



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## REPORT ON THE NEAR FATALITY OF:



**Date of Birth:** 5/13/09  
**Date of Near Fatality:** 9/23/12  
**Date of Oral Report:** 9/23/12

### FAMILY KNOWN TO:

Lancaster County Children and Youth Agency

### REPORT FINALIZED ON:

7-12-13

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))

**Reason for Review**

Senate Bill 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 date 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. Lancaster County has convened a review team in accordance with Act 33 of 2008 related to this report. Team meeting was held on October.10, 2012.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	05/13/2009
[REDACTED]	Mother	[REDACTED] 1985
[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Sister	[REDACTED] 2010
[REDACTED]	Brother	[REDACTED] 2011
[REDACTED]	Foster Mother	[REDACTED] 1990
[REDACTED]	Foster Father	[REDACTED] 1989

**Notification of Near Fatality**

Lancaster County CYA was contacted on 9/23/12 by [REDACTED] to indicate that the Victim Child had been brought to the hospital unresponsive and was being transported to the Hershey Medical Center. At Hershey Medical Center, the child was certified to be in critical condition due to suspected [REDACTED]. This was processed through [REDACTED] and assigned to the Central Region Office of Children, Youth, and Families for investigation, as the alleged incident occurred in an agency foster home.

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

- Reviewed entire Children and Youth case file
- Reviewed medical records from a variety of sources
- Reviewed Law Enforcement interview reports
- Interviewed Placement Services Caseworker, Supervisor
- Attended Act 33 Near-fatality team meeting

**Summary of Services to the Family**

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

Lancaster County CYA became aware of the Victim Child and her biological family in February 2011 when the mother was unable to secure stable housing for her family. She had received [REDACTED], but was still not able to maintain a stable home for her children. The agency opened the mother for in-home services in April 2011 to aid her in finding stable housing and addressing any needs of her children. The

mother and children moved in with the maternal grandmother, where they remained until May 25, 2011 when the maternal grandmother evicted them due to overcrowding in the home. The agency was unable to locate the mother and children until June 2, 2011, when it was learned that the mother had left her children with an aunt in York County.

[REDACTED]. On June 30, 2011, the [REDACTED] contacted the agency to state that she could no longer care for them. The two girls were placed into a Church of the Brethren Youth Service (COBYS) foster home on July 1, 2011. This home was unable to provide care for a third child, so the infant was placed in the home of [REDACTED] on July 3, 2011 after his medical concerns had been resolved. The foster parents were made aware of each other and the importance of establishing a connection between the siblings.

The father of the children was in and out of prison for [REDACTED] charges during agency involvement. He opted not to work on an agency plan, indicating that he wanted the mother to complete her goals and have the children returned.

The mother of the children had been unable to secure stable housing and continued to live with others who had extensive criminal history. She was also not attending visits with the children on a regular basis. The agency changed the permanency goal to adoption for the children on March 12, 2012, [REDACTED]. The foster home caring for the girls did not consider themselves to be a permanent resource for the children at that time so the agency began to transition the girls to the [REDACTED] foster home. There was a month of pre-placement visits that occurred before the girls moved to the home on June 1, 2012. They remained in this home up until the time of incident.

There was no previous agency involvement for the foster parents.

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

The Victim Child was brought to the Reading Hospital unresponsive on September 23, 2012. The child had a [REDACTED] and [REDACTED]. The child also had bruising on her buttocks and abdomen/vaginal area. The foster parents stated that the child had been vomiting on Friday and Saturday, and that night had fallen backward unresponsive when being dressed. The child was [REDACTED] to Hershey Medical Center. At Hershey Medical Center, the child was diagnosed with [REDACTED]. The child was [REDACTED]. The Victim Child was certified to be in critical condition by Dr. [REDACTED] and the ChildSafe Team from Hershey Medical Center. According to Dr. [REDACTED], this child was expected to survive but she would be [REDACTED].

