pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/27/2016
Date of Incident: 06/01/2017
Date of Report to Childline: 06/01/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lancaster County Children and Youth

REPORT FINALIZED ON:
11/02/2017

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:

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, 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.

Act 33 of 2008 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. Lancaster County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 06/14/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	12/27/2016
	Mother	[redacted]1991
	Step-Father	[redacted]1989
	Half-sibling	[redacted]2008
	Half-sibling	[redacted]2009
	Half-sibling	[redacted]2013
	Half-sibling	[redacted]2013
	Half-sibling	[redacted]2015
	Biological Father	[redacted]1975

* Denotes an individual that is not a household member or 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 Multi-Disciplinary Team (MDT) on 06/14/2017 to review and discuss case information. Ongoing discussions were conducted with the Lancaster County Children and Youth (LCCY) caseworker and supervisor.

Children and Youth Involvement prior to Incident:

LCCY received a Child Protective Services (CPS) report of physical abuse on 12/07/2016 concerning two of the siblings being hit with a cord by their step-father. The children were interviewed at school the same [redacted]

[redacted] The family was not contacted until 12/21/2016. A home visit ensued on 01/04/2017 an assessment of the other children and the parents occurred. The mother denied the allegations and there is no documentation on what the step-father reported occurred. The case was closed and made unfounded 01/09/2017.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/01/2017, LCCY received a near fatality report regarding the victim child who was brought to [redacted] Hospital by ambulance. According to the child's mother, she had left the home around 5:00 PM to go to the grocery store and took one of her daughter's with her. She received a call from the child's step-father at 7:30 PM who reported that the victim child had been in a bouncy seat, then starting acting like he had to poop. The step-father got the child up and placed him on the floor to check his diaper. Per the mother, usually the victim child fights having his diaper changed, but the step-father noticed that he was lethargic and unresponsive. When the mother arrived home from the grocery store she called the ambulance and denied the child had sustained any injuries.

The victim child was transferred to [redacted] and had a computerized tomography (CT) scan of the head which revealed multiple head injuries including: a subdural hematoma, including a large component overlying the left cerebral convexity having acute and chronic components and acute components in the left side of the tentorium cerebelli and the inter-hemispheric fissure; left cerebral hemisphere edema; and a right-sided skull fracture. The acute and chronic components of the subdural hematoma indicate a strong likelihood of non-accidental injury. The child had to have part of his skull removed due to significant swelling of his brain. The victim child had no medical history that would account for the injuries. The step-father had been caring for the victim child while the mother was away from the home.

On 06/02/2017, LCCY responded to the family home accompanied by law enforcement, to speak with the step-father who was caring for the other five children living in the home. The mother was at the hospital with the victim child. The Agency advised the step-father that he could not have contact with the children due to the allegations surrounding the unexplained injuries to the subject child. The step-maternal grandfather arrived at the home and agreed to temporarily care for the children. The step-father did not offer an explanation for the injuries to the victim child. The caseworker then responded to the hospital, observing the child and met with the mother. The mother revealed that the victim child is [redacted] with the father who lived in Kansas. The child recently returned home from a visit with the father on 05/21/2017. The attending physician confirmed that all blood on the victim child's brain was new and based upon the severity of the injuries, the child's symptoms would have begun immediately after the injury. The injuries were suspected to be caused by the victim child being slammed into something. The physician reported that the mother said the child was alert and playful upon her leaving the home on the date of incident.

The mother was advised that a safety plan would need to be put into place preventing contact between the step-father and the remaining children in the home. The mother told LCCY that she believed the injuries occurred when the victim child was with his father in Kansas. She reported that she would not comply with the safety plan as she did not want her children to become upset by not being able to see their father. The Agency obtained an emergency custody order the same day and the five half-siblings were placed in temporary foster care. The victim child's father was contacted and he provided the paternity test indicating he is the father as well as the current custody order. [redacted] The biological father of two of the half-siblings was contacted and was residing in Ohio. He had maintained ongoing contact with his children and desired for them to be in his care. At the detention hearing on 06/05/2017, the mother was granted supervised visitation with the five half-siblings and unrestricted contact with the victim child while in the hospital. During visits between the mother and the half-siblings, the mother was repeatedly asked to speak English as concern was expressed that she was speaking to the children about the investigation in Spanish. The adjudication hearing was scheduled for 06/19/2017, but was continued to allow for time to explore the father and kinship resources. At that time, the mother's visits with the victim child were limited to 1-2 hours per week. His biological father flew to Pennsylvania on the weekends and had unlimited visitation with the victim child.

