pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/04/2014
Date of Incident: 06/02/2019
Date of Report to ChildLine: 06/03/2019
CWIS Referral ID: [redacted]

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

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON: 12/12/2019

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.

Dauphin County Social Services for Children and Youth (DCSSCY) has convened a review team in accordance with the Child Protective Services Law related to this report. The review team was convened on 06/28/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	07/04/2014
	Biological Mother	[redacted]1991
	Biological Father	[redacted]1991
	Maternal Grandmother	[redacted]1958
	Paternal Grandmother	[redacted]1960
	Paternal Aunt	[redacted]1994

*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 obtained and reviewed the family file. The Central Region reviewed all the structured case notes, safety and risk assessments, medical records, and other case specific information provided by DCSSCY.

Summary of Circumstances Prior to Incident

The family resides in Lancaster County however the incident occurred in Dauphin County. Lancaster County Children and Youth Social Services Agency nor DCSSCY had any prior involvement with this family.

Circumstances of Child Fatality and Related Case Activity:

On 06/03/2019 at 3:35AM DCSSCY received a Child Protective Service (CPS) report regarding the victim child. The victim child had been seen at [redacted] Hospital on 06/02/2019 the victim child presented with a head injury, but he had been released. The victim child returned to [redacted] Hospital later in the day on 06/02/2019, due to vomiting, a Computerized Axial Tomography (CAT Scan) was done confirming the victim child had a skull fracture and subdural hematoma. On 06/02/2019 the victim child was transported to [redacted]

The father and paternal grandmother were with the victim child at the hospital and they had stated the family went to ride go-karts and the victim child's go-kart crashed and he hit his head on the paternal aunt's elbow during the crash, causing the head injury. However, the certifying physician from [redacted] suspected child abuse as the victim child's injuries were not consistent with the victim child hitting someone's elbow. The victim child was admitted to [redacted] Pediatric Intensive Care Unit and listed to be in critical condition. He was followed by neurosurgery to assess if surgery was needed to remove the blood from his brain. The victim child was with his paternal grandmother and paternal aunt when the incident occurred. The victim child's mother was on vacation, and his father was not present.

On 06/03/2019 at 11:10AM [redacted] informed DCSSCY that after examining the victim child's injuries further they feel the victim child's injuries were consistent with the go karting accident and child abuse is no longer suspected.

On 06/03/10 at 1:40PM DCSSCY met with [redacted]; at that time the victim child was doing well, he was responsive, able to talk and follow commands. The attending physician stated the first story that the victim child hit his head on the paternal aunt's elbow was not plausible. However, the victim child hitting his head on the wall during the go-karting accident is consistent with the injuries.

On 06/03/2019 [redacted] Police and DCSSCY conducted interviews of the family members. According to the paternal grandmother she stated around 2:10pm on 06/02/2019 the victim child and paternal aunt, got in the go-kart together. On the last lap around the track the paternal grandmother waived at them and they waved back. Around 2:14PM the paternal aunt lost control of the go-kart while she was waving back, and they crashed into the yellow metal rail. The paternal grandmother assumed the paternal aunt hit her elbow on the victim child's head from waving because she was crying and holding her elbow. The paternal grandmother stated she unbuckled and removed the victim child from the go-kart and when she tried to stand him up, he fell slightly to the left twice, unable to stand straight. The family then went home shortly after the incident and the victim child went to sleep. The victim child's mother who was on vacation [redacted] called to check on the victim child and the paternal grandmother informed the mother of the go-kart incident. The mother expressed concern that the victim child sleeping was not a good thing and asked the paternal grandmother to take him to [redacted] Hospital to be examined. Around 6:30PM on 06/02/2019

the paternal grandmother took the victim child to [redacted] Hospital Emergency Room to have him examined. According to the paternal grandmother it was determined the victim child was bruised but was okay. She stated a CAT Scan, nor ultrasound was completed. She was told by the attending physician that if the victim child began to vomit to bring him back. The victim child went home with the maternal grandmother who met the paternal grandmother at [redacted] Hospital. Around 9-9:30PM on 06/02/2019 the victim child began throwing up. He was taken back to [redacted] hospital by the maternal grandmother. A CAT Scan was completed showing a skull fracture and brain bleeding. The victim child was then transported via ambulance to [redacted]. While at [redacted] they found a blood clot and needed to do surgery. The victim child also needed a spinal tap due to spiking a fever, extending the victim child's hospital stay. He was discharged to his mother on 06/07/2019.

