pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/20/2006
Date of Incident: 06/30/2017
Date of Report to ChildLine: 06/30/2017
CWIS Referral ID: [redacted]

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

Tioga County Children and Youth Services

REPORT FINALIZED ON:
12/27/2017

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. Section 6349 (b))

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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.

Tioga County has not convened a review team in accordance with the Child Protective Services Law related to this report. There was no Act 33 scheduled, as the incident was unfounded within 30 days.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]*	Victim Child (VC)	04/20/2006
	Maternal Grandmother	[redacted]1955
	Mother	1988
	Father	1985
	Father's Paramour	1985
	Paternal Half-sister	2007
	Paternal Half-sister	2016

* 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 Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective Services (CPS) investigation.

Children and Youth Involvement Prior to Incident:

On 09/21/2015 there was a General Protective Services report to Northumberland County Children and Youth Services for lack of supervision of the VC by his maternal grandmother, his legal guardian. It was reported that the child brought a box cutter to school and threatened to cut another child at school. [redacted] The referral source believed that the maternal grandmother was overwhelmed. The referral source stated that the child's natural mother has "taken a back seat to parenting". The child's mother had

just moved into the home over the summer with her two youngest children. Since then, VC has regressed in school. Reporting source believed there was a [redacted] problem as well as issues with inadequate shelter, personal hygiene and nutrition. Northumberland County Children and Youth Services referred the family for community services and the case was closed.

On 05/28/2015 a report regarding the VC's half-sibling was received by Tioga County Department of Human Services Family Services. The father was threatening to commit suicide in front of the child. The report was validated, the father was referred to community services to address mental health concerns and the case was closed, as the parents were no longer living together at that time.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/30/2017 a referral was made by law enforcement to Tioga County Department of Human Services Family Services (TCDHS-FS) as the VC's father reported that the VC (age 10) went upstairs to use the bathroom, and then father heard a "thud". Father went upstairs and found the VC on the bathroom floor, unresponsive. The father reported picking up the VC and placing him in bed and calling 911 and then calling his paramour and the VC's maternal grandmother, the child's legal guardian with whom he resides. The VC was visiting his father in Tioga County at the time of the incident. It was reported that there were two younger children, VC's paternal half-sisters in the house at the time of the incident. They were reportedly with their father in the living room.

The VC was transported to Robert Packer Hospital in Sayre, Pa where the [redacted] determined the VC was in need of more specialized care [redacted] and the child was life-flighted to Strong Memorial Hospital at Rochester Medical Center in New York [redacted]

[redacted]

[redacted] with the extent of the injury, the VC would most likely not be able to remember what had happened to him. VC [redacted] to home in Northumberland County to the care his maternal grandmother, his legal guardian, on 07/20/2017. He was referred for [redacted]

On 08/01/2017 the case was unfounded. The investigation determination was made primarily due to the inconclusive determination of the treating physicians, therefore the agency concluded that there was not substantial evidence to find culpability by the alleged perpetrator.

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

The case was unfounded in less than 30 days and the county was not required to convene a review team meeting, there was no county report; thus, no further information to report.

Department Review of County Internal Report:

The county was not required to convene a review team meeting since the case was unfounded in less than 30 days, therefore they were not required to complete the county report. There is not a county report due for the department to review.

Department of Human Services Findings:

County Strengths:

- TCDHS-FS met with the hospital staff in New York State to address the VC's safety while the VC was hospitalized, citing the VC's refusal to speak with the father during that time. Agency staff traveled to NY to the hospital and spoke with staff and the family.
- Two other children were in the home. TCDHS-FS visited the VC's father's home, where VC was visiting at time of the incident, and developed a safety plan where close family friends cared for the children for the duration of the investigation.
- TCDHS-FS consulted with the NERO for technical assistance and direction in assuring compliance with the Act 33 process as they have infrequent need to implement the requirements of the statute.

- County Weaknesses:

  There were not any county weaknesses identified.

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

  There were no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

Ongoing technical assistance, trainings, clarifications and resources should continue to be made available to county agencies, particularly those who have limited and infrequent cases in which the Child Fatality/Near Fatality process would apply.