seen by his [REDACTED] and his death.

The Mother and child attended their first appointment with [REDACTED] on November 11, 2011. [REDACTED] had met with the mother in August 2011, while she was still pregnant. However, they were not alerted that the child had been born early, so they did not contact the mother until several weeks after the birth. On November 11, 2011, the [REDACTED] weighed the child, while he was wearing a diaper and sleeper, and recorded his weight at [REDACTED]. The mother had indicated that she was mixing two times the amount of recommended formula in water when she was feeding the baby. This was addressed by the [REDACTED] and she was instructed in the proper feeding methods for the child. [REDACTED] indicated that they did not have any charts from the hospital so they did not know the weight progression of the child and did not feel like the child was in a severe condition.

The mother has a history of medical issues with her children. A previous daughter passed away in 2007 during [REDACTED] when she was under a month old. There was also a [REDACTED] sometime between 2007-2010, although the exact date of birth is not known and could not be located in the family case record. The sibling of the victim child, currently 1 year old, had [REDACTED] as an infant, as reported by mother. This sibling was placed informally with the paternal grandfather and his paramour at the time of the victim child's death with an initial safety plan of no contact with the parents. When the victim child was pronounced dead at York Hospital on November 12, 2011, he weighed [REDACTED]. [REDACTED] had already begun to set in, and the body of the child was extremely concave and appeared to have been [REDACTED].

The mother reported that she was feeding the victim child around 5pm on November 12, 2011 when his eyes began to roll back and his [REDACTED]. The [REDACTED] was necessary due to the child have [REDACTED]. The mother began CPR on the child and called 911.

YCCYS conducted a [REDACTED] investigation with the father and mother named as the Alleged Perpetrators. The investigation was concluded on January 9, 2012 with a status of [REDACTED] for Physical Neglect [REDACTED], for both mother and father. The [REDACTED] status was determined through medical evidence and interviews.

The autopsy of the child was conducted on November 15, 2011 by [REDACTED] and received by the agency on March 13, 2012. The cause of death was determined to be hypernatremic dehydration and malnutrition. The report concludes that the manner of death should be considered homicide.

Current/most recent status of case:

The victim child's sibling had been residing informally with the paternal grandfather and his paramour. A safety plan was in place that the mother and father would not have unsupervised contact with the child. YCCYS had learned that paternal grandfather's paramour had been [REDACTED] as a perpetrator

by omission in 1997 for the sexual abuse of her two children. The paramour explained that she had made the perpetrator move out immediately, and she had been used as a safety plan for the children. The paramour stated that she was [REDACTED] and YCCYS continued to use her and the paternal grandfather as a resource. However, due to the paramour not following through with the [REDACTED], housing conditions, and the inability of the paternal grandfather to understand the severity of the current situation, YCCYS took temporary custody of the victim child's sibling in January 2012. She was placed with cousins who had recently adopted a child through a local adoption agency. These relatives were presented as a resource by the mother and father. The child remains in this home and they are approved as a kinship resource for the child. The parents have supervised visitation with this child. The child also visits with the maternal grandfather and his paramour. These visits are supervised by the kinship parents and the agency.

The family is currently open for placement services with the agency. The parents are working with Justice Works Youth Care which acts as a family advocate and aids the family in finding services. Both parents are attending parenting classes and have received assistance in attending medical appointments for the victim child's sibling. Both mother and father have completed intake appointments with local [REDACTED] and are awaiting services.

The criminal case against the mother and father remains active. No charges have been filed at this time.

Services to children and family:

York Hospital - Medical Services

[REDACTED] - Medical Services

York County Children and Youth Services - Placement and Kinship Services

[REDACTED] - Family Support Services

Justice Works Youth Care – Supportive Services to the Parents

County strengths and deficiencies as identified by the County's fatality report:

A Fatality/Near Fatality Multidisciplinary Team Act 33 meeting was held on November 30, 2011 at York Hospital. The team, comprised of local CYS professionals, several medical professionals, OCYF staff, and [REDACTED] representatives, focused on the communication breakdown which occurred in this case. Information from the hospital was not relayed to [REDACTED] regarding weights of the child. [REDACTED] saw the child the day before he died and did not have a reference point for his weight. It was also discussed that the mother had cancelled several follow up appointments and this was not addressed. The team agreed that York County Children and Youth Services had been efficient at gathering information and contacting family members upon their involvement after the child's death.

County recommendations for changes at the local (County or State) levels as identified in County's fatality report:

- As a result of the Act 33 Meeting, York Hospital was developing protocol for relaying information to [REDACTED] for those families that they know are scheduled to receive those services.
- It was recommended that local physicians develop an alert system to follow up with those patients who are consistently cancelling important visits.
- [REDACTED] current policy on weighing children requires them to do so in a diaper and sleeper. Due to the circumstances of this fatality, they were planning to have an internal discussion regarding this protocol to see if it could be changed.

Central Region findings:

- County response to information received was urgent and thorough.

- The [REDACTED] Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
- The agency made concerted efforts to assure that the victim child's sibling was placed with family. Even when the first family situation disrupted, the agency found other family that could provide kinship services to the child.
- The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
- The agency has continued to provide for the safety of the sibling through placement services and services to the parents.
- Because the hospital staff indicated that they would be working on some alerts and other protocol regarding high-risk children, it is recommended that future MDT meetings revisit these protocol as a means of evaluating and improving them.

Statutory and Regulatory Compliance Issues:

All regulations regarding [REDACTED] investigation and subsequent county services were followed.