



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF



BORN: 06/07/09

Date of incident: 04/23/12

Date of Oral Report: 04/25/12

Report Finalized: 03/28/13

The family was known to Cumberland County Children and Youth Services

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law. (23 Pa. C.S. 6349 (b))

Department of Public Welfare/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dpw.state.pa.us

Reason for Review:

Senate Bill No. 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the report was registered with ChildLine for investigation.

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. Cumberland County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	victim child	06/07/09
[REDACTED]	mother	[REDACTED]/90
[REDACTED]	sibling	[REDACTED]/08
[REDACTED]	sibling	[REDACTED]/10
[REDACTED]	paramour of parent	[REDACTED]/90
[REDACTED]	maternal grandmother	[REDACTED]/66
[REDACTED]	step maternal grandfather	[REDACTED]/64
[REDACTED]	father	[REDACTED]/90
[REDACTED]	father	

*The victim child's father lived in the State of Kansas. It was reported he had limited contact with his children. The father was not in the state during the incident. However, he was notified of the incident. After notification he did eventually return to Pennsylvania to care for his two children.

** [REDACTED] is the father of [REDACTED], after the incident with the victim child, the victim child's sibling, [REDACTED] resided with her father.

Notification of Fatality:

On 04/25/12 Cumberland County Children and Youth Services received a call from a [REDACTED] regarding a child that was admitted to HMC hospital from Holy Spirit Hospital on 04/23/12. At the time of contact the hospital was still looking into results of tests administered to better determine if the child was subjected to an act of child abuse. The medical staff had reason to believe the child may have been subjected to strangulation or suffocation as CT scan found [REDACTED]

[REDACTED] The hospital had reported additional concerns regarding the child's hygiene upon arrival at the hospital. The child presented to be excessively dirty and had a case of [REDACTED]. The Hospital after examining results of further testing and analysis determined the child was certified to be in serious or critical condition as a result of suspected abuse. The report was certified as a near

fatality. HMC contacted ChildLine and the report was registered as a CPS to the county children and youth agency on 04/25/12. The county agency arranged to see the child at the hospital on 04/26/12.

Documents Reviewed and Individuals Interviewed:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case and past referral information records pertaining to the family. Follow up interviews were conducted with the agency caseworker [REDACTED]

[REDACTED] 04/26/12, 05/01/12, 06/22/12.

The regional office participated in the County Internal Near Fatality Review Team meeting on 05/16/12.

Summary of Services to Family:

Previous Children and Youth Involvement:

The agency did have limited involvement with the family. The county agency received a [REDACTED] referral on 04/21/11. It was reported that the conditions of the home the mother and her children were residing in were filthy and the children were not receiving the basic care needed. A county agency worker conducted an unannounced home visit on 04/23/11. The unscheduled home visit determined that the conditions of the home were not in good standing as there were piles of trash bags in the home. One of the children was unclothed upon arrival and standing in a window. The children presented to be dirty. The bedding for the children had what appeared to be feces stains on either the sheets or just the mattress depending on which bedding is being referenced. The caseworker observed similar stains in the carpet and walls. The case record indicated the home was extremely cluttered with debris. The county agency contacted local law enforcement to help provide assistance for the worker while at the home. It was decided the children would stay with a relative; the children went to stay with a maternal great grandmother until the conditions of the home improved. A safety plan was developed on 04/23/11, all parties signed the plan. The conditions of the home did improve. The improvement was observed by the agency worker conducting visits to the home. The county agency closed the referral in June 2011. The family did not provide much cooperation and did not request county agency services. The agency did not open the family for services. The county agency did not have further involvement with the family until notification of the near fatality on 04/25/12.

Circumstances of Child's Fatality:

The child's mother initially reported that when the child awoke on the morning of 04/23/12 the child was not acting normal, and described the child's demeanor as being not as playful as normal. The child was described as having a tired affect. The child did continue a normal daily routine. The child had several episodes of

████████ around 1:00 pm and collapsed in the home at which time the child reportedly went into a state of being unresponsive yet still awake. Household members contacted emergency response (911), an ambulance arrived at the residence and the child was transported to Holy Spirit Hospital, and treated by medical staff. The child's condition was able to be stabilized and the child was transported to HMC for further treatment and testing on 4/23/12. A CT scan was completed on the child. The results of the scan indicated the child had ██████████. It was determined by a medical professional that in order to receive this particular condition the child would have been subjected to ██████████. The child did not have any other significant injuries. However, the medical professional determined that if the child had not been ██████████ by the Holy Spirit Hospital the child would not have survived the incident. It should be referenced that during the time of the incident the mother was staying in the home of a maternal uncle to the victim child.

