pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: 01/28/2014
Date of Near Death: 05/07/2014
Date of Oral Report: 05/07/2014

FAMILY KNOWN TO:

York County CYF

REPORT FINALIZED ON:

02/26/2015

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))

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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, DPW 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. York County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/28/2014
	Mother	[redacted]1975
	Father	[redacted]1976
	Sibling	[redacted]1998
	Sibling	[redacted]2000
	Half-Sibling	[redacted]2005
	Maternal Grandmother	[redacted]1971
	Maternal Grandfather	[redacted]1946
	[redacted] paramour	[redacted]1974
	Maternal Step Grandmother	[redacted]1972
	Father of [redacted]	[redacted]1978
	Father of [redacted]	unk
	Father of [redacted]	[redacted]1978

The parent's current address: [redacted]

Notification of Child Near Fatality:

On May 7, 2014, York County Children, Youth, and Families (CYF) received a report from [redacted] regarding the Victim Child after he was brought into York Hospital in cardiac arrest. [redacted] showed a [redacted] which was believed to be non-accidental. The Physician on duty certified the child to be in critical condition as a result of suspected abuse or neglect. This was certified as a near fatality.

Summary of DPW 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 Victim Child and his family. Medical

records were also reviewed. Conversations and interviews were conducted with the Caseworker [redacted], CPS Supervisor [redacted], and Quality Specialist [redacted] throughout involvement but specifically on May 8, 2014, May 14, 2014, and July 3, 2014 and February 23, 2015. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on June 2, 2014.

Children and Youth Involvement prior to Incident:

The agency had no previous involvement regarding [redacted]. [redacted], [redacted]. and his biological family had involvement with York County CYF when [redacted] was a child; however, this record has been expunged.

The agency has an extensive history of involvement regarding the mother, [redacted], and her three older children. This involvement began in July, 2006 due to two referrals regarding lack of supervision of [redacted] by their mother. Both of these referrals were substantiated and the three children were removed from their mother's custody [redacted] was initially placed with his paternal aunt and then placed with his biological father. [redacted] and his father received [redacted] through [redacted] and both the in-home team and the agency were able to successfully close services for [redacted] and his father. [redacted] and [redacted] were initially placed in the care of the maternal grandfather in July, 2006. They remained in his home until October, 2006, at which time the children were moved into an agency foster home because the maternal grandfather could not be approved for kinship care of the children due to his criminal record. At that time [redacted] father was unknown and [redacted] father was incarcerated at SCI [redacted].

The agency worked on reunification of the children with their mother and provided services to the mother and visitation with her children. The major barriers to reunification efforts were mother's history of drug use (crack), history of incarceration due to drug charges and unstable housing. The mother's drug use appears to be related to the initial concerns of lack of supervision, which brought the family to the attention of the agency. After reunification services were unsuccessful, [redacted] were both adopted by their foster parents.

The agency closed the case on 2/12/10 and up until 5/7/14 had no additional involvement.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child was brought into York Hospital on 5/07/14 at night by his father, maternal grandmother and maternal grandmother's paramour. The child was in cardiac arrest, had no pulse, and was not breathing. The mother was working out of the home at [redacted] when the child stopped breathing. The father is the primary care giver and was alone with the child when he stopped breathing. Both parents reported that no one else cares for the child and no other children were around their child. The parents reported that he had congestion and a runny nose for the past few days. The father

stated that when he had given the child a bottle on 5/07/14, the child coughed and choked. The father reported that the child had formula coming from his nose and then he stopped breathing. The father attempted CPR and rescue breaths. He then took the child to the maternal grandmother's home next door and continued to perform CPR there. The maternal grandmother and her paramour then brought the child and father to the hospital. Dr. [redacted] from the York Hospital certified the child to be in critical condition as a result of suspected child abuse or neglect.

The child was [redacted] and [redacted] to Hershey Medical Center. In an initial exam the child was found to have a [redacted] on his forehead and [redacted] on his left eye lid. [redacted] showed a [redacted] which appeared to be acute, as well as the presence of [redacted]. However, on 5/13/14 Dr. [redacted] stated that after further testing and an MRI it was determined that there was not any [redacted] in the child's [redacted], as originally thought. It was determined that this was trauma from birth. There was also a moderate [redacted] in 1 eye. The skeletal survey was negative. Dr. [redacted] and the Child Protective Team believed the child's injuries could only been caused by severe trauma. When Dr. [redacted] notified the parents of his opinion, the mother became tearful and the father just put his head in his hands. The child remained at Hershey Medical Center.

The child remained [redacted] while in Hershey Medical Center. At an MDT held with treating physicians on 5/29/14, it was stated that the child would be a [redacted], deaf and blind, need a [redacted], and would suffer from [redacted].

A review of the child's medical history showed he was born on 1/28/14 at York Hospital at 35 weeks weighing 4lbs 1.2oz.; transferred to the [redacted] due to [redacted] and [redacted]. Noted risk factors at birth were prematurity and maternal smoking. The child was [redacted] from York Hospital on 2/4/14 to the home of his parents with [redacted]. No concerns were noted. The [redacted] documented that the parents were bonding well and providing independent care to the child. The child was to be seen by [redacted]. On 2/27/14 the child was brought to York Hospital by his parents due to abdominal pain. The child would cry when moving his bowels, had nasal congestion and a productive cough. He was fussy more than normal. He weighed 7lbs. 6oz. The child was [redacted] and followed up by [redacted].

