pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/09/2010
Date of Incident: March 26, 2014
Date of Oral Report: March 26, 2014

FAMILY KNOWN TO:

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:

September 21, 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))

Department of Human Services/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.dhs.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. Dauphin 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	02/09/2010
[redacted]	Sister	[redacted]/2011
[redacted]*	Mother	[redacted]/1971
[redacted]*	Father	[redacted]/1969
[redacted]	Babysitter/Caretaker	[redacted]/1981
[redacted]	Babysitter/Caretaker	[redacted]/1986
[redacted]	Household Member	[redacted]/2009

* The child's mother and father were not members of the household at the time of the incident due to being incarcerated.

Notification of Child Near Fatality:

On March 26, 2014, Dauphin County Social Services for Children and Youth (DCSSCY) received a report from [redacted] regarding the victim child. The child's caretaker, [redacted] called 911 on the date of incident. When Emergency Medical Services (EMS) arrived at the home, [redacted] reported that punishment led to the child falling down the stairs. The victim child was transported to Harrisburg Hospital via ambulance and was subsequently transferred via Harrisburg Life Team EMS to Hershey Medical Center due to the severity of his injuries. The victim child had a [redacted] and was reported to be in critical condition. He was unconscious, covered in bruises of varying ages all over his body, including his face, ears, buttocks, penis, feet, arms and stomach. There were also signs of being punched and loop marks consistent with being struck with a belt. The child also had a healing burn mark behind his right knee.

Summary of DPW Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed current and past case records pertaining to the [redacted] family. The files were inclusive of medical reports, agency safety and risk assessments, court records and case dictation. Follow up interviews were conducted with the caseworker [redacted]. CROCYF also participated in the County Internal Fatality Review Act 33 Team meeting on March 28, 2014 where the case details were presented and discussed.

Children and Youth Involvement prior to Incident:

[redacted] DCSSCY had involvement with the mother in 2011 as the tested positive for illegal substances at birth. The children's father assumed care of the newborn and the victim child and the mother was subsequently incarcerated on charges related to this incident. DCSSCY closed services with the family on 11/14/11. The Agency received another referral on 12/19/11 regarding the mother's heavy drug use, ongoing involvement with prostitution and transient living arrangement. The maternal grandmother was contacted by the DCSSCY and denied concern for the care of the children. The Agency did not initiate further assessment of the referral.

On10/11/2013, a referral was made to DCSSCY regarding the cleanliness of [redacted] home and the children reportedly having bruising. It was also reported that [redacted] was the mother of one of the children in the home and that two additional children, the victim child and his younger sister, were staying with her as their mother was incarcerated. When the caseworker visited the home, [redacted] would not allow entry to her home but caseworker could see into the home and reported that the home did not appear dirty or cluttered. There were neighborhood children playing outside and the caseworker was able to observe [redacted] child, the victim child and the victim child's younger sister. There were no visible bruises on any of the children. [redacted] called the father of the victim child and his sister to come pick the kids up and [redacted] stated that the children resided with their father a few houses down the street not with her. The children were observed, allegations were assessed and the case was closed 10/18/2013 with no further services.

Circumstances of Child Near Fatality and Related Case Activity:

On the date of incident, the DCSSCY became aware of two other children residing in the victim child's home under the supervision of the alleged perpetrators. [redacted] The victim child's sister was taken immediately to Hershey Medical Center for [redacted] and was found to have bruising to her face, arms and body as well as [redacted] on her face and stomach. [redacted] child was examined the following day and not found to have any injuries. .Both children were placed in foster care due to safety concerns. They were initially placed in the same foster home, but were later separated

due to the older child's excessive behavioral issues and tormenting of the victim child's sister. [redacted] child was later released to a family member.

The children's mother and father were incarcerated at the time of the incident. The father arranged for [redacted] to be the primary caretaker for the children while he was incarcerated. [redacted] resides with [redacted] and also acted a caretaker of the victim child and sibling. Both caretakers were present when the victim child reportedly fell down the stairs inside the home.

Medical records confirm the victim child suffered from [redacted] The victim child experienced [redacted] and significant [redacted]. He could not breathe on his own [redacted]. He later required [redacted] He also required [redacted] due to long term impairment in physical functioning. The victim child had significant bruising, both patterned and non-patterned, throughout his body at various stages of healing. He had a burn on his one leg that is about [redacted] from an unknown origin. The attending physician confirmed that the collection of injuries did not come from falling down stairs.

