pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/3/13
Date of Incident: 2/9/14
Date of Oral Report: 2/10/14

FAMILY NOT KNOWN TO:

Lebanon County Children and Youth

REPORT FINALIZED ON:

August 5, 2014

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. Lebanon County convened a review team in accordance with Act 33 of 2008 related to this report. The meeting was held on April 1, 2014.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	mother	[redacted]/93
[redacted]	father	[redacted]/90
[redacted]	victim child	12/3/13

Notification of Child Near Fatality:

On February 9, 2014, the child's mother noticed the child having what appeared to be seizures while at their home. The mother called the father and asked him to come home and take her and the child to Heart of Lancaster Hospital because the mother does not drive. While in the emergency room, the treating physician observed the seizures and the child was immediately transferred to Hershey Medical Center. [redacted] examined the child upon admission and found [redacted] The agency received the report on February 10, 2014.

Summary of DPW Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted with the caseworker the Supervisor and the Agency Director on February 18, 2014. The regional office also participated in the County Internal Fatality Review Team meeting on April 1, 2014 where copies of the hospital records were presented.

Children and Youth Involvement prior to Incident:

The family was not known to Lebanon County Children and Youth prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On February 9, 2014, the child's mother noticed the child having what appeared to be seizures while at their home. The mother called the father and asked him to come home and take her and the child to Heart of Lancaster Hospital because the mother does not drive. While in the emergency room, the treating physician observed the seizures and the child was immediately transferred to Hershey Medical Center. [redacted] examined the child upon admission and found [redacted]

The mother told medical staff at Hershey Medical Center that the father is too rough with the child and she noticed a bruise on the child's chest a few weeks ago. She also observed the father holding the baby and telling the child to stop crying. [redacted] has stipulated that the injuries that the child sustained occurred over an eight to nine week period, which is the child's entire life. The [redacted] Throughout the investigation, it was discovered that the child had [redacted]

The focus of the investigation with Trooper [redacted] of PSP was the father due to allegations made by the mother that he was always rough with the child. There was evidence that the mother confided in and sought advice from the child's maternal grandmother through Facebook about her concerns for the way the father treated the child.

The mother reported that, on the night of the incident, she was very tired and the father volunteered to keep the baby as he was fussy. The father took the child into the garage where he does car detailing and was alone with the child from 2am until 6 am. He brought the child into the room where the mother was sleeping so the child could be fed. At 11:30, the mother noticed the first seizure activity and called the father as noted above.

It was initially believed, per mom's report, that the father may have caused the injuries as she reported his "rough" treatment of the infant and his overall lack of parenting skills. There was evidence that mom confided in maternal grandmother through Facebook about dad's treatment of the infant and her concerns, seeking advice. Maternal grandmother was able to corroborate at least one incident where she witnessed dad being rough with the baby. She noted that she attempted to help dad and he was accepting of the advice and gesture. However, mom reports her attempts to educate dad were met with rude and accusatory comments (ie...don't you think I know how to be a parent?). Mom deleted these conversations from her computer but the maternal grandmother retained them. It is noted, that mom has a lot of alone time with the baby due to dad's numerous jobs. Mom has reported [redacted]. Domestic violence and D&A issues were denied by both parents.

Trooper [redacted] and the Children and Youth caseworker were able to conduct interviews with the parents and both appeared to be bonded with their son. Trooper [redacted] noted that, during questioning, dad's answers were "too perfect". He was noted to be overly calm and distant but cooperative. Body language with the baby was also different during this time. Trooper [redacted] believed that he may be lying due to all of these behaviors. It was later reported that dad looked

up "interview techniques" on the internet so that he would know what to expect with Trooper [redacted] interview which also accounted for the behavioral changes. Trooper [redacted] obtained a warrant for the computer as well as dad's cell phone, in case any information was accessed that way, in an attempt to verify the validity of this claim. Both were sent for analysis. Dad was originally willing to take a polygraph; however, he sought the advice of private legal counsel and was advised to get his own polygraph through an outside agency. Trooper [redacted] also conducted interviews with neighbors but there were no reports that caused any concern. Interviews were also conducted with all relatives that have had contact with the child and all have been cleared as suspects for this case. No new information was gained as a result of any of the interviews.

The CY 48 was submitted on April 4, 2014 with an indicated status; naming the father as the perpetrator of physical abuse. As of this date, no criminal charges have been filed.

Current Case Status:

The child continues to remain in kinship care with family friends who are friends of the child's maternal grandmother. The visits continue to be supervised 1 -2 hours a week at the Kinship home.

[redacted] is involved and is providing [redacted] for both parents. The last court hearing was April 3, 2014 and the next scheduled hearing is in July, 2014.

County Strengths,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 specific changes for recommendation at the state or county level.

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

Department Review of County Internal Report:

The county report was received by the regional office on May 6, 2014. The regional office concurs with the county's internal report.

Department of Public Welfare Findings:

County Strengths: Upon review of the documents associated with this particular case, it would appear there is a 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 weaknesses.

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 Public Welfare Recommendations:

There are no recommendations as a result of this review.