The agency took custody of the child on 6/02/14. The agency initially looked to place him in a foster home that specialized in dealing with medically fragile situations. A foster home could not be found and on 6/26/14 the child was placed in [redacted] in Lancaster. Child remains in this facility receiving targeted care to his medical conditions. A family member has come forward that is interested in providing care for the child. The agency plans to have this individual attend the facility's training program to learn about the extensive care that the child will need in the coming weeks.

The parents were able to visit the child at Hershey Medical Center while supervised by hospital staff and/or [redacted], step maternal grandmother. After additional findings, the court order was changed to the parent's having no contact with the child.

The agency filed their Child Protective Service Investigation (CY48) report with ChildLine on 7/03/14 with a status of Indicated against the father of the child. The child suffered a [redacted]. There were several inconsistencies in the father's story when interviewed on multiple occasions. The father's explanation of the child's injuries is not consistent with the child's medical condition.

Law enforcement first became involved with the child when Officer [redacted] of the [redacted] Police Department stopped the grandmother's car after she drove through a stop sign on the way to York Hospital with the child on 5/7/14. The grandmother explained the situation and Officer [redacted] and [redacted] escorted the child to the York Hospital. Officer [redacted] carried the child into the ER. Officer [redacted] remained at [redacted] to get a statement from the child's father, grandmother and hospital staff. Officer [redacted] then took the father to the [redacted] Police Station for further questioning. The agency submitted the required Report of Suspected [redacted] (CY 104) to the York City Police Department on 5/8/14. A review of the Police Report of Officer [redacted], Officer [redacted] and Officer [redacted] showed the Incident Classification as 2020 – Offenses Against Family – [redacted]. The father told Officer [redacted] two versions of the events regarding his son: First, that after cleaning a pooped diaper, affixing the second strap to the diaper, his son started to freak out and began to show body convulsions simulating a [redacted], then going lifeless. In the second version, the father said that while affixing the diaper strap, his son began to have frantic breathing. The father said he believed his son was choking and picked him up, turned him over and began giving back blows. When he picked up his son the child went limp. His son also was leaking Similac from his left nostril. The father also claimed he provided CPR on the child.

A review of the father's criminal history showed he was arrested in 1996 and pled guilty to possession and/or distribution of small amounts of marihuana; In 1998 pled guilty to retail theft; In July of 2004 a charge of aggravated assault was dismissed; In November of 2004 he pled guilty to aggravated assault and went to prison; In 2005 he was charged with theft with unlawful taking – disposition unreported; In 2009 he pled guilty to manufacturing of controlled substance and sentenced to a regional correctional facility for 3 years.

On 2/5/15, [redacted], with York County Children, Youth and Families related the law enforcement investigation is completed and no charges were filed against the father due to a lack of medical evidence after police consulted with the child's doctors.

The agency conducted Safety Assessments on the family. The Contact Summary/Safety Assessment was completed on 5/7/14 with a Safety Plan for the agency to obtain [redacted] that the parents only have

supervised visits with the child while the child is in the hospital. The Preliminary Safety Assessment was completed on 5/8/14 that supported the visiting restriction. No children remained in the parent's home.

A review of the Family Service Plan showed the family was accepted for service on 5/30/14. The Family Service Plan was completed on 6/27/14. The Family Service Plan was first reviewed on 11/13/14 and is scheduled to be reviewed on 5/10/14. The child's initial Child Permanency Plan was developed on 6/10/14 and was reviewed on 7/8/14 and 10/3/14.

Current Case Status:

York County Children, Youth and Families has an open placement case on the child. The child is placed in kinship care through the [redacted] as of 10/2/14 in the home of [redacted]. They live in the [redacted] area. The kinship parents are assuring the child's medical needs are met, while including the child's parents in his medical care. The child had [redacted] in November, 2014 but returned home the same day. The child is receiving [redacted] through [redacted]. As of 2/23/15, the child is doing well. He has a lot of health struggles though nowhere near as when the child came into care. He is growing and starting to hold himself up and tries to use his legs to stand/walk. He has [redacted] support and lots of doctor visits but he is progressing. The child's mother and father are receiving [redacted] services through [redacted] and drug testing through [redacted]. The drug tests have been negative. [redacted] The family participated in Family Group Decision Making on 10/31/14. The parents both visit the child regularly and are involved in his medical appointments. The current goal is reunification with the mother and father.

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on June 2, 2014 at the York Hospital. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff.

- Strengths:
  The team felt that the agency handled the current CPS investigation well and provided information to all parties involved. The agency maintained consistent communication with the hospitals and medical professionals throughout the case.

- Deficiencies:
  None were noted by the team in regards to the handling of the case by the agency.

- Recommendations for Change at the Local Level:
  No recommendations were made.

- Recommendations for Change at the State Level:
  None noted.

Department Review of County Internal Report:

York County CYS provided a report on the Near Fatality of the Victim Child to the Regional Office on August 21, 2014. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on August 25, 2014.

Department of Public Welfare Findings:

- County Strengths:
  The investigation was conducted timely and in close collaboration with Hershey Medical Center, York Hospital and the [redacted] Police Department.

- County Weaknesses:
  There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of not-compliance noted.

Department of Public Welfare Recommendations:

York County Children, Youth and Families should continue to conduct thorough and timely investigations in coordination with law enforcement officials.