



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 11/20/2014
Date of Incident: 10/14/2015
Date of Report to ChildLine: 10/15/2015
CWIS Referral ID: [REDACTED]

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

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:
04/06/2016

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.

Dauphin 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 10/23/2015.

Family Constellation:

[REDACTED]	Victim Child	11/20/2014
[REDACTED]	Mother	[REDACTED]/1998
* [REDACTED]	Father	[REDACTED]/1996
* [REDACTED]	Half-brother	[REDACTED]/2013
* [REDACTED]	Mothers Cousin	[REDACTED]/1979
[REDACTED]	Paternal Great-Grandmother	unknown
* [REDACTED]	Paternal Grandmother	[REDACTED]/1973
* [REDACTED]	Cousin's Sister	unknown

* 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 participated in the County Internal Fatality Review Team meeting on 10/23/2015. Copies of prior agency involvement were sent on 11/10/2015. An interview with agency workers and a review of copies of medical reports was completed on 03/03/2016.

Children and Youth Involvement prior to Incident:

On 12/04/2013 the agency became involved with the 15-year-old mother regarding concerns for her 2-month-old son (the victim child's older sibling) and the mother's inability to meet his needs. A Family Group Decision Making (FGDM) conference was held on 12/27/2013 and it was determined that the mother and her son would reside with her maternal aunt. The family was accepted for ongoing services by the agency. The son remained [REDACTED] at PinnacleHealth Harrisburg

Hospital [REDACTED]

[REDACTED] . The family agreed to voluntarily participate with ongoing services [REDACTED]

On 10/13/2014, the mother became involved with Juvenile Probation due to charges of theft of services, simple assault, trespassing and [REDACTED]. At that time, the case became a Shared Case between the county children and youth services and the county juvenile probation office.

The mother became pregnant with her second child and delivered the victim child on 11/20/2014. She and the victim child resided with the victim child's paternal grandmother until 01/12/2015 when the mother was [REDACTED] for a violation of her probation. The victim child remained in the household. While at [REDACTED] the mother made allegations that she was sexually assaulted by her uncle who did not reside with her at her grandmothers. Dauphin County Social Services for Children and Youth (DCSSCY) conducted a Child Protective Services investigation on 03/25/2015. Although the mother made the allegations, she refused to cooperate with the investigation and would give no further information about the assault. Therefore, the county could not substantiate the allegations of abuse and the report was unfounded on 05/23/2015.

The victim child remained with the paternal grandmother until February 2015. He then resided with the paternal great-grandmother until the time of the incident on 10/15/2015. The mother [REDACTED] and moved back in with her cousin. On 05/11/2015, the cousin contacted the agency and stated she was no longer willing to care for the mother and the mother returned to her maternal grandmother's home. Shortly thereafter, the mother left the maternal grandmother's home and her whereabouts were unknown.

The mother was found in the state of New York in July of 2015 and [REDACTED] on 07/15/2015 by Juvenile Probation [REDACTED]. She was [REDACTED] on 07/17/2015. She remained there until 09/10/2015 due to the probation violation of leaving the state without permission. On 09/10/2015, the mother [REDACTED] for mothers and children. The victim child's older half-sibling (who had been living with the cousin up until this point) was permitted to reside at the group home with her. The victim child remained in the home of the paternal great-grandmother. The mother ran away from the group home on 09/18/2015. She left the half-sibling at the placement facility. DCSSCY were granted dependency of the half-brother on the same date, and he was placed

with the paternal grandmother as a formal kinship resource home. The mother was found on 10/15/2015 at the time of the near fatality. She was placed in shelter care where she remained as of the time that this report was written.

The county agency closed services out with the victim child on 09/03/2015 as he remained in the care of the paternal great-grandmother. The mother and the victim child's sibling were still open for ongoing services.

On 10/15/2016, the agency received the near fatality report regarding the victim child after the mother and father returned the victim child to the paternal great grandmother's home following a day visit.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/14/2015, the mother (who was on [REDACTED]), and the victim child's father were visiting with the victim child from 8:00 AM until 9:30 PM. After the mother and father returned the victim child to the paternal great-grandmother, the child did not seem to be acting normally according to the paternal great-grandmother. The paternal great-grandmother brought the victim child to the PinnacleHealth Harrisburg Hospital [REDACTED] because the child was presenting as lethargic. The great-grandmother told medical staff the parents had been known to use synthetic marijuana in the past. [REDACTED] [REDACTED], the child was transferred to Penn State Hershey Children's Hospital on 10/15/2015. On that same date, Penn State Hershey Children's Hospital contacted DCSSCY regarding the victim child's condition and the physician certified the child to be in critical condition. [REDACTED]

[REDACTED] By 10/16/2015, the child was alert, active and responsive. [REDACTED] and placed into foster care by the county agency. The victim child continues to reside in foster care.

During a law enforcement interview, the father denied that he had given the victim child marijuana. The mother refused to be interviewed on the advice of her attorney. Although it is believed that the child could possibly have ingested synthetic marijuana (K2), [REDACTED]. Without knowing what ingredients were used to make the marijuana, the K2 test was not effective in making such a determination.

The county agency submitted the CY-48 on 12/14/2015 with an unfounded finding due to the lack of medical evidence. The mother was located by the agency and returned to [REDACTED]. The victim child's father continued to reside with his mother.

Upon the mother's return [REDACTED], she wrote a letter to the victim child's father and sent it to the address where the father and his mother resided. The father's mother opened the letter and sent a copy to the agency. In the letter, the mother referred to using a drug called, "SPACE." She also described how she was [REDACTED]

[REDACTED] because it was still in her system and would be in the victim child's system also. Even with the information in this letter, the agency felt they could not make a finding of abuse regarding either parent due to the lack of medical evidence. The agency did determine a need to continue to provide ongoing services to the family.

[REDACTED]

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 agency investigation complied with regulations and response times as required.

- Deficiencies in compliance with statutes, regulations and services to children and families;

The county agency's report did not reference any specific identified deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The county agency's report did not reference any specific changes or recommendations at the state or county level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

The county agency's report did not reference any specific changes or recommendations at the state or county level.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The report discussed concerns about the first responders not attempting to collect a sample of the drug found in the parents' car. The team also had concerns about the mother not participating in interviews with law enforcement regarding the criminal investigation on the advice of her legal counsel [REDACTED]. The team discussed concerns regarding how the rights of a dependent child could impede investigations of fatalities/near fatalities.

Department Review of County Internal Report:

The Multi-Disciplinary team report was received on 03/11/2016. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

Upon review of the documents associated with this particular case, there appeared to be a positive working collaboration between law enforcement, medical facilities and the county agency.

The county utilized a Family Engagement Meeting to identify appropriate kinship placement options for the children.

- County Weaknesses:

Agency documentation in the case record was segmented, difficult to follow, and lacked detailed information at times.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

As per Chapter 3490.235(g)(2)(i) and the Casework Visitation Bulletin 3490-08-05, the victim child was not seen by a caseworker while in a kinship home during the months of January, February and April of 2015.

Department of Human Services Recommendations:

The agency must develop a plan on how it will monitor casework activity as it relates to monthly visits for children in both foster and kinship homes.

The agency should also review case record documentation throughout the life of a case to determine methods to improve case documentation to ensure that the documentation is detailed and clear. The case information should be maintained in a manner that enables an individual to review the entire record without having to obtain pieces of the record from different areas/sources.