pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 3/6/13
Date of Incident: 3/2/14
Date of Oral Report: 3/2/14

FAMILY NOT KNOWN TO:

Lebanon County Children and Youth Services

REPORT FINALIZED ON:

12/10/14

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Lebanon County convened a review team in accordance with Act 33 of 2008 related to this report on 4/1/14.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]/85
	Father	[redacted]/82
	Great-grandmother	[redacted]/38
	Victim child	3/6/13
	Sister	[redacted]/11
	Brother	[redacted]/09

Notification of Child Near Fatality:

On 3/2/14, [redacted], mother of [redacted], took [redacted] to Good Samaritan Hospital (GSH) due to the child having a [redacted] and very swollen lips that appeared to be burned and swelling in her airway. According to the mother, the child woke at 9:00 a.m. and the mother took the child to the [redacted] at noon. The child was seen by Dr. [redacted] who suspected the child ingested something harmful. The mother stated that the child did not have access to something [redacted] and found her in her crib with the injuries. The child was transferred to Hershey Medical Center on 3/2/14 at 5:00 p.m. for a higher level of care.

Summary of DHS Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the Lebanon County Children and Youth Services (CYS) Caseworker [redacted], the Lebanon CYS Supervisor [redacted] and the Lebanon CYS Director [redacted] on 3/17/14. The Central Region also participated in the county Act 33 meeting related to this case on 4/1/14.

Children and Youth Involvement Prior to Incident:

On 3/22/2011, the agency received a report regarding [redacted]. It was reported that the child was being transferred to Harrisburg Hospital from Hershey Medical Center due to possible ingestion of [redacted]. The concern was that it was the second time this has happened with same child. The biological mother was living with the grandmother at the time. There was no indication that the child ingested any medication and the child did not show any symptoms. It appeared as if [redacted] accidentally dropped the [redacted] and did not pick it up quickly enough. There was no intent nor was there any evidence that the [redacted] were not properly stored in the home. The case was screened out on 3/25/2011, with the determination that the child was supervised appropriately at home. No further concerns were reported.

Circumstances of Child Near Fatality and Related Case Activity:

On 3/2/14, [redacted], mother of [redacted], took [redacted] to GHS due to the child having a white coated thrush tongue and very swollen lips that appeared to be burned and swelling in her airway. According to the mother, the child woke at 9:00 a.m. and the mother took the child to [redacted] at noon. The child was seen by Dr. [redacted] who suspected the child ingested something harmful. The mother stated that the child did not have access to something harmful and found her in her crib with the injuries. The child was transferred to Hershey Medical Center on 3/2/14 at 5:00 p.m. for a higher level of care.

Upon [redacted] to the Hershey Medical Center the child was [redacted] The parents remained vigilant at the hospital throughout the child's time at [redacted]. Lebanon CYS caseworker [redacted] was assigned to the case. The child [redacted] on 3/10/14. The CYS safety plan stipulated that the victim child, and her siblings, have supervised contact with their parents and great-grandmother by an aunt. The aunt took the children to her home in [redacted] County.

Initial on-site visit on 3/2/14 by the police indicated nothing out of the ordinary at the scene. There were no obvious hazards in view. Child locks were not present on cupboards initially but were in place on a later home visit. The only oddity observed during the visit by police was that the child was holding a repelling clip in her hand. Parents, nor siblings, were able to state how she had gotten hold of such an object and all denied giving it to her.

The [redacted] was identified as the primary caregiver and the [redacted] was not home on the evening prior to the presentation of the child at the GHS[redacted]. The parents indicated noticing a small scratch on the child's nose that she kept picking open but all symptoms related to this investigation were only evidenced in the morning.

There was initial cause for questioning regarding the parents' actions as it appeared that they waited a long time to present the child to [redacted]. Within the initial report, the family stated that

the child's condition was present at the time of her waking yet the parents did not report with the child at [redacted] until approximately noon. This family is known to have called 911 in the past, without hesitation, in situations of perceived emergency yet did not on this occasion. During the course of re-interviewing the family, it was made known that the mother's initial phone call was to a maternal aunt. The mother contacted her aunt to request a ride to the hospital. The aunt believed that the mother was exaggerating the symptoms and suggested she call [redacted] to get advice on how to proceed. The mother contacted [redacted] and was directed to go to [redacted]. The mother reported this to the aunt who then came to the home. The aunt noted that upon her arrival she was able to see that something was very wrong with the child and immediately took them to the hospital.

There was also a report of [redacted] missing a tooth. According to the [redacted], this could be explained away as it is a common occurrence during intubation with young children. Interviews with the other children in the home, as well as a grandmother, were not able to provide any rationale for [redacted] condition. There were also no concerns noted with regard to the parenting of the children. A new family safety plan was developed for the children which allowed for them to move back with their parents into the family home with the addition of an uncle for supervision purposes.

Hospital testing has made it possible to rule out some of the preliminary presumptive causes for the child's condition. It was determined that the child ingested an unknown caustic substance. Further testing was completed to see if the [redacted] could be determined, but to no avail. [redacted] reports ruled out all natural chemicals. The [redacted] has not ruled out the possibility of the child's presentation being [redacted]. The parents are very concerned that this could happen again since no cause has been determined.

The CY 48 was completed on 4/2/14 with a status of unfounded due to a lack of evidence to substantiate that abuse/neglect or lack of supervision occurred.

Current Case Status:

Due to a lack of evidence from both the medical community and law enforcement to substantiate that abuse/neglect or lack of supervision occurred, the children were returned home and the case was closed on 4/2/14 as there was no need for services for the family nor was the family requesting any assistance.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

Strengths:
The county agency investigation complied with regulations and response times as required.

Deficiencies:
The county agency's report did not reference any specific identified deficiencies.

Recommendations for Change at the Local Level:
The county agency's report did not reference any recommendation for change at the county level.

Recommendations for Change at the State Level:
The county agency's report did not reference any recommendation for change at the state level.

Department Review of County Internal Report:

The county report was received by the Department on 5/19/14. There were no areas to dispute or concur with identified in the report.

Department of Human Services Findings:

County Strengths:
Upon review of the documents associated with this particular case it would appear there is positive working collaboration between law enforcement and the county agency.

County Weaknesses:
The circumstances of this incident and review of the county's case did not identify any systemic weakness.

Statutory and Regulatory Areas of Non-Compliance:
The review of the county case file notes and medical records did not find any areas of non-compliance.

Department of Human Services Recommendations:

The Department has no recommendations regarding this report. It would appear there is a positive working collaboration between law enforcement and the county agency along with other agencies that are part of the multi-disciplinary team (MDT) process.