The paternal aunt was interviewed and gave the same account of the incident as the paternal grandmother. The father, mother and maternal grandmother were also interviewed. However, they were not present when the incident occurred. The father and maternal grandmother were present at [redacted] The father expressed frustration that they were being treated like they abused the victim child. He was also concerned that no tests were done but they stated the victim child was fine. The mother was [redacted] and immediately came home and was with the victim child at [redacted] on 06/03/2019.

The victim child resides with his mother and maternal grandmother in Lancaster County however the incident occurred at an adventure park in Dauphin County. No alleged perpetrators were listed on this report. [redacted] Police Trooper [redacted] stated he does not believe this incident was child abuse, he feels this was an accident. No charges have been filed. On 06/21/2019 [redacted] Police closed their investigation. On 07/23/2019 DCSSCY determined this investigation to be unfounded. The family was not accepted for services.

At this time the victim child is doing well and has no permanent damage from the incident.

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

Strengths in compliance with statues, regulations and services to children and families:

- Children and Youth promptly initiated contact with the referral source and maintained contact with [redacted] to determine the occurrence of child abuse.
- Child Death Review Team Act 33 was completed.

- Children and Youth and Law Enforcement conducted very detailed interviews with family members narrowing down the incident and further actions to specific times.

Deficiencies in compliance with statues, regulations and services to children and families:

- CYS did not follow time regulations when sending parent notification letters, sending CY104, or conducted initial safety assessment of the home after child was released from hospital.
- CYS obtained medical releases and provided oral notification multiple times.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse**:**

- Speaking to family members more effectively on the circumstances of the incident related to possible child abuse injuries and asking further questions as to whether something outside of what being reported may have occurred.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

- No recommendations currently.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse;

- No recommendations currently.

Department Review of County Internal Report:

The Central Region Office received Dauphin County's Child Near Fatality Team Report on 09/09/2019. The Central Region finds Dauphin County's internal report to be an accurate reflection of the Act 33 meeting which was held on 06/28/2019.

Department of Human Services Findings:

County Strengths:

- DCSSCY conducted a thorough investigation and interviewed family members in a timely manner.

- DCSSCY and [redacted] conducted joint interviews with family members.

- DCSSCY obtained all medical records regarding the victim child from [redacted]

County weaknesses:

- DCSSCY did not meet all regulatory requirements during this Child Protective Service investigation; parents were not sent notification letters in a timely manner and the CY 104 was submitted late. A safety assessment was not conducted at mother's home in a timely manner. The Child Data Collection Tool was also submitted beyond 60 days.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

- DCSSCY will be issued a Licensing Inspection Summary with the following citations regarding this near fatality:

  3490.58(b)(1): Within 72 hours of interviewing the subject, the county agency shall notify the subject in writing of the existence of the report and type of alleged abuse. The county spoke with both parents on 06/03/2019 but did not notify either parent in writing until 06/21/2019.

  3490.91 (a)(10): Law enforcement officials who shall immediately receive reports of suspected child abuse from the county agency, when the initial report or initial review by the county agency gives evidence that the alleged child abuse is one of the following (i) homicide, sexual abuse or exploitation, or serious bodily injury perpetrated by persons whether or not related to the child. The CY 104 was sent on 06/21/2019, however, the agency received the Child Protective Service report on 06/03/2019.

3130.21 (b): The executive officers shall ensure that the agency is operated in conformity with applicable Federal, State and local statutes, ordinances and regulations. The agency did not meet the guidelines regarding Bulletin 3490-06-01 (Safety Assessment and Planning Process). The child was released from [redacted] on 06/07/2019 a safety assessment of mother's home was not conducted until 06/15/2019. Within 3 business days of the identification of additional evidence, circumstances, or information that suggests a change in child's safety (a change may be positive or negative) a safety assessment should be completed.

3130.21 (b): The executive officers shall ensure that the agency is operated in conformity with applicable Federal, State and local statutes, ordinances and regulations. The agency did not meet the guidelines regarding Bulletin 3490-15-01 (Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014). The Child Data Collection Tool was due on 08/02/2019 and not completed until 08/08/2019.

Department of Human Services Recommendations:

- The Central Region recommends all county agencies follow all regulatory requirements when conducting Child Protective Service investigations.

- The Central Region also recommends all county agencies follow the requirements of Bulletin 3490-06-01 (Safety Assessment and Planning Process).

- The Central Region also recommends all county agencies follow the requirements of Bulletin 3490-15-01 (Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014).