pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/06/2014
Date of Incident: 03/15/2015
Date of Report to ChildLine: 03/16/2015
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:
Lancaster County children and Youth

REPORT FINALIZED ON:
8/26/15

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:

Senate Bill 1147, Printer's Number 2159 was signed into law on 07/03/2008. The bill became effective on 12/30/2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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. Lancaster County Children and Youth Services have convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/25/2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	victim child	12/06/2014
	biological mother	[redacted]1993
	biological father	[redacted]1991

* The victim child's mother and father were not living together at time of the incident. The incident occurred at the biological father's residence.

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records and medical records pertaining to the family. Follow up interviews were conducted with the county agency caseworker [redacted] supervisors, [redacted] intake director, [redacted] and agency administrator [redacted] on March 16, 17, 19, & 25, April 16, 20, May 27, and 07/23/15. The Regional Office participated in the County Internal Fatality Review Team meeting held on 3/25/15.

Children and Youth Involvement Prior to Incident:

The family had no history with Lancaster County Children and Youth Services Agency.

Circumstances of Child Near Fatality and Related Case Activity:

On Friday, 3/13/15, the victim child's mother dropped off her three month old child to spend the weekend with the child's father. The child's parents were not residing together however both parents had an agreed upon arrangement for custody of

said child. The child's mother reported that the child's condition was healthy or normal prior to the drop off.

The victim child's father was the sole caretaker at the time of the incident. The victim child was three months old at the time of incident. The child was seen on 03/16/2015 at Lancaster General Hospital due to bruising on her face along with bruising on her right ear and upper eye lid. The victim child was transported on the same day to Penn State Hershey Children's Hospital (PSHCH) for further treatment and evaluation. Further testing discovered the victim child had received [redacted] in addition to bruising to the child's face and eyelid [redacted] registered the report as a near fatality. Both Lancaster County Children and Youth Services Agency and law enforcement received the report on 03/16/2015. The victim child's father reported that on Sunday, 03/15/2015, the child was sleeping on his chest area while he was lying on the couch in the home. According to the father he fell asleep and at some point the child rolled over and fell from the couch.

The child's father did initially report that the child was fine all weekend and she had no issues. He provided an account of their interactions on Friday and Saturday. The child's father mentioned that on Sunday evening around eight or nine pm he lay down on the couch with the child resting on his chest. The child fell asleep on his chest. The father believes he fell asleep around eleven pm. Initially, he referenced that there were times when the child would fall asleep with him and he would always be aware of the child and what the child was doing. He reported he would wake up approximately every hour or so and the baby was fine. She would wake up a few times during the night but would go back to sleep with ease. Around seven-thirty am the father mentioned he felt the baby moving and clawing his chest area with her nails. He felt the child fall off his chest and he attempted to catch the child but stated that in doing so he may have accidently knocked her down. The father reported picking up the child, who was lying on the floor face down and crying. He referenced that he picked up the child to comfort her. According to the father's account, he did not notice bruising to the child until approximately a half-hour later. The victim child's father noted he thought the child hit her head off a cooler and possibly a video game controller which were in near proximity to the couch. Law enforcement notes reference the couch of the home to be approximately 18 inches in height from floor to couch. The floor in the home was carpeted. Medical staff was suspicious of the father's account of the incident based on the injuries the child received.

The child was in serious condition and the child had [redacted] so the child was placed on [redacted]. The county began the investigation immediately with the victim child was seen at the hospital on 03/16/2015. The victim child's mother and father were present at the hospital. It is reported the father took the child to Lancaster General Hospital later in the day on 3/16/15 after discussion with family relatives regarding the incident. The victim child's father became uncooperative and refused to talk to the county children and youth agency or law enforcement during

the investigation process. The father utilized his Fifth Amendment right. The child was [redacted] on 03/20/2015 [redacted] The child was placed into agency foster care. The placement was matched based on foster parent experience with babies and young children with medical needs. The victim child had scheduled follow-up appointments via Lancaster General Health on 03/27/2015 [redacted]. According to the medical records, the victim child did not have any additional [redacted] from PSHCH. The major area of focus in the follow-up appointments was to [redacted] The child had additional follow-up appointments in April of 2015 records indicate no reference to additional complications. Lancaster County Children and Youth Services referred the child to [redacted]

The county agency developed a safety plan in which both parents were allowed to be present at the hospital as long as the child was still [redacted] with the understanding that once the child would be [redacted] the biological father would not be able to be at the child's bedside without supervision. In addition, the child's biological mother requested the county agency to consider the maternal grandmother to the child as a kinship resource.

The county agency made a referral to [redacted] County Children and Youth Services agency to do such as the grandmother resided in that county. During both the county children and youth services agency and law enforcement's investigation the majority of the focus was on the victim child's father as he was the caretaker at the time of incident. The child had no preexisting health issues prior to her scheduled weekend visit with her father. The initial story the father provided did not account scientifically for the injuries the child suffered and medical professionals were suspicious of an act of child abuse. The father refused to talk to both law enforcement and Lancaster County Children and Youth Services Agency. The father was charged with 2 counts aggravated assault, 2 counts reckless endangerment, and 2 counts endangering the welfare of a child. The county founded the CPS investigation on 05/15/2015. The father was incarcerated, however in follow-up with the county, it was learned he has since been released via $25,000 bail. At the time of this report, a date and time for a scheduled hearing has yet to be assigned. Lancaster County Children and Youth Services Agency completed the kinship study on the maternal grandmother and the victim child's mother did move in with her mother in Delaware County shortly after the victim child was released from the hospital. The case was [redacted]

Summary of 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;

The county report made reference that both law enforcement and the county children and youth agency responded immediately when the report was received. [redacted] The agency placed the child with a resource home that has experience with medically needy children. The agency is in the process of collaborating with another agency for kinship approval with a relative out of county. In addition, the report made reference to collaboration with medical providers for the county to be able to review medical records.

Deficiencies in compliance with statutes, regulations and services to children and families;

The county's report referenced a suggestion that the biological father should have participated in new (father) parenting education classes due to the circumstances of being a first time parent and being relatively young in age. The county report did not reference any noncompliance issues regarding the county children and youth agency.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The report made reference that [redacted] and other hospitals should have parents (especially new parents) receive parenting classes while or during their stay in hospital. In addition, as highlighted in the prior section, the biological father could have benefited from parenting education. The report made reference that the individual should participate in fatherhood initiative curriculum offered through the prison.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

The county report did not reference this area.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The report references that Lancaster County Children and Youth Services Agency will seek to bolster collaboration with community [redacted].

Department Review of County Internal Report:

The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case on 07/27/2015. Due to the circumstances of this particular case, there are no areas to dispute within the identified report. The county was provided written feedback via correspondence on 08/18/2015 regarding receipt and review of the content of their report.

Department of Human Services Findings:

County Strengths and Weaknesses:

N/A, The Department does not find any specific strengths or weaknesses based on the circumstances of this case.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.

The Departmental review did not find any areas of noncompliance.

Department of Human Services Recommendations:

The Department concurs with the county recommendations and also recommends that hospitals be encouraged to offer resources, instruction for child care and available supports to new parents prior to discharge.