During a police interview, the foster father admitted to punching the child in the head. He stated that he became frustrated with the Victim Child on Friday night at dinner when she refused to eat. The child then vomited and he roughly removed her from the table and placed her in the shower. He then roughly towed her off, and carried her up the stairs, hitting her head off of the door frame. The Victim Child was then not cooperating with putting on clothes, so the foster father admitted to punching her in the head with a closed fist. The Victim Child was whimpering but not crying. The child was then sick on Saturday and Sunday. At dinner on Sunday, the Victim Child vomited again and immediately went to get in the shower. The

foster father believes that the child also may have fallen in the bathtub. When he was dressing the child, the foster father stated that he forcefully put her shirt over her head and when he let go she fell backward and was unresponsive. He stated that he pinched her upper thighs to make her respond, but this did not work. The foster father denied any sexual contact with the child.

The Foster Mother was interviewed by police on the night of the Foster Father's arrest. She described the Victim Child vomiting on several occasions. She also stated that it was the Foster Father's duty to perform the discipline on the children which would include talking to them. She stated that the Foster Father was upstairs talking to the child for 20 minutes. She did not witness any physical discipline and did not notice any injuries to the child. She was not present in the room when the child became unconscious.

The Foster Father turned himself into the State Police on 09/27/12 with bail being set at \$500,000. The Foster Father's family was initially going to post bail, but when the foster father's attorney learned that the Victim Child could possibly pass away, the foster father remained in prison. He was charged with Aggravated Assault and two counts of Child Endangerment, one for the injuries to the child, and the second for the failure to seek medical treatment immediately.

At the Agency Act 33 meeting on 10/10/12, Dr. [REDACTED] discussed the child's medical condition. She had initially been in a [REDACTED]. She has [REDACTED]

[REDACTED] At that time, she was only experiencing [REDACTED] and responded to pain with contraction of her arms and legs. The child's other organs were doing quite well and remained strong. [REDACTED]. The [REDACTED] felt that her prognosis was poor and she will not have any quality of life, but could live in this state for many years with appropriate medical services. Throughout the next several weeks after this meeting the child did show some progress, being weaned off of [REDACTED]. She responded to touch but was [REDACTED]. Over the Thanksgiving weekend it was reported that she smiled. The medical staff believed that the child can be maintained in a foster home with medical support services.

The Regional Office completed an investigation, filing the CY48 with ChildLine on 11/19/2012. The case was listed as INDICATED. This decision was based on the severity of the Victim Child's injuries and the [REDACTED] confession to the Pennsylvania State Police. [REDACTED] were not interviewed by the Regional Office as their attorney would not provide access.

The resource home of the foster parents was closed by the agency. The two siblings of the victim child remained in a resource home. The Victim Child was still completing services at the [REDACTED] Hospital. Resource homes were being explored for the Victim Child that will be able to address her complex medical needs. The family selected will undergo extensive training by the [REDACTED] Hospital, and [REDACTED] will be provided to aid in the care of the child.

The Foster Father remained incarcerated at the [REDACTED] Prison.

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

The Victim Child was [REDACTED] hospital December 2, 2012. After an

extensive search for a family that could care for this child with her numerous medical needs, the agency contacted the home where the Victim Child had been originally placed through COBYS. This family visited with the child at the hospital and was educated on her medical needs. The family committed to caring for the child and was trained on her daily medical routines. In-home nursing was also provided to the home.

The Victim Child is currently diagnosed with [REDACTED]

The Victim Child receives all of her [REDACTED]. She completed a [REDACTED] and it was recommended that she receive [REDACTED]. She sometimes receives [REDACTED]. She has received [REDACTED] since January 2013 for three times a week. [REDACTED]. The child also receives [REDACTED] three times a week. [REDACTED]

[REDACTED]

The Victim Child is able to smile when people talk to her. There is a concern she has been [REDACTED], often when she turns her head to the left. This is being explored by [REDACTED].

[REDACTED]. The adoption process for the siblings of the Victim Child is moving forward with an expected adoption to occur in the next couple of months. These siblings visit with their sister in her current home, and the two sets of foster parents are committed to this continuing after the adoption. The Victim Child's current home has not committed to adopting the child at this point, but is considering the option. The agency continues to search for a permanent resource simultaneously.

