REPORT ON THE NEAR FATALITY OF:

Date of Birth: 05/24/2019
Date of Incident: 07/01/2019
Date of Report to ChildLine: 07/03/2019
CWIS Referral ID:

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

Lebanon County Children and Youth Services

REPORT FINALIZED ON:
01/09/20

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.

Lebanon 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 July 30, 2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
	Victim Child	05/24/2019
	Mother	1996
	Father	1995
	Sister	2017

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in the Act 33 meeting with the Multi-Disciplinary Team on 07/30/2019 to review and discuss case information. Ongoing discussions were conducted with the Lebanon County Children & Youth Services (LCCYS) staff.

Summary of circumstances prior to Incident:

The Agency noted that family had been the subject of an investigation surrounding

Law enforcement and Lebanon County Children and Youth Services (LCCYS) conducted the investigation

LCCYS received a general protective services report in May 2017 regarding concerns about the family not having air conditioning and mold presenting in the home. The Agency went to the home and determined the allegations of mold were invalid. The home did not have air conditioning however, the lack of air conditioning did not present any safety threats. The report was screened out as invalid

Circumstances of Child Near Fatality and Related Case Activity:
On 07/03/2019, a report was received regarding the victim child being brought to the hospital emergency room (ER) by the mother for having seizures. The child was found to have bleeding on the brain. There was no explanation for the injury. A supplemental report was received on 07/04/2019 certified the child to be in critical condition due to suspected abuse. According to the supplemental report, the mother brought the child to the ER for having seizures and a subdural hemorrhage was detected. The mother reported that two days prior the victim child's sibling had a cold. The father was home with the children and he reported that the victim child was acting strangely and not feeding well. Upon returning home, the mother stated that she noticed the victim child had a runny nose and her eye and arm were "twitching." The mother took both children to urgent care to be seen. The mother stated she was told that the children have a viral illness and she took the children home. The following day the mother stayed home from work to care for the children. She continued to observe "twitching." The mother went to work on the day of incident. The mother called the doctor at noon and made an appointment for that evening. The father report, while the mother was at work Wednesday, the victim child was not feeding well and started to have full body twitching. The mother got home in the evening and the child would not feed and mother noticed whole body shaking and mother took the child to the ER. In the ER, the child was noticed to be having seizures and was given IV medication to stop the seizures. A computerized axial tomography scan was done which showed a bilateral subdural hemorrhage. The mother could not identify a cause for the injury.

The Agency responded to the hospital on 07/03/19 and confirmed the timeline of events. The mother did take the child to on 07/01/2019. The child was examined, was believed to have a viral infection, and was released home to be monitored for additional symptoms. The mother took the child to her primary care physician (PCP) at on 07/03/2019. The PCP advised the child should be seen at the ER at The hospital confirmed the victim child was found to have bilateral subdural/ subarachnoid hemorrhages as well as hypodensity in the right occipital/temporal lobe which was concerning for the possibility of ischemia or edema. Additional medical tests were performed including a dilated ophthalmologic examination, skeletal survey, and a Magnetic Resonance Imaging (MRI). It was discovered that the victim child was found to have multilayered retinal hemorrhages of the right eye. There was no evidence of traumatic bone injury via the skeletal survey, but the MRI noted bi-hemispheric subdural hemorrhage, scattered subarachnoid hemorrhages, brain injury, and retinal hemorrhages. The parents were not able to provide any medical rationale for the child's injuries. The physician felt that these injuries were consistent with non-accidental injury or physical abuse. It was further noted that there were no suggestions of any impact to the infant, only evidence of injuries as a result of shaking.

A safety plan was put in place for the victim child's sibling. Alternate kinship caregivers were identified and responsible to ensure all contact between the parents and children were supervised. Interviews with both parents occurred with LCCYS and law enforcement. The mother offered a consistent and credible timeline of what occurred on the days leading up to the report. Interviews with the father revealed inconsistencies in the account of events and he appeared emotionally distant from the situation. Law enforcement again interviewed the father and he confessed to forcefully shaking the victim child on 07/01/2019. He reported being frustrated with the child refusing to take the bottle from him and using force when holding the victim child.

The child was released from the hospital on 07/09/2019. Medical staff reported that review of the follow up skeletal survey completed on 07/16/2019 exposed the victim child had a non-displaced fracture of the wrist which could have been sustained from grabbing or shaking the infant.

The report was made indicated for physical abuse on 08/06/2019, naming the father as the perpetrator. The case was accepted for ongoing in-home services 08/20/2019. On 09/12/2019, the father was charged with Simple Assault, Aggravated Assault, and Endangering Welfare of Children in response to the incident. The mother stayed in the home of the kinship caretaker and the father resided in a sperate residence until he completes goals established on the family service plan.

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;
  - All involved followed the proper reporting procedures and gathered information in a timely manner.
  - The positive communication and collaboration among the county systems serves to work for the betterment of the families which they serve.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None noted

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - There are currently no recommendations to change the review process in this instance.

- 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.
    - None noted

Department Review of County Internal Report:

LCCYS held an Act 33 meeting on 07/30/2019 where medical information and case information was presented. The County report was received on 10/14/2019 by the Region. The CROCYF notified the County Administrator, via letter, that the report was reviewed, and that the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
    - The county responded promptly and enacted a safety plan for the sibling in the home during the investigation.
    - The Agency collaborated with Law Enforcement and medical providers during the investigation.
    - The Agency engaged with the family to develop goals that would work to towards reunification with the parents while ensuring safety of the victim child and sibling.

- County Weaknesses: and
    - None noted.

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

Department of Human Services Recommendations:
LCCYS is encouraged to discuss stress management in regard to coping with infant children when working with families with newborns.

Generic parenting education should be shared equally amongst all caretakers.