



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 07/07/2010
Date of Near Death: 05/11/2014
Date of Oral Report: 05/11/2014

FAMILY KNOWN:

York County Children, Youth and Families

REPORT FINALIZED ON:

8/11/15

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. 6349 (b))

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. York County has convened a review team in accordance with Act 33 of 2008 related to this report on 6/2/2014 at York Hospital. The review team's report was finalized on 8/6/14. The Central Region Office concurred with the recommendations of the review team on 8/25/14.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother (AP)	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Victim Child (VC)	07/07/2010
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Half-Sibling	[REDACTED] 2013
[REDACTED]	Mother's paramour/AP	[REDACTED] 1987
[REDACTED]	Family friend	[REDACTED] 1994
[REDACTED]	Family friend	[REDACTED] 1980
[REDACTED]	Half-Sibling	[REDACTED] 2009

Notification of Child Near Fatality:

On 5/11/14 York County Children, Youth and Families (agency) received a report from [REDACTED] stating [REDACTED] reported a child near fatality, alleging the VC's condition may be the result of suspected physical abuse by the VC's mother and/or mother's paramour. The VC resided in the home of his mother, mother's paramour and siblings.

On 5/11/14 the VC left his mother's bedroom to go to the bathroom. When the VC did not return to the bedroom, the mother felt the VC was taking too long and sent her paramour to check on the VC. The mother's paramour found the VC unresponsive, lying in the hallway with an old cable cord for the television next to him. The VC had ligature marks around his neck. The VC was taken to York Hospital and then flown to Hershey Medical Center [REDACTED]

On 5/11/14 the agency notified the Central Region Office of Children, Youth and Families of the Near Fatality.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed current and past records pertaining to the [REDACTED] family.

Follow up interviews were conducted with [REDACTED], Quality Program Specialist for York County Children, Youth and Families. Information regarding current status received from [REDACTED], caseworker for York County Children, Youth and Families.

The regional office participated in the County Internal Near Fatality Review Team meeting on 6/2/14 at York Hospital. Representatives in attendance included the agency, [REDACTED] Police Department, York County District Attorney's Office, Dr. [REDACTED] – Pediatrician at York Hospital and [REDACTED] of Central Region OCYF. The review team's report was finalized on 8/6/14. The Central Region Office concurred with the recommendations of the review team on 8/25/14.

A review of the CY 104, Report of Suspected Child Abuse To Law Enforcement Official, showed the agency submitted the report to the [REDACTED] Police Department on 5/11/14. Detective [REDACTED] was assigned the police investigation.

A review of the CY 48 for [REDACTED] dated 6/11/14 showed the alleged perpetrators as the VC's mother and mother's paramour. The status determination was Unfounded. The agency found that based on interviews with the family and VC's medical staff, the incident was an accident.

The VC's medical records from York Hospital and Hershey Medical Center were reviewed by Central Region.

Central Region staff reviewed the Family Service Plan developed on 8/1/14 and the Family Service Plan Review dated 2/1/15.

Children and Youth Involvement prior to Incident:

This family first came to the attention of the agency on 12/9/13. At this time Suffolk County, New York Child Protective Services contacted the agency with a request for a safety assessment of sibling child, [REDACTED]. Suffolk County had most recently become involved with the family on 11/23/13 when [REDACTED] was burned by hot soup and had to be air lifted to Stonybrook Hospital in New York for medical care. At the time, [REDACTED] was in the care of the mother and her biological father, [REDACTED]. The family was in New York visiting relatives when the incident occurred. The family reported to New York CPS that they resided in York County Pennsylvania at that time at [REDACTED]. The home in Suffolk County, New York was reported to be the home of the child's aunt, [REDACTED]. The CPS worker documented that this home was cluttered, dirty and furniture was falling apart, but did meet minimal