[redacted] was interview by [redacted] Police and admitted to striking the child with a hair brush; "popping him on the face" with her hand; and striking him on his butt, arms, and legs with a belt as discipline. She stated that the victim child would fight her on everything, did not like women, and describing aggressive acts towards her including kicking her stomach when she was pregnant which she attributed to later miscarriage. [redacted] alleged she did not recall how the victim child fell down the stairs on the date of incident; however, she admitted that she had hit him just prior to the incident and was at the top of the landing when he fell. [redacted] was the primary caretaker of the child and his sister and was aware of [redacted] behaviors and witnessed her physically discipline the child. He denied ever disciplining the child as it was "not his child". [redacted] was arrested on charges related to this incident.

On 5/20/2014, the Agency indicated [redacted] as a perpetrator by commission as she admitted to hitting the child on the date of incident. [redacted] was indicated as a perpetrator by omission as he did not protect the children from [redacted] acts.

The children's mother was released from [redacted] Prison during the investigation, although her sentence was not up, so that she could spend time with the victim child, as there were concerns about whether he would survive the incident due to the severity of his injuries. She [redacted] was detained for violating her parole. She remains incarcerated and unable to provide care for her children. Their father was released from prison during the initial investigation as well but his current location is not known. He has not been involved in the case and there are warrants for his arrest if he is located.

Current Case Status:

The victim child is currently in a medical foster family home [redacted] DCSSCY searched

for kinship resources, however, none were identified. The victim child's sister is in a foster family home where she maintains routine contact with her paternal grandmother (PGM) and sibling. The PGM initially wanted to be a kinship resource for the sister but later changed her mind due to her own health issues and bonding between the child and her foster parent.

The children's mother was transferred to SCI [redacted] in November 2014 which will limit her ability to visit with the child due the long travel distance. The father's location is unknown at this time. The case remains open for ongoing permanency services.

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

The Dauphin County Child Fatality/Near Fatality Act 33Team met on March 28, 2014.

- Strengths:
  - The communication during the investigation demonstrated cooperation between the Agency and law enforcement. It was also noted that the team was notified and convened in a timely manner.

- Deficiencies:
  - Detailed historical information regarding the family was lacking at the time of the review.
  - There were system entry concerns on how the family is entered into the tracking system through CYS.
  - Concern was also noted about the timeliness of when other children in the household are seen and removed from the situation. The worker responded immediately to the hospital. Upon arrival, the victim child was [redacted] It was unclear at first the extent and details of the child's injuries. It took a few hours to determine the details of other children who were in the care of the alleged perpetrators and their whereabouts. There were eventually found to be at the home of a relative of the caretakers and safety was assessed. Medical exams of the other children were conducted [redacted]
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- Recommendations for Change at the Local Level:
  - To fully investigate the circumstances surrounding the incident.
  - Caseworkers should be provided with supplemental training regarding ways to overcome obstacles when they are being barred from access to the home. This was an issue with past involvement with the children's caretaker.
  - Caseworker to receive guidance on methods to notify incarcerated parents about immediate circumstances pertaining to their children.
  - Support needs to be provided to the parents to deal with their grief.

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

Department Review of County Internal Report:

DCSSCY provided a copy of the Fatality/Near Fatality Act 33Team Review report on May 30, 2014. The report contained the required information and a summary of the findings from the meeting. Written approval of the report was sent to the Agency on August 21, 2014.

Department of Public Welfare Findings:

- County Strengths:
  - County response to the information received was urgent and thorough during the CPS investigation.
  - The CPS investigation was completed in a timely manner and included collaboration with local police and medical professionals.
  - The Act 33 meeting was held within established time frames and included professionals who were able to provide valuable input regarding the child.

- County Weaknesses:
  - The Act 33 happened within two days of the incident resulting in insufficient time to gather significant historical information and all relevant investigation details.

- Statutory and Regulatory Areas of Non-Compliance:
  - Written notification of the CPS investigation was not provided to the father until the close of the investigation. A notification letter was mailed to the father on May 20, 2014. Dauphin County CYS was issued a Licensing Inspection Summary on 12/10/14 citing regulatory non-compliance with 3490.58(b)(c). Written Notification to the parents of a victim child in an alleged abuse case is to be provided within 72 hours unless notification would result in a risk to safety. In this case, there was no risk to safety by notifying the father.

Department of Public Welfare Recommendations:

The Agency should ensure adequate time has elapsed between the date of incident and the Act 33 meeting to allow for time to collect full, comprehensive details of the investigation and provision of a clear status by all involved and should adhere to all regulatory and statutory requirements.