pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/31/2017
Date of Incident: 08/22/2017
Date of Report to ChildLine: 08/22/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Adams County Children and Youth

REPORT FINALIZED ON:
02/08/2018

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. Section 6349 (b))

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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.

Adams County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on September 21, 2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]*	Victim Child	07/31/2017
	Full Sibling	[redacted]2016
	Mother	[redacted]1994
	Paternal Aunt	[redacted]1992
	Paternal 1st Cousin	[redacted]2016
	Father	[redacted]1995

* Denotes an individual that is not a household member (HHM) and did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a meeting with the Act 33 Review panel on 09/21/2017 to review and discuss case information. Additional discussions were conducted with the Adams County Children and Youth Services (ACCYS) supervisor through ongoing telephone calls and email correspondence.

Children and Youth Involvement prior to Incident:

There is no prior history with this family.

Circumstances of Child Near Fatality and Related Case Activity:

On 08/22/2017, a report was received from [redacted] regarding a suspicious head injury to the victim child (VC). According to the mother, who brought the child to the hospital, the child was in bouncy seat upside down not strapped down. The mother went outside for twenty minutes with the paternal aunt and other children living in the home. When they returned inside, the baby was on floor and had lump on left side of head. The mother took the child to the hospital later that evening to have the child checked for any possible injuries. Additional information was received indicating the paternal aunt came into the home while the mother was outside with the other children to put the victim child into the bouncy seat on the dining room table. The paternal aunt said that she had pushed the seat back far enough so that even if the child fell out he would have landed on the table.

ACCYS caseworker and [redacted] Trooper responded to the hospital the day of the report. It was reported that [redacted] had sustained [redacted] that were highly concerning for non-accidental trauma. Preliminary interviews were conducted with both the mother and paternal aunt. They both stated that the mother had placed the VC incorrectly in the seat and then placed the seat on the kitchen table approximately 2 feet away from the edge of the table. Their rationale for placing the VC in the seat incorrectly was that he was born premature and they were fearful of suffocation if he were placed in the seat as instructed. They further explain that the VC sinks down into the seat and the fabric covers his face. It was later stated that the paternal aunt placed the child in the seat and left the seat on the table so the younger children would not touch the infant. The VC was transported to Penn State Hershey Medical Center for further medical care. The Agency and law enforcement went to the home to photograph the environment. The home was found to be cluttered with clothing and had an unpleasant smell.

The mother and paternal aunt resided in the home together along with the victim child and two other minor children, both aged around 1 year. The father of the VC did not live in the home as he was on work release. Based on the allegations and the vulnerability of the other minor children, the agency implemented a safety plan on the day of incident specifying that mother and paternal aunt can have no unsupervised contact with the children. The paternal grandfather and paternal step-grandmother of the victim child were identified to provide supervision of the children when having contact with their respective parent. A Family Group Decision Making (FGDM) meeting occurred following the safety plan hearing on 08/24/17 to discuss assurance of safety during the investigation.

The VC [redacted] injuries are consistent with a fall, however, it is less plausible as described by the family. The mother was re-interviewed but remained consistent with her original story. She acknowledged that her explanation does not seem plausible but did not offer an alternative. The VC would have had to roll out of the bouncy seat and roll an additional 24-30 inches across the table to fall onto the floor. The premature infant was less than one month old and could not

conceivably complete this action independently. A follow-up FGDM occurred on 09/18/17. The safety plan remained in effect and service recommendations were made including parenting education and ongoing protective services from ACCYS. The family was referred to [redacted] parenting program on 10/06/2017.

The case was made indicated on 10/20/2017 because the child sustained an injury due to serious physical neglect by his mother and paternal aunt. He was left unsupervised in an unsafe environment where the child was not secured into the bouncer seat. Law enforcement is not pursing criminal charges. The safety plan was terminated on 10/16/17 upon a referral for Family Support Services (FSS) which would focus on structure and routine in the home. The case was accepted for ongoing services on 10/20/2017.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  - Collaboration between agencies and support systems to the family.
  - Excellent collaboration between law enforcement and children and youth services.
  - Diligent interviews with all parties with children and youth services and law enforcement.
  - Excellent collaboration between victim witness and children and youth services.
  - 10 day county supervisions are occurring at the agency in addition to frequent information sharing between the caseworker and the supervisor.
  - An agency review was completed on the case.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - No deficiencies noted on this case.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - The recommendations made by the team were for the family to participate in [redacted]
  - Offer ongoing-supportive services
  - [redacted]-one on one sessions and interactions in the home setting and parenting education.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - Global recommendation to have more education in the hospital for parents when their child is more premature and some early care recommendations (do's and don'ts).

Department Review of County Internal Report:

The Adams Act 33 Review Team held a meeting to review the circumstances of the case on 09/21/2017. Medical information and case history were presented. The County report was received by the region on 10/24/2017. On 12/08/2017, CROCYF notified, ACCYS Administrator, via letter that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
    - The county responded immediately to the report and interviewed the caregivers in conjunction with law enforcement.
    - The agency promptly enacted a safety plan to assure the safety of the other children in the home.
    - The county worked collaboratively with law enforcement and medical providers throughout the investigation.

- County Weaknesses: and
    - None identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - None identified.

Department of Human Services Recommendations:

The Department of Health is encouraged to work in conjunction with community partners to develop and promulgate educational materials for parents of children born premature with early care recommendations due to their specialized size and developmental needs.