pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: 05/23/2011
Date of Near Death: 08/13/2014
Date of Oral Report: 08/14/2014

FAMILY KNOWN TO:

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

February 18, 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, 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. 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	05/23/2011
	Mother	[redacted]1989
	Father	1971
	Sibling	[redacted]2009
	Mother's Paramour	[redacted]1981
	Mother's Paramour's Daughter	[redacted]2007

**Non-household member at the time of the near fatal incident

Notification of Child Near Fatality:

[redacted] contacted ChildLine after responding to a home for an alleged fall by the victim child. Abuse was suspected due to the injuries and concerns with the mother and her paramour screaming at the children while [redacted] was present. This report was then called out to the on-call worker for York County Children, Youth and Families (CYF) on August 14, 2014.

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 Victim Child and his family. Conversations were conducted with the Caseworker [redacted], CPS Supervisor [redacted], Agency Quality Manager [redacted], and Agency Administrator [redacted] throughout involvement but specifically on August 14, 2014, August 25, 2014, and September 3, 2014. The agency conducted an Act 33 meeting on September 3, 2014 and provided a written report to the Regional Office.

Children and Youth Involvement prior to Incident:
The agency had an extensive history with this family in the recent months prior to the near fatality incident. The mother, victim child, and sibling moved in with the paramour and his child on May 20, 2014. Their involvement with the county began after this date.

On May 22, 2014, the agency received a report of suspected physical abuse on the child of the paramour, with the paramour listed as the alleged perpetrator. The child had stated that her ribs on the right side of her body hurt. She had told a teacher that her father had punched her intentionally when they were playing Spiderman. The child did not have any bruising, but did make a pain statement. This was unfounded on July 1, 2014 and the case was closed. Case documentation was missing some items such as a picture of the child and an assessment of risk. Safety assessments also only listed this child, and not the other children in the home, though the victim child of this near fatality and his sibling were both living in the home at the time.

On May 28, 2014, the agency received a general protective services report regarding the victim child and his sibling. The paramour was listed as the responsible party in this case. It was alleged that the paramour was hurting the children, leaving marks and bruises. Per supervisory consultation notes, the caseworker went out and saw the family and did not observe any injuries, though this was not documented by the caseworker in case notes. The case remained open in conjunction with the May 22 referral and both referrals were closed on July 1, 2014. Case documentation for this case did not include any other visits to the home or interviews. There was also no assessment of risk completed prior to case closure.

On July 25, 2014, the agency received a general protective services report regarding the victim child. The paramour was listed as the responsible party. The maternal grandmother had called stating that the children had bruises and she believed that they came from the paramour. The agency did go out and see the children immediately and documented that there were no bruises and the children did not appear fearful of the paramour. This report was still open in assessment when the next report was received.

On August 4, 2014, the agency received a report of suspected physical abuse regarding the victim child. The paramour was named as the alleged perpetrator in this report. An [redacted] reported that she had seen the paramour pick the victim child up by his arm and toss him. She also saw him squeeze the child's fingers and he cried. The reporting source also stated that the child had a busted lip and scratches on his face. She reported that she received a text from the mother stating that she needed to get out because of what happened to her child's face. When the reporting source asked if the paramour did this, the mother responded with a sad face emoticon and stated "Don't tell anyone." From the case documentation, it appears that the family may have been at the beach when this happened. The caseworker received a text from the mother stating that the child was fine and her children were not in danger. She also stated that she wished that everyone would leave them alone. As there was not any additional case documentation for this report, it is unknown how the mother was contacted to know to text the caseworker. A supervisor consultation note states that the safety of the children

was assured via a photograph, though there are no photographs contained in the record. There was no further contact with the family until the near fatality report was received on August 14, 2014. It does not appear that the caseworker saw the children or met with the family prior to this.

Circumstances of Child Near Fatality and Related Case Activity:

[redacted] was dispatched to the home of the victim child on August 13, 2014 for the report of a fall. According to the [redacted], when they reached the home, the child was on the floor and lethargic. There was bruising on the left side of his face and a bloody lip. The mother's paramour reported that the child fell two to three days ago off of the top bunk bed. There was also multiple bruising on the child's back in different stages of healing. The child complained of back and neck pain. The child was transported to the York Hospital. The other two children in the home, a biological sibling, and the daughter of the paramour, were left in his care at the home. While in the ambulance, the mother provided a story that she was at work and came home and that her paramour said that the child was watching TV and went unresponsive with erratic breathing for five minutes, but then was fine. [redacted] Police were present at the home and met CYF at the hospital.

At the hospital, they observed bruising head to toe. There were also [redacted] on the child's penis. The hair on his back seemed to be burned. The child was diagnosed with a head bleed and possible belly injury. The mother was not cooperative with the hospital and initially blamed some of his bruising on hospital staff. He was flown to Hershey Medical Center. At Hershey, the child was certified to be in serious or critical condition by Dr. [redacted] due to suspected abuse. This was processed as a near fatality.

After learning of the extent and severity of the child's injuries, additional police were called to the home to take protective custody of the other two children in the home. Both were initially placed with the maternal grandparents of the younger child as emergency caretakers. Eventually, the child of the paramour went to live with another woman that she considers her mother, though she is not her biological parent.

The mother initially denied any abuse of the child, or any domestic violence in the home. After continued interviewing by law enforcement, the mother admitted to the police that the paramour has been beating the children with a closed fist since May. The mother was added to the report as a Perpetrator by Omission. The paramour was arrested by [redacted] Police and placed in the [redacted] Prison on August 14, 2014 with charges of Aggravated Assault, Simple Assault, Aggravated Assault – Victim less than 6, and Endangering Welfare of Children.

