



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 11/06/08
DATE of Near-Fatality: Between 3/1/09 and 3/11/09

FAMILY KNOWN TO:
Family not known

REPORT FINALIZED: February 2, 2010

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed by Governor Rendell 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 review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	11/06/2008
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	17 years old
[REDACTED]	Maternal grandmother	

Notification of Fatality/Near Fatality

This child was taken to Carlisle Hospital on 4/1/09 by mother, who reported that the child had "seizure activity." Carlisle Hospital determined the child to have a [REDACTED]

The child was transferred to Hershey Medical Center, [REDACTED]

Father, [REDACTED], 17 y.o., and mother [REDACTED], 19 y.o. lived together with their infant son. Father was primary caregiver for the child on March 8,9,10, 2009, while mother was at work. On March 10, mother and father had a dispute during which time it was alleged that the father grabbed the baby by the arm. Mother left the home with the baby, and went to her aunt's house for the night. On March 11, 2009 father returned to his home state of Ohio. He has not returned to PA since. When the mother was questioned about what may have led to the child's condition, the only incident she could think of was the one which occurred between her and the father on 4/1/09.

Documents Reviewed and Individuals Interviewed:

[REDACTED] intake supervisor
[REDACTED] case file
Medical records from Hershey Medical Center

Case Chronology:

On Wednesday, 4/1/09 following the [REDACTED] Emergency Duty CW [REDACTED] & PSP Troopers [REDACTED] met with [REDACTED]

The caseworker and officers met with Mother and saw the child. Mother stated that she and child's father had an argument on 3/10/09, four weeks earlier, during which time father grabbed mother's arms, not the child's arm as described in preliminary and follow-up reports. On April 1, Mother brought child to ER because she believed he'd had a seizure. Child was transported to Hershey Medical Center shortly thereafter. A safety plan was developed stating that the child was being admitted to HMC, and child's contact with all adults would be monitored by the hospital..

Meanwhile, on April 2 & 3, the caseworker spoke a number of times with [REDACTED]

[REDACTED]. These calls related to [REDACTED]

including an MRI. [REDACTED] The brain was normal with normal blood flow. In regard to the reported seizure, [REDACTED] this could be normal in some children. There were absolutely no concerns regarding mother's care of the child. Hershey Medical Center believed that Carlisle Hospital had diagnosed the [REDACTED] in error. [REDACTED] There was not a safety plan at the time of discharge, due to the doctors' conclusion that no injury had occurred.

On Tuesday, 4/7/09, CYs caseworker [REDACTED] met with [REDACTED] and [REDACTED] at their home. She reviewed the [REDACTED] investigation procedures and had mother sign consent for a photograph of the child. A safety plan was signed, requiring that mother "continue to provide for the basic needs of [REDACTED]" Caseworker [REDACTED] completed a PA Model Risk Assessment on April 15, 2009. The overall risk was "Z" - no risk. All of the risk factors for father and paternal grandmother are unknown. Mother and [REDACTED] who had been living in a separate household with [REDACTED], went to live with maternal grandmother. The case was officially closed on April 15, 2009.

Previous CYs involvement:

none

Circumstances of child's near fatality:

Child was transferred from Carlisle Hospital to Hershey Medical Center. [REDACTED] There were no findings of trauma, no findings suggesting abuse, no indication of a [REDACTED] and no medical condition of any kind. There was no evidence of seizures. [REDACTED]

Current/most recent status of case:

[REDACTED] This finding was supported by the fact that the child did not receive a serious physical injury, the child was not in serious pain and the child's everyday activities were not hindered. The criminal investigation was concluded with no prosecution.

Child was [REDACTED] no medical follow up is needed. The father was still back at his family home in Ohio, exact address unknown. Maternal grandmother is a support to the mother. The original safety plan, requiring mother to have supervision whenever with her child, was lifted at the time of child's discharge from hospital.

Police closed their case without any charges when it was determined there was no injury to the child.

Services to children and family:

None offered or provided.

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

County was not required to conduct a fatality review team.

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

County was not required to conduct a fatality review team.

Central Region findings:

STRENGTHS:

The CYs and law enforcement (LEO) worked collaboratively from the time of the report and throughout. Communication was immediate and both CYs and LEO kept each other informed.

[REDACTED] Given that no injury had occurred this served to move the case along quickly and minimized the impact of an investigation on a very frightened young mother.

DEFICIENCIES:

Neither the dictation nor the risk assessment demonstrates a comprehensive assessment of family strengths and risk factors. There is no documentation of any inquiry regarding maternal grandmother with whom mother was living following the baby's hospitalization. Best practice would include a full assessment of strengths and risk factors in the child's living environment despite the hospital's misdiagnosis, [REDACTED].

The Risk Assessment rated "family violence" as "No Risk" despite the initial report that father and mother had argued and he grabbed her arms then left the relationship and moved to Ohio. The caseworker said that domestic violence services were not discussed since parents were no longer living together. The dictation does not indicate that parents' relationship was discussed nor what role father was expected to play, if any, in his child's future. Father was 17, two years younger than Mother, suggesting a possible lack of parenting skills and/or questionable commitment to his child.

Statutory and Regulatory Compliance Issues:

None