standards. Regarding the incident in which [REDACTED] was burned, it was determined that the mother was in the kitchen with [REDACTED] and her 6 year old half sibling, [REDACTED], who resides in New York. The mother reportedly left the kitchen to use the bathroom. While the mother was out of the room, [REDACTED] pulled over a bowl of hot soup that was sitting on the table and onto herself and the half sibling. The mother reported to hear [REDACTED] crying and returned to the kitchen. Medical attention was sought for both children. [REDACTED] had [REDACTED] to her chest and back, was [REDACTED] to the hospital that day, and later [REDACTED] to the care of her mother and father. Although the father, grandmother and other relatives were reportedly in the home at the time of the incident, there were no witnesses. Upon interviews with those adults in the home at the time and the 6 year old half-sibling, it was determined that [REDACTED] burns were the result of an accident due to lack of supervision. The mother and father reported to the CPS caseworker in New York that they had planned to return home to [REDACTED], Pennsylvania. On or around December 3, 2013 the family returned home to [REDACTED]. The CPS caseworker from New York last had phone contact with mother on December 9, 2013 at which time she reported that [REDACTED] was doing well and had a follow up appointment for her [REDACTED] with the pediatrician "next Tuesday".

In the request for safety assessment made by the CPS caseworker from New York on 12/9/13, it was also requested that agency verify the child's [REDACTED] and medical follow-up needed. CPS was concerned that the child needed to see a [REDACTED], rather than the pediatrician.

In response to the referral from New York, the agency's screening department attempted to contact the mother by phone on 12/16/13, 12/18/13 and 12/26/13. Messages were left for the mother on each of these occasions to call back. On 12/26/13, the mother returned the messages reporting that [REDACTED] has a follow up appointment at Hershey medical Center on 1/16/14. The screener informed the mother that the Agency would contact her on 1/17/14 to follow up regarding this appointment. On 1/17/14 the screening department called the mother but her phone was disconnected. The screener then called Hershey Medical Center and spoke with [REDACTED], who reported that the family was not seen. On 1/17/14, an intake caseworker was assigned to this report for investigation. On 1/24/14, the assigned caseworker attempted to contact the mother on her home phone and cell phone; both numbers were disconnected. The caseworker went to the home on 1/24/14 and no one was home. The caseworker noted that there were no footprints in the snow which had been present for days prior. The caseworker left a note for the mother and/or her paramour to call the caseworker. On 1/29/14, the caseworker attempted to call the mother and the number was still disconnected. On 1/29/14, the caseworker left a message for the New York CPS caseworker stating that York CYF had been unable to locate the family. No additional contact was made between York CYF and New York CPSr. The caseworker went to the home again on 1/31/14 and left another note for the mother and her paramour. The caseworker contacted the York County [REDACTED] on 2/11/14, and determined that [REDACTED], mother and her paramour were [REDACTED]. The case was screened out in February 2014. The agency closed the case on 2/11/14. The courtesy assessment was not completed by the agency, although the agency made an effort to contact the family. No letter of response to Suffolk County was found in the record. It should be noted that Suffolk County CPS did not report knowledge of any other siblings/children residing in the home with the mother, mother's paramour and [REDACTED] in [REDACTED].

Prior to the report received on 11/23/13 by New York CPS, this family has an extensive history of involvement with CPS in Suffolk County, New York. This history was sent to York CYF on 12/9/13 with the referral made at that time. This involvement begins on 1/25/93 regarding a report in which the mother was named the subject child in an indicated (substantiated) report of child maltreatment. A review of the New York records, lists that the mother was involved in five indicated reports as a child from 1993-1996. As a mother, she has been named in fourteen reports from 4/7/2009 through the most recent report regarding [REDACTED] on 11/23/13. This includes unfounded reports, indicated reports and another disposition listed as "SUS". The mother's paramour is listed as a child in three indicated reports from 5/1/90-5/17/95. He is listed in two additional reports as an adult, one unfounded and the most recent report dated 11/23/13 regarding [REDACTED] had not been known to Suffolk County New York CPS prior to the 11/23/13 reports.

