pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/03/2014
Date of Incident: 11/03/2015
Date of Report to ChildLine: 11/03/2015
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Adams County CYS

REPORT FINALIZED ON:
04/26/2016

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. Section 6349 (b))

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Reason for Review:
Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Adams County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on11/23/2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	12/03/2014
[redacted]	Mother	[redacted]1992
[redacted]	Father	[redacted]1989
*[redacted]	Sibling	[redacted]2013

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. CERO staff conducted interviews with the following Adams County Staff: Intake Caseworker, Intake Supervisor, and Family Support Worker. These interviews occurred on 11/04/2015, 11/23/2015 and 04/01/2016. CERO staff participated in the Act 33 meeting that occurred on 11/23/2015 in which medical professionals, agency staff, and legal counsel were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:
Adams County CYS first became involved with this family in November 2013. On 11/03/2013, the agency received a physical child abuse report that a two-month old female child was present at the hospital, and [redacted]. The mother could not explain the injuries. The mother was listed as the alleged perpetrator on this case. The doctor was questioned regarding the child being in serious or critical condition, and did not believe that the child met the criteria to be certified as a near fatality. A skeletal survey [redacted] The child displayed symptoms that were indicative of shaken baby syndrome.

The agency immediately began an investigation. The child was [redacted] in an agency foster home on 11/07/2013. The parents offered differing stories on the causation of the injuries. The mother stated that the child had hit her head on the bar of a baby swing. The father stated that he had been holding the child in a doorway and her head bumped the door way. Neither parent provided an explanation for [redacted]. The agency completed the investigation on 12/20/2013 with a status of Indicated, with both the mother and father listed as perpetrators. [redacted] on 01/30/2014, a finding of physical abuse was ordered and the status of the case was updated to Founded. Charges were not filed on this case at the time of the investigation.

The agency worked with the family, providing visitation and parenting instruction services through [redacted]. The parents received [redacted] Throughout the case, the family struggled with housing issues. Throughout involvement with CYS, the parents also split up and got back together several times. During their times apart, each would blame the other for the child's injuries. However, they would then get back together and support each other in stating that the injuries were not caused by the other. There was contact with law enforcement throughout agency dictation as their investigation remained ongoing, but due to the inconsistency in stories, charges were not filed.

[redacted]

The victim child was born on 12/03/2014. The agency had been monitoring the pregnancy while they had an open case with the family in regards to the other child. There were concerns that the mother was not receiving prenatal care. The agency [redacted] placed him with an agency foster home on 12/04/2014, when he [redacted] from the hospital.

The agency provided services to the family, connecting them to [redacted] services, as well as parenting instruction. The parents were cooperative with services and showed significant progress on their plans. During the reunification process the agency worked with the parents on refraining from physical discipline, safe sleeping practices, appropriate feeding, and making sure that there was activity and engagement between the parents and child. The agency returned the victim child to the care of his parents on 08/18/2015. [redacted]

On 10/07/2015, the agency received a child abuse report of suspected physical abuse after the victim child was found to have a bruise on his buttocks that allegedly came from the father spanking the child. The mother also stated that the child's testicles had been black and blue. This was reported by the mother to the ongoing caseworker two weeks after the incident that caused the bruising. Safety was assessed at this time and the child was determined to be safe in the home with the mother. A safety plan was not put in place for the child. The mother had

expressed to the worker that she was fearful of the father and that he had no patience for the child. She believed that the child was spanked by the father because he tried to pull some DJ equipment down off of a table. The mother also disclosed some domestic violence by the father as he had broken her tablet, threatened to break her phone, and she felt that if she tried to evict him from the residence, he would push in the air conditioner to get to her. This report was being assessed by the agency when the new child abuse report came in regarding the victim child that was certified as a near fatality.

Despite the open CPS case, [redacted] closed the in-home case on 10/13/2015. The 10/07/2015 CPS case was completed on 12/02/2015 with a status of Indicated. The father was listed as Perpetrator by Commission and the mother was listed as Perpetrator by Omission as she waited several weeks to report the incident. It was determined that the father struck the child, who was under one year old at the time of the incident, resulting in injury.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/03/2015, the agency received a child abuse report regarding the victim child. The mother brought the child to Gettysburg Hospital stating that the child had been injured a half an hour before arriving. The child was unconscious at this time. She stated that his father had been carrying him up the stairs and the child threw his head back hitting the father's shoulder causing injury. The child had a depressed skull fracture and a large hematoma on the back of his head. The description of the incident was not consistent with the injuries. [redacted] and full skeletal were completed on the child at Gettysburg Hospital. He was transferred to Hershey Medical Center by ambulance so that he could be evaluated by the Child Protection Team. The mother did not ride in the ambulance with the child. The child was certified to be in serious condition by Dr. [redacted], and was classified as a near fatality.

[redacted] He was [redacted] and placed in the foster home where he had previously resided. The parents agreed to the child remaining in foster care [redacted]

When interviewed, the father stated that they were at a friend's house and that the child had pulled himself up on the couch to a standing position, trying to reach for a toy. He then fell backwards and hit his head on the hard concrete floor. The father stated that he had picked the child up and started to walk upstairs with him when his eyes rolled back in his head. The friend had called 911, but the father was afraid that the child wouldn't make it if they had to wait for an ambulance so he and the mother took the child in the car to the hospital.

