



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

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



**Date of Birth: 01/16/2014**  
**Date of Incident: 08/06/2015**  
**Date of Report to ChildLine: 08/11/2015**  
**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Adams County CYS

### **REPORT FINALIZED ON:**

1/07/2016

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.

Adams 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 September 9, 2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	01/16/2014
[REDACTED]	Mother	[REDACTED] 1972
[REDACTED]	Father	[REDACTED] 1961
[REDACTED]	Half-Sibling	[REDACTED] 2002
[REDACTED]	Half-Sibling	[REDACTED] 1999
* [REDACTED]	Neighbor	[REDACTED] 2004
* [REDACTED]	Neighbor	[REDACTED] 2000

\* 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 (CERO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. CERO staff conducted interviews with the following Adams County Staff: Intake Caseworker, Intake Supervisor, and Family Support Worker. These interviews occurred on December 15-16, 22, 2015. CERO staff participated in the Act 33 meeting that occurred on September 9, 2015 in which medical professionals, agency staff, and legal counsel were present and provided information regarding the incident, as well as historical information. Staff from Carroll County, Maryland child services were also present to provide history on the family.

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

January 31, 2014 – April 21, 2014

The victim child was born prematurely at 35 weeks on January 16, 2014 at Carroll Hospital Center in Maryland. The child was 3 lbs at the time of birth. The child was [REDACTED] and the mother tested positive for cocaine and opiates. This was originally received by Carroll County CPS, and they saw the child and other children in the family. It was determined that the family lived in [REDACTED],

so a referral was faxed to Adams County CYC on January 31, 2014. The faxed letter detailed the family's history of involvement with Carroll County, and requested a home visit and assessment of the mother's home in [REDACTED]. The child remained in the hospital [REDACTED].

Agency records show this referral being assigned to a worker on February 24, 2014. In discussion with agency staff, it cannot be determined why the case was not assigned until this date, and does not appear that any action occurred on the case between January 31 and February 24, 2014. The assigned caseworker made 3 unannounced visits to the home and no one appeared to be present. A letter was sent scheduling a visit on March 19, 2014, and the mother was a no-show. The caseworker received a call from the mother on March 22, 2014 stating that she was bringing the child home that day. The caseworker then made an unannounced visit on March 24, 2014 and saw the mother and child. There is no evidence that the agency made a request for the child to be seen while he was still in the hospital in Maryland. The mother reported that her two other children were living with their brother in [REDACTED], Maryland to finish out the school year there. The caseworker did not see the child again until April 17, 2014, after he had been in the hospital [REDACTED]. It was at this visit that the mother's drug use was discussed. She stated that she had been at a friend's house who was smoking cocaine and she must have ingested some of the smoke. She stated that she is on [REDACTED]. Agency records report that the mother was following through with all medical care for the child. The case was closed on April 21, 2014, with no additional services. It does not appear that a drug screen was ever administered, or that the agency received any records from Carroll County regarding the mother's extensive history with their agency (as reported in the letter from Carroll County). Based on the dates of the initial information from Carroll County being provided to the agency, the agency did not complete the intake assessment within the required 60 day time frame.

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

On August 11, 2015, Adams County CYC received a referral [REDACTED] regarding the victim child. The child was admitted to the Hershey Medical Center on August 6, 2015 with [REDACTED] and life-threatening clinical symptoms. Abuse was not initially suspected due to the child's extensive medical history which [REDACTED]. The treating physician ordered a full skeletal survey and [REDACTED]. The skeletal survey showed no signs of trauma or abuse, [REDACTED]. The mother had reported to the hospital that the child had fallen on August 5, 2015. It was felt that this did not match with the injuries and was called into ChildLine as suspected abuse. [REDACTED]. The child was certified to be in serious condition and was registered as a near fatality.

The caseworker from Adams County CYC and law enforcement arrived at Hershey Medical Center and spoke with the treating physician. According to the treating physician, the child's [REDACTED] could cause some of the injuries, however

████████████████████ would have been caused by significant ██████████. They had not suspected abuse at the onset of hospital admission due to other factors ██████████, and the mother's explanation of a possible fall, which could have caused the injury based on the child's medical history. It was not until after the hospital ██████████ that the mother started talking about a short time frame when a neighbor child had been alone with the child and may have accidentally caused the injury. All stories corroborated that the father had not be present at the time of the incident. The treating physician believed that any trauma to cause the injury would have occurred immediately prior to the injury.

The mother was interviewed by police and CYS and described two incidents. She discussed a fall that the child had endured as he was walking with his sister in the home. He had fallen backward and hit his head on the floor divider between two rooms. The mother did not see any injury and reported that the child seemed fine the next morning so she did not pursue any medical care. On that second day, she reported that two neighbor girls were at her home while she was cleaning out the child's room. The one child, a 10 year old girl, known to be hyperactive, grabbed the child and ran outside with him. When the mother came outside a couple minutes later, the girl was holding the child with a hand to his head talking about a "fall". The mother reports that this sounded suspicious but she put the child in his stroller and walked to the mailbox. While doing this, the child began to vomit and defecate at the same time and appeared to be having a seizure. The mother had her son contact emergency services and an ambulance came and took the child to be flown directly to Hershey Medical Center. She also stated that the young girl kept crying and trying to hug her and seemed like she had something more to say.

