



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 01/25/2017
Date of Incident: 03/30/2017
Date of Report to ChildLine: 03/31/2017
CWIS Referral ID#: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

09/08/2017

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:

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 Children, Youth and Families (YCCYF) has convened a review team meeting on 04/18/2017, in accordance with the Child Protective Services Law related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/25/2017
[REDACTED]	Biological Mother	[REDACTED] 1997
[REDACTED]	Biological Father	[REDACTED] 1991
* [REDACTED]	Paternal Grandmother	[REDACTED] 1969
* [REDACTED]	Paternal Grandfather	[REDACTED] 1961

*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. The Central Region reviewed various reports, assessments, and case documentation provided by YCCYF. Central Region staff also had ongoing telephone and email communications regarding this case. The Central Region also participated in the County Internal Fatality Review Team meeting on 04/18/2017.

Children and Youth Involvement prior to Incident:

The family was not known to YCCYF at the time of the incident. There is no prior history.

Circumstances of Child Near Fatality and Related Case Activity:

On 03/30/2017, around 4:00AM the father was awakened by the sound of the child screaming. He attempted to call the mother at work, but was unsuccessful reaching her. He then contacted paternal grandparents. He had stated that he was unable to soothe the child and had asked the paternal grandparents for suggestions. The paternal grandfather arrived at the home to provide assistance. The mother returned home from work around 6:00 AM after realizing that she had multiple missed calls from the father. When she arrived the paternal grandfather and father were preparing to leave for the hospital. The mother removed the victim child from his car seat and noticed that his left ear was purple, he had a small bruise, and a knot on his head. The mother reported that he did not have any marks when she bathed him and put him to bed around 11:00 PM the night before. He was

transported by the parents to the [REDACTED] Hospital at the insistence of the paternal grandparents.

Dr. [REDACTED] of [REDACTED] Hospital had certified the victim child to be in critical and serious condition due to possible abuse. He had swelling under his left eye and the left side of his face was swollen and bruised. [REDACTED]

[REDACTED] On 3/30/2017, he was transferred to Hershey Medical Center.

On 04/03/2017, the victim child [REDACTED] Hershey Medical Center. Both parents denied harming the victim child. [REDACTED]

[REDACTED] Neither parent has any other children. A few days later [REDACTED] contacted YCCYF and stated she was not comfortable with the safety plan any longer because she did not feel comfortable supervising contact between the victim child and his father. The victim child was then placed in the care of his paternal grandparents.

During the investigation the father had stated he dropped the victim child, however, [REDACTED] the injuries were not consistent with a fall. Eventually the father had told the [REDACTED] Police Department that he slapped the victim child in the face because he would not stop crying. He also admitted to being intoxicated the night of the incident. On 05/16/2017, the case was indicated and the father was charged with aggravated assault and endangering the welfare of a child. He is currently incarcerated at [REDACTED] Prison awaiting his hearing. It has been recommended that he complete parenting courses, drug and alcohol courses, and anger management courses while incarcerated. Although the mother was not indicated or charged YCCYF had concerns with her based on statements she had made during the investigation. It is unclear if she had knowledge or had witnessed the father abusing the victim child.

The victim child remains in the care of his paternal grandparents who have been approved as formal kinship caregivers. [REDACTED]

[REDACTED] The mother is participating in the Nurturing Parents Program [REDACTED] and Non-offending parenting classes through [REDACTED]. The goal is for the victim child to return to his mother's care [REDACTED]

County Strengths and 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, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;
 - The police responded quickly in order to initiate the law enforcement investigation.
 - The Agency was promptly notified of the referral so that an assessment could occur.
 - [REDACTED] was referred and an assessment completed.
 - Positive collaboration and communication with law enforcement.

- Deficiencies in compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;
 - 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;
 - None identified.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - Increase awareness of mental health screenings for parents.

Department Review of County Internal Report:

The Central Region Office received the York County Child Near Fatality Team Report on 06/29/2017. The Central Region 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 04/18/2017.

Department of Human Services Findings:

- County Strengths:
YCCYF responded to the incident in a timely manner and interviewed all parties and provided thorough documentation of these interviews in the case record.

YCCYF obtained all medical documentation from the [REDACTED] Hospital and Hershey Medical Center. They also consulted with Dr. [REDACTED] throughout the investigation.

They worked collaboratively with the [REDACTED] Police Department.

YCCYF submitted all regulatory required documentation to the Central Region Office and ChildLine in a timely manner.

Although the mother was not indicated or charged, YCCYF has set up and provided services to her to ensure the victim child will be safe when he is returned to her care.

- County Weaknesses:
There were no county weaknesses noted by the Central Region Office pertaining to this near fatality.

- Statutory and Regulatory Areas of Non-Compliance:
There were no regulatory areas of non-compliance regarding this near fatality.

Department of Human Services Recommendations:

The Central Region Office recognizes York County Children, Youth, and Families on going compliance with regulations regarding child fatalities and near fatalities. YCCYF continues to work collaboratively with law enforcement, medical personnel and service providers. The Central Region recommends continuation in these areas. The Central Region is also in agreement with YCCYF recommendation to increase awareness of mental health screening for parents. The Central Region also commends YCCYF in their efforts to ensure the safe return of children to their home through appropriate family specific service providing.