The mother stated that they had been playing a game on the Wii at the friend's house and she looked over and saw the child on the father's lap and it looked like he had just been crying. She did not see the child fall, but stated that she was very focused on the game that they were playing. She stated that the father then took

the child and said he was going to put him to bed. Soon after this he came back with the child and the child was limp and having trouble breathing. She stated that she was the one that was worried about the ambulance so they took him to the hospital in their car. When they got to the hospital, the child was vomiting. She reported to the caseworker that she thought at the time that it reminded her of her other child that had been shaken, but she also stated that the father would never do this.

The friends that were present during the incident were interviewed by the police and their information was shared with the agency. The friends reported that they did not witness a fall, and could not corroborate the story of either parent. In a later interview, the mother stated that she knows her child didn't fall. She stated that she was in this for the child and while she didn't see anything happen, she does not think that it happened the way that it was described by the father. She expressed concern that the child was always fussy around the father and that he was a "momma's boy". [redacted] By 12/01/2015, the mother had moved out from the father's apartment and was living with her mother.

Adams County CYS filed their investigation report with ChildLine on 12/21/2015 with a status of Indicated. The child's injuries were determined to be non-accidental and occurred while the child was in the care of the father. The father was listed as perpetrator by commission. The father was arrested on 12/03/2015 and was confined to [redacted] Prison. He was charged with five counts of aggravated assault and two counts of endangering the welfare of children. The father entered a guilty plea to one count of aggravated assault on 03/24/2016. His sentencing is scheduled for 06/21/2016. The mother of the child was subsequently arrested on 02/15/2016 and confined to the [redacted] Prison with charges of aggravated assault and endangering the welfare of children. These charges stemmed from the criminal investigation involving the sister of the victim child in October 2013. She is currently awaiting formal arraignment.

Doctors have reported that the child is doing very well despite the incident. [redacted] The foster mother reports that the child is much skinnier than he ever was when he stayed with them the first time. After several weeks in care, the foster mother for the child reports that he is coming back to himself and eating a lot. It is unknown if the child will have future complications from any of the injuries at this time.

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

- Strengths in compliance with statutes, regulations and services to children and families;
    - Excellent collaboration between Law Enforcement and Children and Youth Services.
    - Diligent interviews with all parties with Children and Youth Services and Law Enforcement.

- 10-day county supervisions are occurring at the agency in addition to frequent information sharing between the caseworker and supervisor.
- An Agency Review was completed on the case.
- The medical team has been in constant communication with the caseworker and Law Enforcement.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - When a new CPS case comes in on an open Family Support case, keeping the family support case open until the conclusion of the CPS case.
  - Agency Staffing/Meeting for all open cases when a new CPS is received.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; [redacted]
  - More domestic violence education.
  - When a CPS is received on a child who is 1 year and younger, a medical evaluation and skeletal survey should be completed.
  - When a CPS is received on any child who is under 1 year old, notification to law enforcement should be sent.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - Obtaining records from the doctor on all subject children under 3 on all general protective service, child protective service, and ongoing protective service cases.

Department Review of County Internal Report:

The Central Region Office received the Adams County Child Fatality Team Report on01/20/2016. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 11/23/2015. As the case activity continued beyond the November meeting, there are finding that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Adams County Administration on 02/08/2016.

Department of Human Services Findings:

- County Strengths:
  - The county demonstrated appropriate collaboration with law enforcement and medical professionals throughout the current investigation.

- The agency worked quickly to put parameters in place to assure that the child would not be unsupervised around the parents given the questionable nature of his injuries.

- County Weaknesses:
  - The agency closed the ongoing case with the family within a week after receiving a CPS report on the victim child. This report was ultimately indicated and would most likely have necessitated the need for continued ongoing services.
  - When the agency received information that the child had been injured by the father, and that there had been visible bruising, the child was determined to be safe, despite the father still being present in the home and the mother delaying reporting the injury, or seeking medical treatment.
  - The agency is not completing In-Home Safety Assessments on the home of origin at the conclusion of a CPS investigation if the victim child is placed.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  Adams County CYS was found to be out of compliance in the following areas:
  - 3130.21(b) – In the CPS investigation dated 10/07/15, the agency assessed the child to be Safe with the mother and father, despite the mother stating that the father had harmed the child and she did not seek out medical care for the child.
  - 3130.21(b) – In CPS investigations completed on 12/19/13, 12/02/15, and 12/28/15, the agency did not complete a Safety Assessment for the Conclusion of Investigation interval.
  - 3130.21(b) – A Safety Assessment completed on 4/28/15, while the child was still in care, states that the child is "Safe with a Comprehensive Plan", however there is not a Safety Plan found in agency documentation.

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings of this review:

- While the agency has already made plans to address the concern, the Department agrees with the agency recommendation that policy and procedure needs to be developed in regards to closing ongoing cases when there is an active CPS or GPS assessment on the family. This will avoid the need to process a new ongoing case opening, and assure communication of all workers involved with the family.
- The agency needs to review their process in regards to CPS Safety Assessments at the appropriate intervals, even if a child is in placement. Protocol should be established to assure that these assessments are completed.