pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/29/2016
Date of Incident: 08/08/2017
Date of Oral Report: 08/14/2017
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

01/02/2018

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. 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.

York County Children, Youth and Families (YCCYF) has not convened a review team meeting because they received the report on 08/14/2017, and determined the status of the investigation to be unfounded and submitted the CY 48 to ChildLine on 09/08/2017. Since this determination was made within 30 days of the report to ChildLine an Act 33 review team meeting was not required.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	08/29/2016
	Biological Mother	[redacted]1994
	Biological Father	[redacted]1993
	Sibling	[redacted]2014

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all records pertaining to the family. The Central Region reviewed medical records [redacted] preliminary and conclusive safety assessments, risk assessment, and case notes provided by YCCYF. Central Region staff also had ongoing telephone and email communications regarding this case.

Summary of Circumstances Prior to Incident:

The family had no prior involvement with York County Children, Youth and Families.

Circumstances of Child Near Fatality and Related Case Activity:

On 08/14/2017, the victim child's mother and father took the victim child to Hanover Hospital. The mother reported that on or about 08/08/2017 the victim child was seated in a table top highchair having dinner. The mother stated she was present along with the victim child's father and 3 year old sibling. The victim child pushed himself off the table, falling to the floor. The mother stated she did not see how the victim child landed as she was on the other side of the table. She stated the victim child cried for about 5 minutes. The mother also stated that the victim

child appeared to be fine with the exception of a small mark above his left eye. The mother did take a photograph and contacted the maternal grandmother for guidance. The parents did not seek medical attention at the time of the incident, because the victim child appeared to be fine.

On 08/14/17, the paternal grandmother was babysitting the victim child and his sibling and noticed a bump on the left side of the victim child's head. The paternal grandmother called the mother and father and they took the victim child to the Hanover Emergency Room. It was determined that the victim child had [redacted] The child was transported to Hershey Medical Center after [redacted] was noted.

On 08/14/2017, YCCYF attempted to implement a Safety Plan with the parents, not only for the victim child but because of the risk of maltreatment for the other child in the home. The parents refused to agree to the Safety Plan. This request occurred at the same time the Hershey Medical Center Child Abuse Team determined that the injuries were consistent with the fall from the high chair. It was also determined that the delay in medical care was not medical neglect. [redacted] Both parents and the sibling were present and attentive during the victim child's hospitalization. The parents stated they would be cooperative with the agency but denied causing any harm to their child.

On 08/16/2017, the victim child [redacted] into his parents care. On 08/17/2017, YCCYF made a home visit and found no areas of concern.

The [redacted] Police Department found no areas of concern and closed their case with no charges being filed.

On 09/08/2017, YCCYF submitted the CY 48 as unfounded against both parents and closed the case.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

An Act 33 team meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine. The report was received by ChildlLine on 08/14/2017 and the CY 48 was filed as unfounded on 09/08/2017.

Department Review of County Internal Report:

An Act 33 Team meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine.

Department of Human Services Findings:

- County Strengths:
  YCCYF responded to this near fatality immediately and conducted interviews in a timely manner. There was also thorough documentation of the interviews in the file.

  YCCYF obtained all medical records and consulted with Hershey Medical Center Child Abuse Team immediately.

  They worked collaboratively with the [redacted] Police Department.

  YCCYF submitted all regulatory required documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses:

  No areas of weakness were noted regarding this near fatality.

- Statutory and Regulatory Areas of Non-Compliance:

  There were no regulatory violations regarding this near fatality.

Department of Human Services Recommendations:

The Central Region Office recommends York County Children, Youth, and Families continues to meet all regulatory guidelines regarding the Child Protective Service Law and child fatalities and near fatalities. The Central Region Office also recommends the agency continues to thoroughly document all case notes regarding all child fatality/near fatality reports. The Central Region Office also recommends YCCYF continue to work collaboratively with law enforcement, medical personnel, service providers and the Central Region Office.