The Foster Father entered a guilty plea on February 15, 2013 for the count of aggravated assault, and the two counts of endangering the welfare of children. He remains incarcerated at the [REDACTED] Prison. A Pre-Sentencing Investigation was ordered by the court and was filed on March 21, 2013. As a part of this investigation, the agency provided a statement regarding the child, her current condition, and the progress that has been made in the foster home. The Sentencing hearing is scheduled for May 24, 2013.

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

- Agency resource parents must undergo a rigorous review which includes background checks, medical exams, questionnaires, 16 hours of training, and understanding of agency policies and procedures.
- This particular agency resource home was pre-adoptive and willing to provide care for sibling groups. The family also had relative and community supports.
- The agency acted immediately and removed the siblings of the victim child. The resource home was also closed.
  - The agency should examine its current practice of placing multiple children with new resource parents, and look at mentorship for these new families.
  - Caseworker visits should be increased during transition times in placements and with new foster parents.
  - There was also concern that this couple had only been married for just over a year and were possibly not experienced enough to be parents to three children.

### **Department Review of County Internal Report:**

Lancaster County CYA submitted an internal report regarding the near fatality incident. This was developed as a result of the Act 33 meeting and contained input shared at that meeting. The report reflects the in-depth discussion at the meeting about the age of the foster parents, their experience fostering sibling groups, and suggestions for the agency to improve supervision with young or new foster parents in the future. The report indicates that the review team did not feel that this incident could have been prevented as the family had received a positive evaluation and there was no indication that the father would act out towards the child as he did. The report was reviewed by the Program Representative for Lancaster CYA and found to be appropriate and acceptable.

### **Department of Public Welfare Findings:**

#### **County Strengths:**

- The county Act 33 Meeting was a comprehensive, multi-disciplinary group that met within the required timeframe. The meeting for this case was well-attended and valuable input was provided by the physicians attending to the child, and community members.
- The agency made excellent efforts to assure that these siblings were placed in a home together.
- Intensive visitation services had been provided to the mother of the children for a period of several months. The mother was given many opportunities to cooperate, and only after the mother did not show for visits several times did the agency seek to reduce these services.
- It was observed that the agency workers rallied around each other in dealing with this difficult situation. Several workers helped to cover the day to day casework of the identified worker while he was monitoring the child in the hospital and communicating with her family.
- The county agency assured that excellent medical care was provided to the victim child, and that the other children were immediately removed from the home and seen by a medical professional.
- Despite the children now being placed in two separate homes, the two younger siblings are able to visit their sister. The foster parents of the children have established a connection and are committed to making sure that the children have contact with each other.

**County Weaknesses:**

- The Foster Father was not present for many of the monthly meetings with the caseworker in the home. His interactions with the children could not be observed on a regular basis.
- When discussing discipline with the foster parents, the agency could have completed a more in-depth assessment of the foster parents' attitudes on physical punishment, stressing the importance of compliance with the discipline policy.

**Statutory and Regulatory Compliance Issues:**

Lancaster County CYA was issued an Inspection Summary with citations pertaining to the agency foster parents and their violation of the discipline policy and failure to seek medical care for the child. The agency submitted a plan of correction indicating that these items would continue to be reviewed with foster parents during orientation and subsequent yearly evaluations and trainings.

**Department of Public Welfare Recommendations:**

The Department supports the suggestions of community members during the Act 33 meeting, indicating that the agency should seek to provide extra support to young and new foster parents, especially if they are agreeing to a large sibling group. It would be beneficial for these new foster parents to have a connection with more experienced foster parents as a means of support.

The review of the agency's files found that, while monthly visits were occurring in the foster home, the Foster Father was often not at the home during these visits. Because of this, it would be hard for the agency to assess the Foster Father's interaction with the children. It is possible that strained interactions could have been observed if they were present in this situation. The agency workers should attempt to make home visits when both parents can be present to obtain an accurate assessment of the placement home.