During a children's alliance interview, the Paramour's daughter stated that the victim child had been dropped. The sister also disclosed abuse. Between the two of them, there were 11 reports made, some physical, some sexual. Lancaster County CYS was handling two of these. These regarded the biological father of the victim child and his sibling; where the family was living prior to May 2014. These were later unfounded.

The Victim Child was [redacted] the Hershey Medical Center on August 16, 2014 and was placed with his sibling at the Maternal Grandparents'. The child had a cast on his wrist as he had a [redacted]. There were no [redacted] injuries and the child experienced a rapid recovery. He was receiving some [redacted] for sporadic [redacted]. The Mother was able to visit the children through supervised visits at the CYF agency.

The Mother was arrested on September 2, 2014 for simple assault and endangering the welfare of a child. The child stated that the mother had burned his back. She made bail and moved into an efficiency apartment in [redacted].

The agency filed a report with ChildLine on October 2, 2014 with a status of INDICATED for the Mother and her Paramour. The investigation determined that the child suffered multiple traumatic injuries which caused severe pain and impairment of functioning which were caused by both the Mother and her Paramour.

Current Case Status:

The family was opened for services with the agency as the children were found to be dependent. They remained in placement. The mother is working with Pressley Ridge Intensive Family Services in dealing with [redacted], domestic violence, empowerment classes, employment, and [redacted]. The children receive [redacted] twice a week in the home of their grandparents through [redacted]. The mother has supervised visits with the children in the home of the grandparents. [redacted] has also been supervising visits between the two younger children and their biological father, who lives in Lancaster.

A Family Group Decision Making meeting was held on September 26, 2014 with the goal of providing supports to the mother as she works towards reunification with her children.

[redacted] is scheduled for January 26, 2015, which will include discussions of ordering a finding of abuse in this case.

The paramour remains incarcerated at the [redacted] Prison. There is a pre-trial conference scheduled in February 2015 for both the mother and the paramour. The mother has agreed to cooperate fully in the trial against the paramour. If this occurs, she will only be charged with Endangering the Welfare of a Child.

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

A Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on September 3, 2014 at the York Hospital Pediatric Unit. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff.

- Strengths:
  - The agency did not note any strengths in their Child Near Fatality Report.

- Deficiencies:
  - The agency acknowledges that there were oversights in the cases prior to the near fatality incident. They will be addressing all concerns through a Plan of Correction. Some of the components of the plan are included in the Recommendations.

- Recommendations for Change at the Local Level:
  - The agency has included directives in their plan of correction regarding doing individual interviews for all subjects and witnesses of CPS/GPS reports, this includes all children.
  - The agency has put a protocol in place to gather all medical information for CPS reports.
  - The Quality Service Department will monitor CPS cases and complete ongoing case reviews to assure the plan is followed.

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

Department Review of County Internal Report:

York County CYF provided a report on the Near Fatality of the Victim Child to the Regional Office on October 31, 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 November 3, 2014.

Department of Human Services Findings:

- County Strengths:
  - County response to information received was urgent and thorough during **this** CPS investigation.
  - The CPS Investigation was completed in a timely manner and included collaboration with local police and medical professionals.
  - The agency took all concerns with the current and past cases seriously and made efforts to address all questions and concerns.

- County Weaknesses:
  - The previous cases on this family, Child Abuse and General Protective Services, were not completed appropriately, sometimes in a manner that could have affected the safety of the children.
  - Case documentation of interviews, home visits, and other collateral contacts were not completed on the previous cases.
  - Supervisory oversight in the previous cases, while documented, was not addressing any of the missing information, or lack of actual casework being completed.

- Statutory and Regulatory Areas of Non-Compliance:
  - 3490.55(a) – In one CPS File, the child was not seen within 24 hours of the receipt of the report.
  - 3490.55(b) – In one CPS File, the agency did not immediately begin the investigation upon the receipt of the report.
  - 3490.55(c) – In two CPS Files, the agency did not assure the safety of the victim child or other children in the home.
  - 3490.55(d), 3490.232(g) – In one CPS File and one GPS File, there was no documentation of interviews with the child or someone responsible for the child.
  - 3490.55(f) – In two CPS Files, there were no pictures of the child or the injuries to the child.
  - 3490.55(i), 3490.232(f) – In two CPS Files and one GPS File, there was no documented visits to the child's home.
  - 3490.61(a) – In one CPS File, there was one missing 10 day supervisor review.
  - 3490.232(c) – In one GPS File, a response time was not assigned to determine when the child should be seen.
  - 3490.234(a) – In one GPS File, there was no documentation that the parents were verbally notified of the investigation.
  - 3490.234(b)(1-2) – In one GPS File, there was no letter sent to the family detailing that the agency had completed the assessment.
  - 3490.321(h)(1) – In one CPS File and two GPS Files, a risk assessment was not competed at the conclusion of the assessment.
  - 3130.21(b) – In one CPS File, a Preliminary Safety Assessment Worksheet was not completed.
  - 3130.21(b) – In one CPS File, a Closing Safety Assessment states that the child was seen, but there was no documentation of the visit found in the case file.
  - 3130.21(b) – In one GPS File, both the Preliminary and the Closing Safety Assessment Worksheet do not list one of the children in the home on the assessment.

Department of Human Services Recommendations:

As noted above, there were numerous concerns and regulatory violations with the agency handling of the cases for this family. The agency was issued a Licensing Inspection Summary on September 12, 2014, that listed all violations of regulation. The agency provided a plan of correction for the citations which will be monitored by the Regional Office through periodic file reviews and annual licensing inspections.