



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 02-06-14

Date of Incident: 5/30/14 to 7/15/14

Date of Oral Report: 7/16/14

FAMILY NOT KNOWN TO:

Schuylkill County Children and Youth Services (CYS)

REPORT FINALIZED ON:

2/18/2015

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, 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. Schuylkill County Children and Youth Services (CYS) 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>
██████████	Child Victim (CV)	02/06/14
██████████	Sibling	██████████/13
██████████	Mother	██████████/95
██████████	Father of CV	██████████/93
██████████	Father of Sibling*	unknown

*non household member

Notification of Child (Near) Fatality:

On 7/15/14 Schuylkill County CYs was contacted by VC's ██████████. The ██████████ reported she was calling with speculations. ██████████ reported ██████████ was calling about two children who have been ██████████. She reported over the last few weeks a stomach virus had spread throughout ██████████ and the illness had eventually affected VC and VC's sibling. ██████████ reported the children were seen by their Primary Care Physician (PCP) and diagnosed with a viral infection. ██████████ also reported VC's mother also took her to the local hospital due to her symptoms continuing; VC was provided fluids for dehydration.

The ██████████ reported VC's mother ██████████ children a few weeks ago and did not appear well. The VC's mother reported ██████████ she hit her head getting out of her car and gave herself a concussion. The ██████████ reported that the other day the VC's mother came into the daycare and was wearing a foot brace. The VC's mother reported ██████████ she had been playing with the children and while chasing one of the children, cut her foot on a rock. The ██████████ felt the VC's mother's statements, at those times, were reasonable.

The [REDACTED] heard earlier in the day the VC's mother took the VC to the hospital and VC was subsequently life-flighted to Lehigh Valley for [REDACTED]. The [REDACTED] stated she could not say the children were being abused however felt she should make someone aware, just in case. The information was taken and forwarded to the intake department so further information could be obtained to determine if CYS needed to be involved.

On 7/16/14 the intake screener contacted the [REDACTED] and inquired if any further information was available regarding the status of the VC. [REDACTED] reported the VC was [REDACTED] due to concerns she may have a [REDACTED]. The [REDACTED] reported she did not think the parents were abusive toward the children but does wonder about domestic violence due to several recent injuries exhibited by the VC's mother.

On 7/16/14 the intake screener conducted an inquiry through the [REDACTED] to obtain further information regarding the VC and her parents. It was discovered in December 2013 the VC's mother moved from what appeared to be her mother's residence into a home with the VC's father. It appeared the VC's mother gave birth to the VC in February 2014 and returned to work [REDACTED]. The intake screener also conducted an inquiry to check for Protection from Abuse orders. There were none found.

On 7/16/14 the intake screener consulted with the Child Protective Services (CPS) supervisor, and since the agency had not received information [REDACTED] suspected abuse with the VC, the information would be held at this time for further assessment.

At 7/16/14 at 11:06pm the on call worker was contacted with information [REDACTED] reporting a near fatality incident with the VC. [REDACTED] Lehigh Valley Hospital contacted [REDACTED] to report the VC was brought into the emergency room on 7/15/14 for altered mental status. The VC was given an [REDACTED]. [REDACTED] reported suspicion the injuries were caused by non-accidental trauma. At the time of admission, the VC's parents were unable to provide an explanation or mechanism of injury. [REDACTED] reported the VC's mother has been very cooperative with hospital staff and asks many questions, however, the VC's father presents as quiet and does not ask questions. [REDACTED] explained the VC was expected to survive her injuries but was being treated for [REDACTED] and was viewed as being in critical condition. [REDACTED] explained the VC was seen previously [REDACTED] at Lehigh Valley Hospital on 7/3/14 for vomiting.

Summary of DPW Child (Near) Fatality Review Activities:

The Northeast Regional Office (NERO) obtained and reviewed all current records regarding this case. This includes all interviews and medical reports. The family was unknown to the agency prior to this incident. NERO also attended the Act 33 Meeting on July 25, 2014.

Children and Youth Involvement prior to Incident:

The family was not known to Schuylkill County Children and Youth Services prior to the VC's near fatality.

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

On 7/17/14 CW [REDACTED] was assigned this CPS investigation. CW [REDACTED] and the [REDACTED] of the [REDACTED] Police Department traveled to Lehigh Valley Hospital at which time preliminary contact was made with medical staff to discuss the VC's injuries. During this contact it was reported that the VC had sustained [REDACTED]. Information at that time was at a minimum but the medical team was able to report the VC was suspected to have sustained the injuries as a result of non-accidental trauma. The medical team was asked if the injuries were consistent with a baby who had been shaken. Staff explained the injuries can be sustained in this manner however there would need to be further testing medically to determine/rule out any [REDACTED] which may have caused the injuries. Staff reported a skeletal survey had already been completed and was negative for fractures. Staff reported a [REDACTED] to rule out medical causes for the bleeding. The VC was waiting consultation for [REDACTED]. After discussing the VC's medical state, CW [REDACTED] interviewed the father on this date. While CW [REDACTED] was interviewing the VC's father, the police [REDACTED] interviewed the VC's mother. Upon completion of the interviews CW [REDACTED] and the [REDACTED] switched and interviewed the other parent. The VC's mother was unable to provide CW [REDACTED] with any explanation for the VC's injuries.

