pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/14/2018
Date of Incident: 06/02/2018
Date of Report to ChildLine: 06/02/2018
CWIS Referral ID: [redacted]

FAMILY 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:

01/28/2019

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 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 has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 06/22/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/14/2018
	Mother	[redacted]/1988
	Father	[redacted]/1987
	Sibling	[redacted]/2016

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) attended the Act 33 meeting on 06/22/2018 and requested all case records pertaining to the family. The County Review Team Report was not received within the required timeframe. Requests were made for this report which was received and reviewed by CERO staff on 11/07/2018. All records for this report were also not made available within a timely manner. Numerous request was made by CERO staff to obtain access to these records. Once access was made available all records were reviewed. CERO staff spoke with Dauphin County Social Services for Children and Youth (DCSSCY) staff involved with this case.

Children and Youth Involvement prior to Incident:
The family was not previously known to DCSSCY.

Circumstances of Child Fatality and Related Case Activity:
A report was received by DCSSCY on 06/02/2018 with concerns for a 2-month-old infant who was taken to the emergency room suffering from seizures. The victim child was taken to her doctor's office that morning due to concerns that she appeared to be twitching. Previously, the victim child had been taken to the doctor's office for a check-up on 05/22/2018 and a concern was noted for the child's head circumference. Her head circumference was previously measuring in the tenth percentile and at this appointment it had increased to the ninety-eighth percentile. At this point, a cranial ultra sound was scheduled for 05/31/2018, but the mother no showed this appointment and it needed to be rescheduled for a few

weeks later. Due to this previous identified concern, and the victim child now having seizure activity the medical team recommended that the child be taken to the hospital for evaluation.

At the hospital, the victim child was found to have old and new subdural hematomas and skull fractures on each side of her head. When interviewed regarding the injuries, the mother reported that on 06/01/2018 she put the victim child down for a nap around noon and noticed that her right leg was popping in a rhythmic manner. When the victim child woke up around 2:30 PM, her mother noticed that her fist was hard and straight and she appeared to be shivering. The mother then left the home to run errands and returned in the evening to put the victim child to bed and noticed that she was twitching again. When the mother continued to notice her twitching the next day, she contacted the doctor's office to have the victim child seen. When asked about how the infant had received the injuries, she reported that when the child was 10-days-old that she had fallen out of her swing while swaddled. The mother claimed that she had found the victim child face down on the floor and immediately called the doctor. This explanation, however, was not found to account for the injuries to the child. The father refused to be interviewed regarding the victim child's injuries.

The victim child has an older sibling who was also residing in the home at the time of the incident. On 06/02/2018, local law enforcement took protective custody of the victim child and her sibling in order to ensure their safety. DCSSCY then put a safety pan in place that both children would be cared for by their maternal aunt and grandmother and that all their contact with their parents would be supervised. DCSSCY has since been granted dependency of both the children who were placed under third party court order protective services. The children remain in the home of their grandmother and maternal aunt at this time.

On 08/01/2018, DCSSCY indicated the case naming the victim child's mother and father as perpetrators of child abuse. During the investigative process it was found that the victim child's parents were the sole caretakers for the child during the time that the injuries would have occurred, the parents were utilizing illegal substances while caring for the child, and that local law enforcement had previously been called to the parents' home on 05/14/2018, due to concerns that the mother was suffering from [redacted] and [redacted] due to the stress of caring for the child. On 07/24/2018, the mother was criminally charged with aggravated assault and two counts of endangering the welfare of a minor. The father was also criminally charged on this date with two counts of endangering the welfare of a minor.

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;
  At this time the County's Child Fatality Report has not yet been received.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:
    - At this time the County's Child Fatality Report has not yet been received.

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

    - At this time the County's Child Fatality Report has not yet been received.

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

    - At this time the County's Child Fatality Report has not yet been received.

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

    - At this time the County's Child Fatality Report has not yet been received.

Department Review of County Internal Report:

The County did not submit their report in a timely manner within the required 90-day timeframe. At this time, the County's report has not yet been received.

Department of Human Services Findings:

- County Strengths:
    - The agency immediately began the investigation, cooperated with medical personal, and assured the safety of the children involved.
    - The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.

- County Weaknesses:
    - The Agency did not provide a County Child Fatality report to the Department within the required 90 days of convening the Act 33 team.
    - Numerous requests had to be made to the County in order to obtain all the necessary records for review.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - §6365 (d)(4)(v): The Agency did not provide a County Child Fatality report to the Department within the required 90 days of convening the Act 33 team.

- §3490.235 (f): The Family Service Plan was completed by the caseworker on 08/29/2018, but as of the date the records were reviewed on 09/19/2018, the supervisor had not yet reviewed or signed this plan, which was out of compliance with the required 10-day timeframe.

A Licensing Inspection Summary was issued on 12/05/2018 to address these identified areas of non-compliance.

Department of Human Services Recommendations:

The Department recommends that when potential concerns are identified for [redacted] help should be offered to these mothers and follow-up should occur to assist in locating appropriate resources.