Circumstances of Child Near Fatality and Related Case Activity:

On 5/11/14, the Agency received a referral/notification of a child near fatality, alleging the VC's condition may be the result of suspected physical abuse by the mother and/or the mother's paramour. The VC had been residing in the care of the mother and the mother's paramour at the time of the incident. Also in the home were the VC's half-sibling and full-siblings. Between approximately 9:00am-10:00am on 5/11/14, the four children, mother and mother's paramour were in the mother's bedroom. The VC left the bedroom to use the bathroom. When the mother and her paramour noticed that the VC was taking a long time, the mother's paramour left the bedroom to check on the VC. At this time, he found the VC unresponsive, lying in the hallway with a cable cord for the television next to him. The cable cord was long, flexible and tied to a door knob in the hallway. The mother had replaced this old cord for a new cable cord the previous day and had put the cord in a trash bag that was left in the hallway where the VC was found. The mother's paramour took the cord off of the VC's neck and noted there were ligature marks where the cord had been. The mother's paramour carried the VC back into the bedroom. The mother began performing CPR while her paramour called 911. When EMS arrived at the home they transported the VC to York Hospital. After assessment at the York Hospital [REDACTED], including the [REDACTED], the VC was flown to Hershey Medical Center. The treating physicians at York Hospital and Hershey Medical Center initially suspected child abuse. Initially, they did not feel the VC could have caused this condition himself or exerted enough force to pass out and lose a pulse. The VC was [REDACTED] at Hershey Medical Center.

On 5/11/14, [REDACTED] Police Detective [REDACTED] and Emergency Duty Caseworker [REDACTED] [REDACTED], conducted interviews with the mother and mother's paramour at the [REDACTED] Police Station. Following these interviews the Detective and Caseworker conducted a home visit to the neighbor's home where the sibling children currently were staying and mother's home where the incident had occurred. The cable cord that had been around the VC's neck was seen and it was noted that there were approximately 13 other cords in the home. The VC is unable to be interviewed due to his medical condition.

A MDT meeting was held at Hershey Medical Center on 5/20/14. Included in this meeting was the District Attorney's Office, the [REDACTED] Police Department, the caseworker and the Hershey Medical Center physician. The team reviewed photos of the home, the cable cord and information obtained by all parties regarding the incident involving the VC. The team concluded that it was possible the incident was an accident and had occurred the way the mother and paramour had explained. The cord was flexible enough to have gotten tied around the VC's neck. If the cord was tied to the door at the top of the steps, the doctors felt it was feasible that he could have gotten himself stuck and caused himself to lose consciousness. Although the entire incident was concerning, the doctors felt it could have been accidental in nature. The doctor's stated that for a child the size and weight of the VC, it would only take a few minutes for him to suffer severe brain damage.

[REDACTED], Quality Program Specialist for York County Office of Children, Youth and Families reviewed the agency's past and current investigation and assessment records regarding the family. This review of records included medical records from York Hospital and Hershey Medical Center.

All of the children have [REDACTED]. It was recommended that the Agency assist the family with getting all of the children connected to the York Hospital [REDACTED]. Earlier this year, the family moved to [REDACTED] from New York and has not established a family doctor.

It was also recommended to connect the oldest child to the Hershey Medical Center [REDACTED]. The mother has a [REDACTED] for this child but has not obtained the [REDACTED] due to transportation barriers. The Agency will assist the family in obtaining this [REDACTED] and with transportation barriers.

Finally, it was recommended that the caseworker contact the New York county children protective services agency and obtain records for a clear understanding of the family's prior involvement with services while they resided in New York.

A review of the CY 48 for [REDACTED] dated 6/11/14 showed the alleged perpetrators as the VC's mother and mother's paramour. The status determination was Unfounded. The agency found that based on interviews with the family, the incident was an accident.

