pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY

[redacted]

Date of Birth: 11/20/2012
Date of Incident: 09/27/2016
Date of Report to ChildLine: 09/27/2016
CWIS Referral ID: [redacted]

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

York County Office of Children, Youth, & Families

REPORT FINALIZED ON:
04/11/2017

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))

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 Office of Children, Youth and Families convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/25/16.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Biological Mother	[redacted]/1994
[redacted] *	Biological Father	[redacted]/1993
[redacted]	Victim child	11/20/2012
[redacted]	Maternal half sibling	[redacted]/2014
[redacted] *	Paternal half sibling	[redacted]/2015
[redacted] *	Father's Paramour	[redacted]/1995
[redacted] *	Father's Paramour's friend	[redacted]/1997

* 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 Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. The CRO did attend the Act 33 meeting on 10/25/2016.

Children and Youth Involvement prior to Incident:
York County Office of Children, Youth, and Families (YCOCYF) first became involved with the mother and the victim child on 04/12/2016 after receiving a referral of physical abuse. The allegations were that the victim child had bruising to her buttocks from being spanked by her mother and a caregiver. The agency responded immediately to the referral and met with the victim child, mother, and the caregiver that same day. The agency conducted the initial safety assessment, photos were taken and no injuries were visible. The agency unfounded this investigation on 05/08/2016. Both mother and caretaker denied any use of physical discipline, there were no bruises on the child and no disclosures were made. No services were deemed necessary for the family as the risk was determined to be low.

On September 19, 2016, YCOCYF received a GPS referral regarding the victim child, naming the mother as the alleged perpetrator. The referral alleged that mother was beating the victim child and leaving marks on the victim child, including a "big mark" on her face some time in August of 2016. The agency responded to the allegations that same day and determined the victim child and maternal half sibling were safe after completing the preliminary safety assessment. The mother stated that the victim child had a small scar above her eye due to her half sibling throwing a toy at the child. After conducting interviews with both the mother and father, no safety concerns were noted and the risk was determined to be low. The agency invalidated and closed the referral on 10/19/2016.

Circumstances of Child Near Fatality and Related Case Activity:
On 09/27/16, the near fatality CPS report was received via ChildLine naming the mother and the father's paramour as possible perpetrators of the abuse. The victim child had significant bruising to her face and head. [redacted], certified the report as a near fatality and the victim child was transported to [redacted].

On the day of the incident, the child and her paternal half sibling were in the care of the father's paramour. The father's paramour reported that she woke the child up between 12:00AM and 1:00AM to go to the bathroom and noticed that the victim child had bruising to the front of her head. She called the victim child's mother at around 1:00 AM and told her that the child was acting out and not behaving. The mother then went to the father's paramour's house and noticed the bruises on the victim child's neck and back of the head. The father's paramour told the mother that the victim child fell down the stairs. The mother instructed the father's paramour to take the victim child to the hospital as the mother had to go to work. The father's paramour took the child to [redacted] where the victim child was initially examined before being transferred to [redacted] and admitted to the Pediatric Intensive Care Unit. The victim child disclosed to the referral source that her father's paramour pushed her down the stairs. The mother and the father's paramour were seen discussing the incident which concerned hospital staff which is why mother and father's paramour were initially named as the alleged perpetrators.

On 09/27/16, a GPS referral was opened on the victim child's maternal half sibling due to safety concerns with the mother. A safety plan was completed with the mother regarding the victim child and the maternal half sibling. All contact between the mother and her children would be supervised by a friend of the mother. The agency conducted the verbal clearances on the mother's friend and found her to be appropriate.

A GPS referral was also opened on 09/27/16 regarding the victim child's paternal half sibling due to his mother being named as an alleged perpetrator. The victim child's paternal half sibling was placed in foster care since his mother could not identify a viable person to assure safety.

On 09/27/2016, the victim child's mother was interviewed by a York City Police Detective and a YCOCYF caseworker. The mother sated that at 1:00AM, the father's paramour called her to say that the victim child was acting out. The mother said that she went to the father's paramour's home and found the victim child on the floor. The mother stated that she tapped the victim child on the arm and that is when she saw the bruising to the victim child's head and neck. The mother said that the father's paramour told her that the victim child fell down the stairs. The mother said that she told the father's paramour to take the victim child to the hospital while the mother went to work. The other said that she was later called and asked to come to the hospital. The mother stated that she received a text from the father's paramour admitting that she had hit the victim child. The [redacted] informed the mother that she would not be criminally charged. YCOCYF put a safety plan in place that was mentioned above to allow for more time to gather additional information regarding the allegations.

