pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/03/2017
Date of Incident: 12/07/2017
Date of Report to ChildLine: 12/07/2017
CWIS Referral ID: [redacted]

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

Monroe County Children and Youth Services

REPORT FINALIZED ON:
06/11/2018

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.

Monroe 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 01/03/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	09/03/2017
	Biological Mother	[redacted]/1997
	Biological Father	[redacted]/1993
	Half-sibling	[redacted]/2014
	Maternal Grandmother	[redacted]/1980
	Maternal Uncle	[redacted]/2003
	Father of Half-Sibling	[redacted]/1994

* 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 of Children, Youth and Families (NERO) obtained and reviewed all case records pertaining to the [redacted] family. NERO staff participated in the Act 33 meeting that occurred on 01/03/2018. Law enforcement, county caseworker, and county supervisor were also present at this meeting and provided information regarding their investigation.

Summary of circumstances prior to Incident:

The family was known to Monroe County Children and Youth Services (MCCYS) as a child abuse investigation had been completed on 11/28/2017 in response to a report received on 10/19/2017 that the victim child was being treated at the emergency room (ER) for a [redacted]. During that investigation, the father reported that he may have been a little rough with the child when changing his

diaper. The [redacted] reported that it was possible that the injury could have occurred accidentally. Based on this finding, the incident was unfounded and the case was closed with the agency at that time.

In June 2016, the agency completed a general protective services assessment in response to a report alleging parental drug abuse and inadequate supervision. The allegations were determined to be invalid and the case was closed. The mother and father were also known to the agency as children.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/07/2017, MCCYS initiated a child abuse investigation in response to receipt of a Child Protective Services report stating that the victim child came into the hospital with bloody stools and was admitted for anemia. The victim child was found to have fractures to both arms, both legs and ribs as well as blood in his lung. Only one of the [redacted] was present when the child presented for [redacted] in October 2017. The parents were unable to provide any explanation for the injuries and the father was identified as the alleged perpetrator as he was the primary caretaker for the child.

MCCYS responded to the family home to ensure safety of the half sibling of the victim child. It was learned that the half sibling was in the care of his father. MCCYS spoke with the [redacted] who reported that the victim child had been vomiting the prior three to four days and seemed lethargic for the prior two days. She also reported that she was aware of the reason for MCCYS involvement and that she would not allow the father of the victim child to return to her home.

MCCYS then responded to [redacted] on 12/07/2017. Upon arrival at the hospital, caseworkers learned that the father had been escorted off of hospital property by security as he had become aggressive after hearing about the injuries. It was reported by hospital staff that the father made statements that he didn't squeeze the victim child or hold his legs down. MCCYS was able to interview the mother at the hospital. She reported that she took the victim child to the hospital one week prior on 11/29/2017, due to vomiting and the victim child was diagnosed with congestion and dehydration. She reported that the victim child was discharged and they were directed to follow-up with the pediatrician which they did on 12/01/2017. The mother reported that the victim child began to eat again but then on 12/05/2017, he had a decreased appetite and began vomiting. The victim child was then taken to [redacted] on 12/06/2017. The mother reported that the victim child has a history of vomiting and had previously been diagnosed with Gastroesophageal Reflux Disorder (GERD) for which he was treated with Zantac. The mother also reported that the victim child had allergies to milk, soy, and formula with iron.

The [redacted] reported that the father is the primary caregiver for the victim child while she is at work but once she returns home, she is the primary caregiver. The [redacted] was asked to explain the injuries to the victim child. She reported that she

never saw any signs of abuse. She denied causing the injuries. When asked about domestic violence, the [redacted] reported that the father gets frustrated easily, gets mad, hits stuff, and blacks out. The [redacted] denied ever seeing the father mad at the victim child. The [redacted] also reported that she was upset when she found out about the injuries to the victim child, but that the father did not appear shocked or upset. The [redacted] was then asked about the prior injury to the victim child. The [redacted] reported that the father never told her about the injury. She reported that she had returned home from work and noticed the victim child's arm was limp when she went to pick him up. The [redacted] reported that the father apologized and told her that if he did do something to the victim child then it was an accident when he was trying to put on the victim child's coat. The [redacted] reported that the doctor at the hospital believed the father's story and deemed the injury accidental.

MCCYS determined that the victim child was not safe in the care of the mother and father and filed a shelter care petition. The victim child's half-sibling was in the care of his biological father at the time the agency responded. The half-sibling remained in the care of his biological father who has filed for custody of the half-sibling. The victim child was released from the hospital on 12/11/2017 and placed in [redacted].

On 12/12/2017, MCCYS conducted interviews with the maternal uncle. The maternal uncle denied witnessing any incidents of abuse or maltreatment.

On 12/13/2017, MCCYS learned that the mother filed for a [redacted] on behalf of victim child. It was also learned on this date, that the father had been interviewed by law enforcement and admitted to causing the injuries to the victim child but maintained that the injuries were accidental. On 12/14/2017, the half-sibling was seen at the [redacted] for a medical exam. A full skeletal exam was completed with no evidence of any injuries noted. On 12/27/2017, the half-sibling returned to the [redacted] for a forensic interview and disclosed no incidents of abuse.