The case record review indicated the mother's residency lacked stability as it appears to be often changing from various family members or friends. On 04/25/12 the county children and youth agency received a numbered child abuse report on the victim child pertaining to the incident which required medical attention. The medical staff from HMC registered the report as a near fatality. According to medical records if the child was not ██████████ at Holy Spirit Hospital the child would not have survived the incident. The results of the medical procedures and testing determined the child had ██████████. The finding correlates to having been suffocated or strangled. The testing found no other substantial injuries to the child. The injury was allegedly a result of abuse or non-accidental trauma. The hospital staff also reported that the child's hygiene was exceedingly dirty. The child was reported to have a case of ██████████. The medical staff notes also referenced that the mother was in dirty clothing and presented as ██████████. The hospital staff had additional concern of possible substance abuse in the home as the victim child's mother's paramour mentioned to hospital staff that if anyone in the home was utilizing drugs it would be cleaned up so the children could not get into the substance. The county children and youth agency staff went to the hospital on 04/26/12 to discuss the circumstances of the report with the mother and to assess the victim child along with sibling's safety. The caseworker and detectives from the local police department interviewed the child's mother and paramour at the hospital. During the interview process the mother's paramour referenced that there was a short period of time when he was with the children by himself as the child's mother went to a neighbor's home to make cool aid. The mother's paramour recalled having played a game with the victim child with a pillow. The game was described as a pillow fight but there was a brief time period where he would place a pillow over the child's face / airway. The paramour did not have reason to believe this interaction was hurtful to the child.

The county agency assessed the victim child and the siblings' safety. A safety plan was developed the same day ensuring the children have no contact with the paramour [REDACTED]. A family resource was identified to help ensure the safety plan would be followed. The maternal grandparents of the victim child were the supervising resource placed on the plan. The county children and youth agency went to the home to ensure the residence was a safe resource for the children and background clearances were done on the grandparents. There were no injuries to the victim child's siblings. The victim child was released from the hospital on 04/30/12. The child's mother would be able to reside with her children however the maternal grandparents would be providing supervision during the investigation. The county children and youth agency completed the Child Protective Service (CPS) investigation on 06/22/12 and indicated the mother's paramour for physical abuse for suffocation of the child. Since the mother was out of the home for the short period of time when the incident most likely occurred she was not indicated in the agency's investigation. Law enforcement is currently not pursuing charges to any parties associated with the incident. The children's mother reportedly met the paramour approximately two weeks prior to the incident. The paramour recently was released from prison; the mother knew the paramour as they were childhood acquaintances. Law enforcement did not pursue charges as they questioned [REDACTED] intellect or capacity for understanding the nature of the investigation. He is of low intellectual functioning. He attempted to take a polygraph but was unable to finish as his understanding for the process and questioning of events (timeline) was sporadic. The results of the testing could not determine anything conclusive.

Current Case Status:

The county children and youth agency did indicate the mother's paramour for abuse of the victim child. The county agency continued to have the case open for in-home services. The county was assessing the mother's needs and helping her work on areas to help increase parental capacity. During this time period the children were staying in the care of the maternal grandparents under conditions of a safety plan. The county agency became in touch with both sets of biological fathers of the children. They were responsive and willing to take on a more active role in the lives of their children and both worked with the county agency to become the full time resource from their children. [REDACTED], the father of [REDACTED] traveled back to the Pennsylvania. He now resides in Pennsylvania and has been granted custody of his children. The father of the children's sibling, [REDACTED], has custody of his child and she resides with her father currently. The children's mother at the time of agency case closure has experienced difficulty with maintaining stable housing of her own. The maternal grandparents who were providing a role of supervision for the children were in agreement with the children residing with their fathers and still have a role in the children's lives. In review of the case notes the children's mother still maintains contact with her children however arrangements go through both fathers as they have sole custody of the children.

County Strengths and Deficiencies as Identified by the County's Fatality Report:

The agency did not outline specifics within the report. The agency responded immediately to the report of the child near fatality. Hospital personnel reported the incident in a timely manner. The agency followed protocol for CPS investigations. Collaboration between hospital staff, local police, and the county agency was positive. Medical records were essential in providing the county agency with the evidence needed for reaching determination for incident to be indicated for child abuse.

County Recommendations for changes at the Local Levels as identified by Fatality Report:

The county's report did not reference any specific recommendations for change at the local level nor was there reference to any systemic issues pertaining to the case.

Recommendations for changes at the State Level:

The county's report did not reference any specific recommendations for change at the State Level.

Department Review of County Internal Report:

The Department received the county report on May 29th 2012. Participation in the county agency's internal child fatality review meeting along with review of the information in the case record, the department found the report to be accurate.

Department of Public Welfare Findings:

County Strengths:

The county was able to respond immediately to the report when received. The agency developed a safety plan. The victim child and siblings were seen and their safety was assessed the same day as the report of the child near fatality. The county attempted to engage the family and offered services to the family. The county was willing to have the children reside in the least restrictive placement setting as possible yet the setting was able to promote and foster the children's safety and well being. In addition this is a case in which the county engaged biological fathers of the children and help with arrangements and support to have both fathers become the full time resources for the children.

County Weaknesses:

The Departmental review did not pinpoint any weakness with the county agency's handling of this case. At the time of incident the county agency was not providing services to the family nor did the family contact the agency seeking intervention.

Statutory and Regulatory Compliance issues:

Review of the county investigation and case file found no areas of non-compliance both in the area of the GPS received in April 2011 and the CPS received in April of 2012.

Department of Public Welfare Recommendations:

The Department does not reference any particular recommendations for this reported case.