On 7/17/14 CW [REDACTED] visited the home of the maternal grandmother (MGM) in order to assess the safety of the VC's half sibling. On 7/18/14 CW [REDACTED] was contacted by the VC's mother. The mother reported that she had a conversation with the father and she believed that he may have been the one who injured the child. CW [REDACTED] contacted the police [REDACTED] on 7/18/14 and explained the call just received. The [REDACTED] suggested CW [REDACTED] request a secondary interview with both parents at the police station that day. At 12:08pm the VC's father arrived and was provided his Miranda Rights by the [REDACTED]. The VC's father was questioned regarding his statement to the VC's mother earlier in the day. The VC's father reported an incident when he was watching TV and became agitated because the VC kept crying, despite his attempts to comfort her. The VC's father reported he exerted a great deal of force when pushing the VC in the bouncy seat, causing separation between the VC and the chair which she was buckled into. The VC's father explained how the VC lunged forward in the chair and slammed back in a manner that the chair compressed and the VC's head made contact with the floor. The VC's father reported the onset of the VC's viral illness symptoms were the next day. The VC's father re-enacted the incident with the VC in her bouncy seat with a doll. CW [REDACTED] and the [REDACTED] made contact with Lehigh Valley doctors on 7/18/14 to inquire if the VC's father's reported mechanism of injury was consistent with the VC's injuries. Lehigh Valley doctors expressed it would be.

On 7/18/14 the VC's father was arraigned before the Magisterial District Judge for charges of Recklessly Endangering another Person, Simple Assault, and Aggravated Assault. The VC's father was incarcerated at the [REDACTED] Prison on \$100,000 straight cash bail.

On 7/28/14 the VC's mother was awarded a temporary PFA against the VC's father, on behalf of the VC. A final PFA hearing was held 8/13/14 and the VC's father agreed to a 2 year, no contact order.

On 7/30/14 the VC was transferred to [REDACTED] where she remained until 9/5/14.

On 7/31/14 Lehigh Valley Hospital received results from the VC's medical testing, indicating no underlying [REDACTED] indicative for the VC's injuries.

On 8/25/14 the CY48 was completed on the VC as INDICATED for physical abuse naming her father, as perpetrator.

Current Case Status:

The perpetrator is out on bail and is residing with his parents. The criminal charges are still pending. A preliminary hearing is scheduled for November 14, 2014.

The VC's mother and the children were opened for agency services to provide support through the criminal proceeding, provide support in the VC's [REDACTED] and monitor the VC's mother's relationship with the VC's father, although she has responded appropriately thus far. The VC's mother has responded appropriately to the VC's medical needs, the VC's sibling's emotional needs and securing a residence independent of the VC's father. The VC's mother has required constant emotional support in coping with her family situation.

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

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. A review team meeting was held by Schuylkill County CYS on July 25, 2014, in accordance with Act 33 of 2008 related to this report. Various members of the community and community providers attended the meeting.

- **Strengths:** The team praised the mother's actions in continuing to pursue an explanation for the VC's symptoms and praised the Lehigh Valley hospital's subsequent testing to indicate non accidental trauma.
- **Deficiencies:** The doctor pointed out concerns for a significant increase in the VC's head circumference, documented in the PCP records, from 7/1/14 – 7/15/14. The doctor discussed how the increase appeared to go unnoticed. A discussion was held regarding the need for training and education to local PCPs regarding indicators, signs and reporting of suspected child abuse.

- Recommendations for Change at the Local Level: Recommendations were made for Schuylkill County CYC to complete an Ages and Stages Assessment on the VC's sibling to rule out any necessary referrals and to obtain a Release of Information to gather the sibling's medical records from his PCP.
- Recommendations for Change at the State Level: There were no recommendations for change on the state level in this case.

Department Review of County Internal Report:

The county report was received by NERO on 10/21/14. NERO sent the State Response to the County Report on 10-23-14 stating that NERO agreed with the preliminary findings in this case.

Department of Public Welfare Findings:

- County Strengths: The County held a timely Act 33 meeting regarding this case. The county has a strong Act 33 team who critically reviews the facts of the case. The team was able to identify [REDACTED] and subsequently came up with a plan to provide training to the local PCP's to correct this issue in the future.
- County Weaknesses: The team did not identify any weaknesses related to the children and youth agency. The family was not known to the agency prior to the abuse. As mentioned above, [REDACTED], but they also came up with a plan of correction to train the local PCP's on this issue.
- Statutory and Regulatory Areas of Non-Compliance:

There were no statutory or regulatory areas of non-compliance noted in relation to this case.

Department of Public Welfare Recommendations:

The NERO has no further recommendations beyond the recommendations made by the Act 33 team regarding this case.