The adjudication hearing was held on 07/17/2017. Two half-siblings were released to their biological father in Ohio and the victim child was released to the custody of his father as the condition of dependency did not exist for these children. The three remaining half-sibling remain in foster care and kinship resources are being explored.

The subject child remained at [redacted] until 07/03/2017 when he was transferred to [redacted] Hospital. While at the rehab, the victim child received occupational, speech, and physical therapy. He was discharged from the rehabilitation facility on 07/30/2017 and went to Kansas with his biological father. The child will continue to receive therapies in the home setting and will need to have a prosthetic skull flap inserted around his 2nd birthday.

The report was indicated on 07/25/2017, naming the step-father as the perpetrator. He was the primary caregiver of the victim child when the injuries occurred. The physician stated the onset of the injuries would have presented shortly after they occurred. On 08/11/2017, the step-father was charged with aggravated assault, aggravated assault of a person under 13 years old, endangering the welfare of a child, and recklessly endangering another person. He was released on bail.

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;
  - An immediate response tag was assigned to the case.
  - The Agency started its investigation immediately.
  - An LEO was filed on the step-father, [redacted]
  - A safety plan was developed for the older children to ensure their safety.
  - When the safety plan could not be agreed upon by all parties, the Agency petition for custody of all of the children.
  - The Agency worked collaboratively with the police and [redacted] Hospital Staff to make an informed decision about [redacted] injuries. It was determined that his injuries are not accidental.
  - The child was transferred to [redacted] hospital for treatment.
  - The child abuse team at [redacted] were consulted to aid in devolving a timeline for the child's injuries.
  - [redacted] will be referred to [redacted] for screening as per CAPTA regulation upon his discharge from the hospital.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - A review of the most recent referral received on this family shows that further assessment could have been beneficial.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Public service announcements encouraging the community to report suspected child abuse.

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - Public service announcements encouraging the community to report suspected child abuse.

Department Review of County Internal Report:

The Lancaster County Multi-Disciplinary Team held an Act 33 meeting on 06/14/2017 where medical information and case information was presented. The County report was received by the Region on 09/05/2017. The CROCYF notified the LCCY 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 Agency worked cooperatively with law enforcement and medical providers.
- The Agency took swift steps to ensure the safety of the other children residing in the home.
- The Agency sought out the fathers of three of the children in the home and worked to explore their protective capacities to care for the child to minimize unnecessary time in out of home care. These children were released to the father at the time of adjudication.
- The Agency conducted a thorough investigation and provided comprehensive documentation of the events that occurred.

- <u>County Weaknesses: and</u>
  - During the prior involvement with the family, the Agency failed to meet statutory guidelines regarding safety assessment of the children and caregivers.
    - The two identified victim children were interviewed at school on the day of the report, 12/07/2016. The other children in the home as well as both caregivers were not assessed until a home visit on 01/04/2017. The case was closed on 01/09/2017. Supervisory notes indicate the caseworker was told multiple times to conduct the home visit but failed to do so. The caseworker left the Agency on 01/10/2017.
    - The initial safety assessment worksheet was not completed until 01/09/17, 33 days after the two victim children were first seen and assessed for safety. The closing safety assessment worksheet was also dated 01/09/2017.

- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>
  - Per weaknesses identified above, the Agency failed to ensure safety of the child and other children in the home. It is not possible to assess safety without contact with a caregiver. LCCY failed to assess the presence of safety threats related to the caregiver and the other children living in the home within 72 hours of contact with the identified child(ren).

    The Department will issue a Licensing Inspection Summary for violation of 3490.55 (a) and (c); as well as the Safety Assessment and Management Process Bulletin 3490-06-01. The Department will follow up with the county to assure compliance with their plan of correction.

<u>Department of Human Services Recommendations:</u>

The Department recommends that the supervisory review process be re-evaluated to assess and include action steps to be implemented when casework staff fail to follow directions of the supervisor.