



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF**



**Date of Birth: 09/20/1995**  
**Date of Near Fatality Incident: 12/06/2011**

**FAMILY KNOWN TO:**  
York County Children & Youth Services

Date of Report: June 12, 2012

**Reason for Review**

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated, or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. York County has convened a review team in accordance with Act 33 of 2008 related to this report. The team meeting was held on January 5, 2012.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	09/20/1995
[REDACTED]	Mother	[REDACTED] 1961
[REDACTED]	Father	[REDACTED] 2951
[REDACTED]	Sister	[REDACTED] 1991

**Notification of Fatality/Near Fatality**

The child has [REDACTED]. On December 1, 2011, the child was seen by her primary care physician (PCP). The child was diagnosed with a [REDACTED] [REDACTED] and the child was referred for a chest x-ray. The PCP never received x-ray results and called mother on December 5, 2011 to follow up. Mother said the child was fine and the [REDACTED] [REDACTED] was filled but never picked up. The child's condition worsened and mother took her to the hospital on December 6, 2011 in [REDACTED]. The child was transferred to Hershey Medical Center and [REDACTED]. The child was admitted to Hershey Medical Center [REDACTED] on December 6, 2011. The report was [REDACTED] [REDACTED]

The child was [REDACTED] on December 8, 2011. [REDACTED]

[REDACTED] On admission, the child was very dirty and her toenails and fingernails were very long. There were feces under her nails. Nurses said they never saw a child so poorly cared for. The child had a rash in the folds of her neck and groin. A doctor at Hershey Medical Center stated that the child was in critical condition based on suspected neglect at the time of her admission.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Central Regional office reviewed the entire child and family file maintained by York County Children & Youth Services, attended the Act 33 Multi-disciplinary team meeting held on January 5, 2012, interviewed the investigating and ongoing York CYS caseworkers and reviewed the child's medical and educational files.

**Summary of Services to the Family**

**Children and Youth involvement prior to Incident:**

**June 2, 1996:** Referral regarding Victim Child, who was 9 months old and was left in a vehicle while mother and older sister were in the [REDACTED] store for at least 30 minutes. [REDACTED] was completed and children were determined to be safe, although both the police and CYS worker believed that mother left child in the car on other occasions. Parents were living together at the time and both were employed. They denied drug and alcohol issues and described themselves as "easy-going." Housing conditions were not an issue. Safety and risk were comprehensively assessed using the Child At Risk Field System (CARF), a tool that was utilized by the county at that time. The case was closed at the conclusion of the investigation on July 10, 1996.

**March 26, 2007:** Referral [REDACTED] and found marijuana and prescription medication in the possession of parents and sister, then age 15. Sister was removed from the home. Both parents and Sister were charged with drug-related offenses. Both parents had [REDACTED]. Father was [REDACTED]. Both parents admitted smoking marijuana daily, which they did not believe was "serious." They described themselves as "a product of the 60's." Parents lived in the same house but slept separately due to father's back pain.

Following a stay at Children's Home of York (CHOY) Shelter from March 26, 2007 through May 15, 2007, the sister went to a [REDACTED] from May 15, 2007 through August 1, 2007.

The service plan included the sister and parents cooperating with any [REDACTED] and being available for announced and unannounced visits to the home by the caseworker.

The sister was [REDACTED] and participated in [REDACTED], then weekly [REDACTED]. At one point, father and sister expressed concern about mother's continued drinking. It is not clear how/whether this was addressed.

**Circumstances of child's near fatality and related case activity:**

**INVESTIGATION:**

[REDACTED]. She had failed to follow through on a recommended x-ray and did not promptly fill a prescription after the victim child was seen by the doctor on December 1, 2011. York County Children and Youth [REDACTED] on January 13, 2012. The agency interviewed all family members, requested and reviewed medical and school records and verified the parents' follow-through on the doctor's recommendations.

