pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: January 10, 2012
Date of Incident: March 13, 2014
Date of Oral Report: March 13, 2014

FAMILY KNOWN TO:

Lebanon County Children and Youth

REPORT FINALIZED ON:

September 4, 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))

Department of Public Welfare/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dpw.state.pa.us

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 related to this report on May 6, 2014 in accordance with Act 33 of 2008.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	mother	[redacted]/89
[redacted]	mother's paramour	[redacted]/83
[redacted]	paramour's daughter	[redacted]/06
[redacted]	paramour's son	[redacted]/03
[redacted]	mother's son (victim child)	[redacted]/12
* [redacted]	child's biological father	

*Not a household member

Notification of Child Near Fatality:

[redacted] called Lebanon County C&Y to report that, on March 13, 2014, the biological mother and her paramour brought the victim child to Hershey Medical Center [redacted] at 12:00am. The child was seen by the [redacted] doctor. The child suffered an [redacted] (head injury) and other bruising throughout the body. The child was brought to [redacted] on February 20, 2014 for a head injury and bruising on his body as well. The head injury and bruising on the child documented on March 13, 2014 are similar to the injuries reported and documented on February 20, 2014. The child had been admitted to [redacted].

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 family. Follow up interviews were conducted with the caseworker, the casework supervisor and the Agency Director on April 1, 2014. The regional office also participated in the County Internal Fatality Review Team meeting on May 6, 2014 where copies of the medical examiner's reports were presented.

Children and Youth Involvement prior to Incident:

9-10-13 – It was reported to Schuylkill County CYS that [redacted] is violent, depressed and sleeps all day and recounted the incident from the previous day. It was also reported that [redacted] used the top bunk bed to detain the child (which is similar to the current report).

9-13-13 - Lebanon County CYS received notice of the report from Schuylkill County as [redacted] was residing in [redacted]) with the great-grandmother.

9-23-13 - Lebanon CYS made contact with [redacted] and discussed appropriate sleeping arrangements and supervision and closed the case.

2-24-14 – Referral received from Schuylkill County CYS referencing the 2-21-14 incident that was reported. This also included additional concerns of bruising and other injuries, as well as a lack of weight gain. These concerns occurred over a span of time while he had visitation with his father.

2-25-14 – Lebanon County CYS caseworker contacted the social worker at [redacted] regarding concerns noted by biological father. The [redacted] reported that the [redacted] team at HMC had no concerns of abuse. The only concern noted was regarding [redacted] and, as a result, a referral was made to [redacted] Based on these findings, the case was not accepted by Lebanon CYS for services.

Circumstances of Child Near Fatality and Related Case Activity:

[redacted] called Lebanon County C&Y to report that on March 13, 2014, the biological mother and her paramour brought the victim child to Hershey Medical Center [redacted] at 12:00am. The child was seen by the [redacted]. The child suffered an [redacted] (head injury) and other bruising throughout the body. The child was brought to [redacted] on February 20, 2014 for a head injury and bruising on his body as well. The head injury and bruising on the child documented on March 13, 2014 are similar to the injuries reported and documented on February 20, 2014. The child had been admitted to [redacted]

It was reported by [redacted] that the results of a CAT scan showed [redacted] from an old [redacted] as well as [redacted] at the back of the [redacted] from a more recent injury. There were pictures of [redacted] on the body. The victim child had [redacted] levels in his body. The completion of a [redacted] noted an old [redacted]. The child was noted to appear [redacted] and had been witnessed picking at lips that were quite chapped. The child appears to have no long term damage but will more than likely have more testing to verify this.

A CYS caseworker was assigned to the case. Throughout the investigation, it was necessary to complete a time line due to the multiple traumas and injuries sustained by the child. The time line presents as follows:

2-9-13 - [redacted] records indicate the child was taken to the [redacted] in Schuylkill County when [redacted] reportedly fell while holding the child which caused a [redacted]. At that time, [redacted] was given [redacted] for pain and told to follow-up with another [redacted]

4-5-13 – The child was taken to the [redacted] for a well-baby check and a [redacted] was noted for which the parents had no explanation.

9-9-13 - [redacted] reportedly put the child in the top bunk bed and left the home. The child was heard crying by another household member and reported it to biological father.

12-1-13 - Approximate date [redacted] moves in with current paramour.

2-2-14 – Unexplained [redacted]. This was only discovered through the course of this investigation and was deemed to have happened on this date based on the stage of healing (at time of presentation to the [redacted]).

2-21-14 - [redacted] paramour reported that he was down the hall watching TV when he heard a thump on the floor. Upon investigating, he discovered the child on the floor with his body rigid after apparently falling out of the top bunk bed. He was then Life Lioned to the Hershey Medical Center [redacted]. Injuries sustained as a result of this fall included a [redacted] and abrasions. Mother's paramour noted seizure activity with eyes rolling back in his head, legs and arms jerking, and he was not breathing. It was noted by [redacted] that the account for the injuries seemed plausible so no further action was taken. No bone scan was completed nor was a phone call placed to CYS.

2-22-14 – [redacted] hospital.

2-23-14 – [redacted] reports an account that occurred on this day whereby the child was not walking appropriately. He became rigid and fell on his face without putting his arms out to break his fall. Mom shook the child and he responded. Mother's paramour called HMC three times but was not instructed to bring the child to the hospital but rather to wait until his follow-up appointment at the end of March. Mother's paramour took pictures of the child's pupils which indicated that they were not the same size. Phone records received by CYS verify the calls placed to the hospital.

3-13-14 – Child was transported to HMC by ambulance due to seizure like activity, unconsciousness and not breathing.

3-13-14 ~ 3-18-14 – During the time the child was in the hospital, multiple injuries were discovered: bruises [redacted] and several small bruises to his lower

back. [redacted] His lips were very sore as they had been picked at over a long period of time resulting in scabbing.

During interviews conducted by the caseworker [redacted], the child's biological [redacted] and the [redacted], it was noted that [redacted] frequently sleeps and leaves the child unattended resulting in potential harm to the child. The caseworker was able to corroborate these reports on [redacted] own, as when [redacted] presented to the home, [redacted] was sleeping and unaware of [redacted] presence showing little regard for [redacted] engagement or cooperation with this investigation.

Throughout this investigation, information was gathered that also helped to determine that the [redacted] would not be an appropriate custody resource for [redacted] due to [redacted] ongoing legal involvement.

The Child Abuse Team of [redacted] County voted, unanimously, to indicate the [redacted] in this case. It was also decided that the [redacted] would not be indicated in this case due to the findings of the investigation.

The CY 48 was submitted on May 7, 2014 indicating the [redacted] due to [redacted] lack of supervision as [redacted] slept while the child was left unattended in the top bunk bed and, as a result, the child fell multiple times causing his injuries.

Current Case Status:

A permanency plan has been developed for the child. The child remained in [redacted] foster care placement [redacted]. The child moved in with his paternal aunt on that date. The mother participates in biweekly supervised visitation. The mother also meets regularly [redacted]. The natural father does not visit the child regularly and does not consistently meet [redacted]. When he does visit, those visits are also supervised. The mother continues to live with her paramour. No criminal charges have been filed at this time; however, the criminal case is still pending. The PSP wants the mother to take a polygraph test which she has avoided.

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 local level.

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

Department Review of County Internal Report:

The county report was received on May 6, 2014. There were no areas to dispute or concerns with the 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 along with other agencies that are part of the multi-disciplinary team (MDT) process.

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 Public Welfare Recommendations:

There are no recommendations as a result of this review.