The two other children of the mother were interviewed and did not report any inappropriate actions by their mother. The daughter claimed that she had seen the neighbor girl put the victim child in a stroller and run up and down the driveway pushing him. The agency and police scheduled interviews for the two neighbor girls that had been present, but their mother refused the interview since she could not observe at the Child Advocacy Center. This was then moved to the police barracks so that the mother could observe the interviews. The older of the two neighbor girls did not observe any incidents and reported to be in her house when the child began to seize. Her sister came to the home to tell her something had happened and she went back over to observe. The 10 year old child stated that she had just brought the child outside and sat on the patio and the child began to cry, but then the mother came outside with the stroller. She stated that she has played rough with the child but never hurt him. She stated that she and the daughter had been gently tossing him on the bed earlier and he seemed to be having fun. The mother was in the room when this occurred.

The child was transferred to the Hershey Medical Center ██████████ on August 20, 2015. His condition had improved, ██████████. On August 27, 2015, the mother took a polygraph at the police station. It was reported that her polygraph showed signs of deception, but when interviewed after

the polygraph, she continued to deny causing any harm to the child, and requested a lawyer. The agency caseworker contacted the family on September 9, 2015, and was informed that the child had been released to them. The agency did not receive any notification from Hershey Medical Center [REDACTED]

[REDACTED] At that time, the caseworker scheduled to see the child in the home on September 14, 2015 due to the number of appointments that were scheduled for the child that week. The agency also reported no immediate safety concerns with the child in the home.

On September 9, 2015, the Act 33 meeting occurred at the Adams County 911 Center. At this meeting, the treating physician indicated that he has re-reviewed the child's records and discovered that the original images were not as severe as depicted in case notes. He believes a less severe trauma could have caused the child's injuries such as rough play or tossing the child on the bed.

On September 14, 2015, the caseworker met with the family and discussed the case, including that the family would be open for agency supportive services. The parents were cooperative with this. The agency will be monitoring to assure that the follow-up medical appointments are kept for the victim child. The agency will also be assisting the mother's oldest child [REDACTED]

Adams County CYC filed their investigation report with ChildLine on October 9, 2015 with a status of Unfounded. This decision was based on the medical opinion provided by the treating physician stating that abuse could not be medically confirmed. It was felt that there was still not enough research available on all of the child's [REDACTED] to state that they did not contribute to any of the child's injuries. No charges were filed against any party in this case. The family was opened for ongoing services and is currently working with [REDACTED]

[REDACTED] The child is reported to be back to his normal behaviors and physical state prior to the incident.

**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 county reports excellent collaboration with local law enforcement in conducting the investigation.
  - Response to the concerns was expeditious and supported through supervision.
  - Information shared between medical personnel and the agency was efficient and readily available.
  
- Deficiencies in compliance with statutes, regulations and services to children and families;

- The agency could have shown more diligence in gathering information from a variety of sources in regard to previous referrals on the family, as well as providing referrals to more follow-up services.
- The agency did not conduct sufficient family finding measures in previous referrals.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Education regarding premature children [REDACTED] for mothers and agency workers to identify services necessary to help the child/family.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None Noted
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - The agency could increase direct contact between workers when transferring cases across county/state lines to prevent loss of information.

**Department Review of County Internal Report:**

The Central Region Office received the Adams County Child Fatality Team Report on November 4, 2015. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on September 9, 2015. As the case activity continued beyond the September meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Adams County Administration on December 14, 2015.

**Department of Human Services Findings:**

- County Strengths:
  - The county demonstrated appropriate collaboration with law enforcement and medical professionals throughout the current investigation.
  - The family has been opened for services not only to address the needs of the identified child, but also to provide for the other children in the family with a variety of county programs and supports.
- County Weaknesses:
  - The agency did not assign the previous referral on the family for assessment until 24 days after it was received. The child was in the hospital during this entire period, but was not seen until one month after the case was assigned.

- During previous involvement with the family, records were not requested from Maryland, despite reports that the mother had extensive CYS involvement in that state.
  - The previous referral regarded the mother testing positive for cocaine. During agency involvement, a drug screen was not conducted, nor was there any discussion of possible drug assessments for treatment.
  - When the child was released to the parents from the hospital, the agency did not see the child until five days after they had knowledge that the child was back in the home. While the family was very busy with appointments, the agency could have sent a worker out in the evening to see the family and assure the safety of the child.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. Adams County CYS was found to be out of compliance in the following areas:
    - 3490.232(c) – The agency assigned the case for assessment on 2/24/14 and assigned a 48 hour response time frame to see the child. The child was not seen until 3/24/14. The child had been in the hospital in Maryland up until 3/22/14, and the agency did not request that Maryland see the child to meet response times.
    - 3490.232(e) – The agency received a referral on the child on 1/31/14, but did not assign the case until 2/24/14. The case was closed on 4/21/14. The agency did not complete the assessment in 60 days.
    - 3490.232(i) – The agency completed the assessment in 2014 without providing drug screens to the mother or following up on attendance at medical appointments, despite the mother testing positive for drugs at the birth of the child and concerns regarding the child's [REDACTED] [REDACTED]. This did not appear to meet an appropriate level of service for the nature of the report.

**Department of Human Services Recommendations:**

DHS offers the following recommendations to practice as a result of the findings of this review:

- The agency should review existing policies regarding referrals from other states/counties and assure there are established guidelines for requesting information from the other parties, and assigning the referrals in appropriate timeframes. If policies/protocols do not exist, they should be developed.
- It would behoove the agency to establish some form of Memorandum of Understanding with those counties in Maryland bordering Adams County in regard to providing case information. A detailed history of this family provided to Adams County at the onset of the investigation would have benefitted the caseworkers and supervisors assessing the family.