MCCYS interviewed the father on 12/19/2017. The father reported that he was the primary caregiver for the victim child while the mother was at work. The father reported that the prior injury to the victim child was accidentally caused when he grabbed the victim child's shirt to take it off and grabbed the sleeves, possibly pulling too hard. The father admitted to a prior incident of domestic violence involving the mother when she was pregnant with the victim child. He reported that he had been drinking, blacked out, and punched the mother in the stomach. The father reported that he was supposed to follow-up with [redacted] after the incident but that he did not. He reported that he gets angry easily. When asked how the victim child sustained his injuries, the father stated that he had already met with law enforcement and told them that he caused the injuries but that they were accidental. When asked to explain, the father reported that the injured ribs were from him holding the victim child and having to squeeze him when the father bends down to get the bottle or pacifier. He reported that the leg injuries may have been from pulling the victim child too hard out of the sling

carrier and that sometimes when pulling the child out of the carrier, his feet would get stuck.

The father was arrested on 01/05/2018 and charged with aggravated assault, simple assault and endangering the welfare of children. The report was indicated on 01/11/2018 for causing serious bodily injury to the victim child. The father was named the perpetrator. Consult with medical professionals revealed that it was possible that the mother did not know the severity and extent of the victim child's injuries as the victim child had no visible physical injuries. Further, the mother had taken the victim child for medical care repeatedly as outlined in this report.

The victim child remains [redacted]. His injuries have healed and require no further follow up medical care at this time. The victim child has been referred for [redacted] and receives weekly physical therapy. The mother is engaging in [redacted] and visits weekly with the victim child supervised at MCCYS. The half-sibling of the victim child remains in the custody of this father. The mother also has supervised visits with this child.

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, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;

  CYS and Law enforcement responded timely and ensured safety of the children. Law enforcement and CYS remain in contact and share information as needed.

- 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;

  Initial hospital didn't make referral to ChildLine when child was seen on 12/6/2017. CYS needs to ensure that CY 104's are sent to Law Enforcement so that detectives can follow up after patrolmen have initially responded. A CY 104 was not sent on the previous CPS investigation in October 2017; however, Law Enforcement was at the hospital at the time of the incident being referred with CYS.

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

  MCCYS and CAC Director will reach out to local hospitals to discuss need for pediatric radiologists to review x-rays on nonverbal children.

  The county is recommended to get a second opinion on serious injuries of nonverbal children.

CYS to make sure they are reviewing all prior records to gain case history and are asking more specific questions during their interviews with parents regarding the six domains of safety assessment.

Conduct additional mandating reporting training with local hospitals to ensure that reports are being made.

The Monroe County Child Advocacy Center's Director will work with local medical providers around mandating reporting concerns.

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

  None

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

  None

Department Review of County Internal Report:

The county review team report was received by NERO on 02/20/2018. The Department concurs with the findings and recommendations of the county review team.

Department of Human Services Findings:

- County Strengths:
  - MCCYS and law enforcement completed a joint and thorough investigation in response to the December 2017 report.
  - MCCYS and the community review team were able to identify areas for practice improvement in investigations completed by both law enforcement and the county child welfare agency.
  - MCCYS quickly implemented policy and practice changes that they felt would be beneficial in ensuring child safety and responding to family service needs in future investigations.

- County Weaknesses:
  - MCCYS and law enforcement relied on the medical opinion of an ER physician stating that the October 2017 incident could have been accidental. This was a verbal opinion provided at the time of the ER visit. The ER physician was not known to have expertise in child maltreatment and this determination was made prior to any interviews conducted with household members. MCCYS has since implemented a

policy requiring a second medical opinion in cases involving serious physical injuries.
  - All appropriate law enforcement parties were not involved in the October 2017 investigation.
  - MCCYS had difficulty determining what information could be provided to the parent of the sibling of the victim child.
  - Review of the case record reveals that intake staff may be in need of additional training and guidance regarding how to complete investigations and assessments in households involving multiple family units.
- MCCYS has identified a need for guidance from the Department regarding what information can and should be provided to a parent of a sibling of an identified victim child in an investigation when the child of the parent resides in the household where the abuse incident occurred. Therefore it is recommended that the county prepare a policy clarification to address this issue.
- In response to the county's concern that county detectives were not provided timely notification by MCCYS or patrol officers during the October 2017 investigation, it is recommended that the county's multidisciplinary investigative protocol should be reviewed, amended if appropriate, and distributed to all county child welfare and law enforcement staff.
- In response to concerns identified in the county report regarding notification to law enforcement and consultation with medical experts, it is recommended that MCCYS ensure that an internal review process is developed and implemented to assess compliance with CPS investigation requirements and best practice as well as compliance with the county multidisciplinary investigative protocol.
- Medical staff at the facility that first provided medical treatment to the victim child failed to make a report of suspected abuse. It is recommended that the concerns identified in the county review team meeting regarding hospital staff actions in the Act 33 meeting be addressed by county law enforcement staff with hospital administration.

- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>
The case file was reviewed during the agency's annual licensing inspection. Citations were issued and included in the annual licensing inspection summary for non-compliance with 3130.68, 3130.67, 3460.55, CPSL 6368, and 3490.58. These citations were issued for non-compliance with requirements associated with notification to parents at the time of a child's placement, provision of visitation to parents, taking of photographic

identification during the investigation, and verbal and written notification to subjects of the investigation.

Department of Human Services Recommendations:

- County child welfare and law enforcement agencies need to ensure that medical professionals providing a medical opinion regarding the mechanism of an injury are provided with all available information and reports. It is also recommended that counties secure a written medical opinion when investigating reports of serious physical injury and ensure the medical professional is qualified to provide the opinion requested.