At the Act 33 review team meeting, the [REDACTED] on the team stated his clear opinion that the child's condition was not likely due to ongoing neglect. He stated that children with [REDACTED] are more susceptible to respiratory infections and more likely to go into respiratory failure than [REDACTED] population. The [REDACTED] is very commonly seen in people when they are ill, and not indicative of malnutrition. In regard to the [REDACTED], he stated that this is also common among persons with [REDACTED]. It is possible to develop this [REDACTED] over a period of a few days. The doctor believed that the [REDACTED] as well. Non-compliance with medication and doctor's orders is also not uncommon and mother's failure to obtain the recommended x-ray was not alarming in itself. The mother explained that the child normally is bathed daily but did not have baths in the week prior to her hospitalization because she was ill and not attending school. The [REDACTED] likely developed during that time period.

A detective who responded to this report (and previous incidents) stated that he observed mother to have either [REDACTED] or [REDACTED]. She responded as [REDACTED] when her daughter was hospitalized but a day later was very cooperative and told the CYS caseworker that this report was "my cry for help." She described being [REDACTED] when her husband left in May 2011 but has no other formal history of [REDACTED].

**Current/most recent status of case:**

The parents have been married for 23 years. In recent years, they remained in the same household but were "separated." In May 2011, father left the household when mother had a new boyfriend. Father moved to Harrisburg and 20 year old sister went to live there with him. Neither mother nor father is employed. Both attend classes at Harrisburg Area Community College (HACC). Father is in a Human Services track and is doing a field placement at a D&A Rehab facility. The sister was on probation on drug-related charges and was recently incarcerated for failure to comply [REDACTED].

When the victim child was hospitalized, the mother described it as "a wake-up call." She admitted to providing a fast food diet to her daughter. She bathes the victim child but was "not comfortable looking down there" and was not scrupulous about assuring that her genital area was clean and dry. The victim child did wear adult diapers but threw them around the house, so mother discontinued the diapers and "just kept after her" to

use the bathroom. There were no support services in place for the victim child at the time of the present referral.

Law enforcement does not plan to take any action. A nutrition consultation was recommended for [REDACTED] as well as other support services to assist parents in the daily care of their daughter. The father returned to the home in December, 2011 and assists with the victim child's care. The family has been accepted for ongoing in-home services. The caseworker facilitated the referral for home health care and visits with the family monthly to assure that other [REDACTED] [REDACTED] are in place. The PCP verified that the child was free of respiratory problems, infections and rashes at a visit in early January. Testing for illegal drugs was negative for both parents and the adult sister living in the home.

As of the writing of this report, [REDACTED] assists the family three days/week for four hours/visit. Both parents are enthusiastic about this support and state that they are enjoying their daughter more since the struggles with bathing and personal care are diminished. The parents have made an effort to improve the child's diet and since her hospitalization, she has lost 30-40 pounds. [REDACTED]  
[REDACTED]

**County strengths and deficiencies as identified by the County's near-fatality report:**

**County Strengths:**

The county's near-fatality report was completed on January 24, 2012. There were no specific strengths identified.

**County Weaknesses:**

None identified.

**County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:**

As a result of the review, it was identified that there is a need for medical providers, treating children and youth diagnosed with [REDACTED], to be aware of and educated on the special medical and health issues that these patients may be prone to.

**Department of Public Welfare Findings:**

**County Strengths:**

- The county completed internal case review and near fatality report in a timely manner.
- [REDACTED] was established promptly and is effective in improving the child's medical condition and relieving the stress of care giving for both parents.

**County Weaknesses:**

- During the 1½ years in 2007-2008 that services were provided to the family, the focus was on the older sister. There is minimal mention of the victim child in the case notes. She is assessed as "safe" in safety assessment tools but there is no detail of her care, condition, or the impact of parent's [REDACTED] on the victim child's care. No collateral contacts were made with the school or other service providers regarding the victim child.
- The multi-disciplinary team did not include anyone representing services to persons with [REDACTED], school personnel, or [REDACTED] professionals, all disciplines that would have insight and knowledge of resources pertinent to the family
- Case management and other services from the [REDACTED] office have been delayed due to testing/[REDACTED] barriers

**Statutory and Regulatory Compliance Issues:**

None