Current Case Status:

The criminal investigation has been completed at this time and the police and York County District Attorney's Office are not charging the mother or her paramour. The CPS investigation has also been completed and the report was unfounded as there were no findings of abuse from the medical professionals involved, perpetrator admission or other information determined to suggest abuse had occurred. At the conclusion of the investigation the medical professional team involved felt that it is unusual but plausible that the child could have received the injuries as reported by the mother and her paramour. Due to risk factors in the home, the family was accepted for ongoing services. The family is currently working with [REDACTED]

The VC was moved from the Hershey Medical Center to the Hershey [REDACTED]. His prognosis is unclear at that time; however, he has suffered [REDACTED] and is not expected to regain any significant amount of functioning. The siblings and half-sibling remain in the care of the mother and mother's paramour at this time. A safety plan was in place during the investigation, for two family friends, [REDACTED], to supervise all contact between the three children, mother and mother's paramour. This safety plan was ended when the investigation was completed.

The family previously received services through Suffolk County New York CPS. They are currently receiving [REDACTED] and accepted for ongoing services through the Agency. The family was connected to the Hershey Medical Center for medical services for the sibling [REDACTED].

As of 3/16/15 the incident involving the VC was ruled an accident. The VC is home with his parents. The VC was never in the custody of the agency or in agency placement. The VC's medical condition is [REDACTED]. The agency is still providing General Protective Services to the family. Also involved with the family [REDACTED] provides respite when needed. [REDACTED] is in place for [REDACTED]

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

The regional office participated in the County Internal Near Fatality Review Team meeting on 6/2/14 at York Hospital. Representatives in attendance included the agency, [REDACTED] Police Department, York County District Attorney's Office, Dr. [REDACTED] - Pediatrician at York Hospital and [REDACTED] of Central Region OCYF. The review team's report was finalized on 8/6/14. The Central Region Office concurred with the recommendations of the review team on 8/25/14.

- Strengths: The agency worked collaboratively with York Hospital, Hershey Medical Center and the [REDACTED] Police Department in investigating the Near Fatality Report.
- Deficiencies: The agency did not complete the assessment requested by Suffolk County, New York [REDACTED] to ensure [REDACTED] had follow up treatment for burns shed received in Suffolk County, New York. The agency did make a concerted effort to locate the family.
- Recommendations for Change at the Local Level: None identified at this time.
- Recommendations for Change at the State Level: None identified at this time.

Department Review of County Internal Report:

The regional office participated in the County Internal Near Fatality Review Team meeting on 6/2/14 at York Hospital. Representatives in attendance included the agency, [REDACTED] Police Department, York County District Attorney's Office, Dr. [REDACTED] – Pediatrician at York Hospital and [REDACTED] of Central Region OCYF. The review team's report was finalized on 8/6/14. The Central Region Office concurred with the recommendations of the review team in a written report sent to agency director, [REDACTED], on 8/25/14.

Department of Public Welfare Findings:

- County Strengths: During the period of the Near Fatality Report, the agency worked with medical staff and police officials in determining the status determination of Unfounded in that the injuries to the VC were accidental.
- County Weaknesses: The agency did not complete the assessment requested by Suffolk County, NY regarding follow up medical treatment for burns [REDACTED] received while visiting relatives in that county. The agency did make a concerted effort to locate the family.
- Statutory and Regulatory Areas of Non-Compliance:
A file review of the case found a violation of 3490.232(c), regarding assigning response times to intake reports. The agency received the referral on 12/09/13 and did not assign the case for assessment until 1/17/14. A Licensing Inspection Summary was not issued for this citation as it has been cited on a subsequent licensing review since the violation occurred. The agency has provided a plan of correction to address the violation.

Department of Public Welfare Recommendations:

York County Children, Youth and Families should continue to work with medical staff and police officials in investigating Near Fatality Report.