pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/11/2016
Date of Incident: 05/31/2018
Date of Report to ChildLine: 06/01/2018
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:
12/27/2018

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))

Reason for Review:
Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families, 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.

Lancaster 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 06/27/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/11/2016
[redacted]	Sibling	[redacted]2015
[redacted]	Biological Mother	[redacted]1987
[redacted]	Biological Father	[redacted]1989

Summary of OCYF Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff discussed the case with the county on 06/27/2018 and 07/18/2018.

Summary of Circumstances prior to Incident:
Lancaster County Children and Youth Agency (LCCYA) received a Child Protective Services (CPS) referral on 06/27/2017 regarding the victim child. The child was diagnosed as [redacted], despite the parents keeping documentation on all that the child was eating. They brought the child to the hospital but refused to allow the child to be admitted for monitoring. They left the hospital against medical advice. The agency completed the investigation, determining that the condition of the child did not deteriorate as a result of the parents leaving the hospital. The parents were appropriate and were providing adequate care to the child. The report was filed as Unfounded and closed on 08/04/2017. No additional services were provided.

A CPS referral was received on 11/05/2017 for both the victim child and the biological sibling alleging physical abuse by the father of the children approximately five months prior to the report. The mother had a Protection from Abuse (PFA) order against the father. The agency also received a General Protective Services

(GPS) report on the same date regarding the alleged domestic violence. The father did admit to using physical discipline on the children but denied any act that would be considered abusive. There were no injuries found on the children. The family did not request any further services. The agency Unfounded the CPS cases and closed the GPS case on 12/15/2017.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/01/2018, LCCYA received a report of suspected physical abuse involving the victim child. The child was brought into [redacted] by emergency medical services. After X-rays it was determined that the child had a pneumomediastinum subcutaneous emphysema in the neck and right side of the chest. This would have been caused by trauma to the back of the neck and soft tissues. It was alleged that on 05/31/2018, the child had been brushing his teeth in the bathroom with the father and the toothbrush hit the back of his throat. On 06/01/2018, the child's neck was red and swollen and he was taken to the pediatrician, who contacted emergency medical services. Due to the nature of the injury and the explanation, it was determined that the child was in serious condition as the result of potential abuse and was certified as a near fatality. The child was transported to [redacted] from [redacted]

At [redacted] the child was placed in the pediatric intensive care unit (PICU) and received a CT-scan. This scan showed an abscess at the back of the child's throat which was draining pus. The child was intubated which allowed the abscess to heal on its own as the child would be receiving tube feedings. The police and agency interviewed the parents separately at the hospital. The father stated that he had been helping the child brush his teeth with a new toothbrush when the child bobbed his head forward and he felt the toothbrush hit the back of the child's throat. The child spit up some mucus, but there was no blood present. Child was given Tylenol and slept through the night. The next afternoon the child had a swollen neck so he was taken to the doctor. The mother stated that she had been in the next room when she heard the child gag. She went to see what happened and she also observed the child spitting up mucus. The biological sibling of the child was present at the hospital and seen by the agency worker.

The agency also received a CPS report on the family on 06/07/2018. This report was received after the child had a skeletal survey as a part of his assessment during the hospital stay from the 06/01/2018 incident. It was found that the child had a subacute nondisplaced fracture involving the proximal right humeral metaphysis. The injury was believed to be over two weeks old and would have been caused by forcefully pulling, jerking, or wrenching the arm. The agency implemented a safety plan on 06/08/2018 stating that the mother could have supervised contact with the children and the father could not have contact. This plan was confirmed by court on 06/13/2018.

On 06/15/2018, the child was discharged from the hospital to the care of the mother and maternal grandmother. On 6/22/18, the mother informed the agency that they would no longer comply with the safety plan. Due to this the agency

[redacted] on this date as the investigation was still ongoing and the parents could not assure safety.

Lancaster County CYA filed their investigation report with ChildLine on 07/30/2018 with a status of Unfounded. Based on consultation with the medical team it could not be determined that the child's injuries were as a result of abuse. The victim child's throat has healed with no further complications.

In regard to the arm fracture, the parents could not provide any credible explanation for the injury. The agency completed this case on 08/02/2018 and filed it as Indicated for physical abuse with both parents named as perpetrators.

The children [redacted] and have been [redacted] with the maternal grandmother since 08/08/2018.

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 time was assigned and the Agency met with the family the same day.
  - The Agency assessed the other child in the home to assure his safety.
  - The Agency conveyed the seriousness of the report and discussed safety concerns.
  - The Agency completed Safety and Risk Assessments on the family to help guide their practice.
  - A very collaborative investigation has occurred for this case between the hospital, police and Children and Youth Agency.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - A safety plan was developed to assure the ongoing safety of the children. The parents were not compliant with the safety plan and the children [redacted] to assure their ongoing safety.
  - The family was accepted for ongoing services.
  - The victim child was referred to [redacted]

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - A [redacted] Plan would be developed to include goals addressing parenting, [redacted] domestic violence, financial stability, stable housing and remaining committed to the children.

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None noted.

Department Review of County Internal Report:

The Central Region Office received the Lancaster County Child Fatality Team Report on 10/09/2018. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 06/27/2018 and 07/18/2018. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Lancaster County Administration on 10/10/2018.

Department of Human Services Findings:

- County Strengths:
    - Collaboration between LCCYA, law enforcement, and hospital staff was observed throughout case involvement. There was a lot of consultation with medical staff to determine appropriate outcomes of investigations.
    - The agency worker handled all concerns and questions quickly as they would arise on the case.
    - The agency conducted a quick and successfully kinship evaluation to assure that the children remained connected to their family.
- County Weaknesses:
    - None noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - 3130.21(b) (Safety Assessment Bulletin) – In an investigation received on 06/27/2017, the child was seen on 06/28/2017, but a preliminary safety assessment was not completed until 08/04/2017. This is beyond the 72-hour time frame. This violation was cited on the agency's annual inspection occurring in March 2018, and a plan of correction was approved. There will not be a Licensing Inspection Summary (LIS) issued for this current violation.

Department of Human Services Recommendations:

There were prior reports concerning the father's interaction with the children and potential harm as well as a history of reported domestic violence and a PFA. Ongoing collaboration between child welfare and domestic partner violence agencies remain necessary in providing support, education and resources toward prevention of occurrences of maltreatment.