The [redacted] interviewed the father's paramour on 09/27/2016. The father's paramour admitted that she was responsible for the victim child's injuries and gave in detail, the events leading up to the victim child's injuries. The father's paramour said that she shoved the victim child in the face and onto the floor. She then lifted the victim child up, hit her head on the doorknob and dropped her onto the floor and threw her again. The father's paramour stated that this was due to the victim child wetting her pants.

During the investigation, it was learned that the father's paramour's friend was at the home at the time of the incident. The interview with the father's paramour's friend occurred on 11/01/2016 with the police and agency personnel. The father's paramour's friend admitted that she was present at the time of the incident and watched the father's paramour physically abuse the victim child multiple times throughout the course of that afternoon and evening.

At the conclusion of the investigation; it was determined that both the father's paramour and the father's paramour's friend were responsible for the victim child's injuries. On 11/07/2016, YCOCYF indicated the father's paramour for physical abuse for causing bodily injury to a child and the father's paramour's friend for not intervening and failing to protect a child.

The father's paramour was criminally charged with aggravated assault, aggravated assault of a victim less than 6 years old, endangering the welfare of a child and obstruction. On 12/03/2016, the father's paramour was released on bond and is awaiting a trial which is expected to begin in the summer of 2017. As of the writing of this report, the father's paramour's friend has not been criminally charged.

The victim child remained hospitalized from 09/27/2016, until 09/30/2016. The victim child's discharge diagnosis was large cephalohematoma with bruising over face, eyes, ears, hands, fingers, shoulders, neck and soft tissue swelling involving the scalp. She was discharged to the care of her mother with an approved safety plan completed by YCOCYF. The victim child continued to have brain scans to monitor healing. The victim child was seen at [redacted] Hospital on 10/28/16 for follow-

up care. It was reported that the victim child was healing normally and there were no signs of infections or complications. There was no [redacted].

The agency determined that the mother did not play a role in the injuries to the victim child. The conclusion of the agency's safety assessment concluded that both the victim child and her maternal half sibling were safe. The mother appeared appropriately concerned throughout the investigation for the victim child. The mother did share that she has struggled with appropriate parenting decisions and admits to allowing others to care for her children. The case was accepted for ongoing services to assist the mother with obtaining parenting skills and to help the victim child deal with the trauma of the abuse.

The agency received information that the mother had sent and received text messages stating that she had been physically abusive towards the victim child regarding this incident. This led to a CPS investigation regarding the victim child as well as a GPS investigation on the maternal half sibling. These referrals were made on 11/16/2016. The agency unfounded the CPS investigation due to the fact that the police and agency had already questioned the mother regarding these text messages and there was no validity that the text messages were true. The GPS investigation was invalidated.

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 quick collaboration between the CYF Agency and the local police department to interview both mother and father's paramour regarding the allegations.

  The CYF caseworker proceeded with a safety plan, even though mother was no longer a suspect in the current abuse. Due to previous involvement, it was in the best interest of the child's and sibling's safety to initially proceed with a safety plan of no unsupervised contact with mother.

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

  None reported.

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

  Assessing the children for [redacted], as well as [redacted] for the victim child

- 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.

  Recommendations for the community include improved child care available to parents. Mother was using her limited support system for child care due to her working hours. More options for child care available to mom may have assisted her in finding a more appropriate caretaker.

  A second recommendation included more parenting support available in the community for young parents. An improved understanding of child development and expectations may have given the perpetrator other ways to discipline the child when she was not meeting the requests of the perpetrator.

Department Review of County Internal Report:

The YCOCYF Child Death Review Team held an Act 33 meeting on 10/25/2016 at York Hospital where medical information and case history were presented. The county report of the Act 33 meeting was received by the CRO on 01/17/2017. On 01/18/2017, the CRO sent correspondence to YCOCYF via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

County Strengths:

- YCOCYF responded to the referral immediately.
- YCOCYF conducted joint interviews with Law Enforcement and communicated well with each other.
- YCOCYF continued with a safety plan for the mother to allow more time to fully assess the case.
- YCOCYF Act 33 meeting was well represented by county personnel, medical providers, and law enforcement. The meeting was very thorough and the county seemed receptive to suggestions made by others.

County Weaknesses: and

None noted

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

None noted

Department of Human Services Recommendations:

DHS recommends that YCOCYF continue their current Act33 protocol and processes so timely investigations continue to occur.