pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/18/2018
Date of Incident: 07/10/2019
Date of Report to ChildLine: 07/10/2019
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
01/09/2020

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))

Department of Human Services/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg., 2nd Fl., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772.7071
Hiram G. Andrews Center | 727 Goucher Street | Johnstown, PA 15905 | 814.254.0177 | F 814.254.0198
www.dhs.state.pa.us

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 Children and Youth Services (ACC&YS) has convened a review team in accordance with the Child Protective Services Law related to this report. The review team convened on 08/06/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/18/2018
	Biological sister	[redacted]2016
	Paternal half-brother	2010
	Biological Father	1987
	Biological Mother	1988

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged Adams County Children and Youth Services (ACCYS) administrator and supervisor to discuss the incident. The Human Service Program Representative also attended the agency's Act 33 meeting on 08/06/2019.

Summary of circumstances prior to Incident:

The family was not known to the agency prior to the Incident.

Circumstances of Child Near Fatality and Related Case Activity:

The mother, who was home with the victim child all day on 07/10/2019, reported that the child had been fussy from the time she woke at 8:30 a.m. The mother gave the child Ibuprofen and put her down for a nap at 3:00 p.m. The child woke at 4:00 p.m. and was still fussy and wanted to be held by her mother. The child ate a small amount of dinner and when the father returned home from work, at approximately 5:20 p.m., he could hear the child screaming and crying as he approached the family residence. The mother left the home to go to work at

approximately 6:00 p.m. and took the two children she had been babysitting with her in order to return them to their home. Shortly after the mother left for the evening, the father took the victim child upstairs to change her as she would not stop crying. He reported that when he stood her up after he changed her, she fell to the floor. This was later characterized as a loss of consciousness just prior to the fall.

The father called 911 at 6:17 p.m. and the ambulance arrived at 6:28 p.m. The victim child arrived at [redacted] at 7:22 p.m. and was life flighted to [redacted] at 8:55 p.m. where she underwent brain surgery to address a large subdural hematoma with a large midline shift. The child also presented with retinal hemorrhages. Adams County Children and Youth Services received a Child Protective Service (CPS) report on 07/11/2019 at 12:08 a.m.

The parents were interviewed by agency staff on 07/11/2019 and both reported that the victim child had been pushed by her 3-year-old sister on Wednesday of the prior week and when she fell at that time, she hit her head on the hardwood floor. The parents offered no other explanations for the injury to the victim child. The agency consulted with medical personnel who felt that the injury was not consistent with the history provided by the parents. The report was then upgraded to a Near Fatality for the CROCYF on 07/12/2019. Adams County Children and Youth Services engaged additional family members in a safety plan for which they agreed to provide all supervision for the parents with the children. The paternal half-brother of the victim resided primarily in another state with his mother and only visited the father. Although he was initially on the safety plan, once his mother took appropriate court action to assure his safety via a modification of custody order, he was removed from the safety plan and returned to his mother.

Although the mother has been formally interviewed by ACCYS and the police, the father has declined formal police interviews. Criminal charges have not been filed at this time, but the police investigation continues. On 09/06/2019 Adams County Children and Youth Services indicated child abuse reports against both parents and opened the family for in-home services. The victim child and her sibling were adjudicated dependent on 10/04/2019 and the agency has provided in-home services to the family since the end of the investigation.

The agency has provided the mother and father with parenting services. The parenting services program is an intensive evidence-based program that consists of lessons on various parenting topics. Observations of real time parenting is used to determine if a transfer of learning has occurred. The program typically takes several months to complete. The agency continues to see the children weekly, in different locations, in order to assure their safety. The parents are each expected to undergo [redacted] and to follow any resulting recommendations. The agency will monitor to assure that this occurs. [redacted] has been involved with the victim child since her release from the hospital and she has been evaluated monthly to determine if there is a need for services. To date, it has

been determined that the victim child [redacted]
The family continues to cooperate with In-home services.

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;
  - The agency responded quickly to the report and two caseworkers responded to the hospital to conduct separate interviews of parents.
  - The family has several natural supports that prevented the agency from placing the children in traditional foster care during the investigation.
  - There was strong collaboration between Agencies and support systems to the family.
  - Excellent Collaboration between Law Enforcement and Children and Youth Services.
  - Quick response by ACCYS to the hospital to conduct interviews of alleged perpetrators.
  - 10-day county supervisions are occurring at the agency in addition to frequent information sharing between the caseworker and the supervisor.
  - An Act 33 Team Meeting was completed on this case.
  - The agency facilitated a family meeting immediately before implementing the safety plan.
  - The agency has provided the family supports through [redacted] to assist with the concerns identified.
  - The agency will be adjudicating [redacted] to continue agency oversight for the safety of the children.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The investigating detective was unable to respond to the hospital immediately due to a shortage of staff at the department. In the future it may be beneficial to reach out to the District Attorney's office to obtain assistance from County Detectives for a quicker response or to reach out to Pennsylvania State Police.
  - This hospital stated that the investigation and collaboration may have been set in motion quicker if they would have immediately stated the report was a Near Fatality instead of waiting a couple of days.
  - It was noted by the Children's Advocacy Center that the two non-household member children that the mother was babysitting could have been interviewed at the CAC. [redacted] The caseworker and detective noted that the Children's Advocacy Center knew about the other children that were at the home that day and did not encourage their interview at the time of [redacted] The CAC clarified they

would be willing to take on these forensic interviews in the future due to an increase in their staff.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - It was identified that at the County Control level police in the jurisdiction could be automatically notified/dispatched at the time of the call so they can determine whether police presence is needed.
    - MDIT will bring these cases up for discussion during the monthly MDIT meetings.
    - Law enforcement will be reaching out to County Control to assure they consistently notify police when emergency services are being dispatched so that law enforcement can make the determination as to whether or not police need to respond.
    - The agency will request interviews at the Children's Advocacy Center for all children, both household member and collateral for egregious situations such as this.

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

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

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting report was received by CROCYF on 10/01/2019. The CROCYF attended the Act 33 Child Near-Fatality Review Team meeting on 08/06/2019 and finds the county's report to be representative of what was discussed at the meeting.

Department of Human Services Findings:

- County Strengths:
    - The agency responded immediately and completed the investigation in a timely manner. The agency thoroughly assessed the response by the agency and local law enforcement and identified several recommendations for change at the local level that will ensure rapid police involvement and collaboration with Adams County Children and Youth Services.

- County Weaknesses:
    - At the time of this report, CROCYF has not identified any County weaknesses.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - At the time of this report, CROCYF has not identified any area of non-compliance.

Department of Human Services Recommendations:

The CROCYF agrees with recommendations made by the Act 33 Team Review, specifically:

- that the county agency and District Attorney's Office develop a protocol for ensuring immediate Law Enforcement involvement on all Fatality and Near Fatality reports.
- that the Child Advocacy Center be utilized to interview all child witnesses to a Fatality or Near Fatality.