



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## REPORT ON THE NEAR FATALITY OF

[REDACTED]

**Date of Birth: 04/16/2013**  
**Date of Near Death: 10/28/2014**  
**Date of Oral Report: 10/28/2014**

### FAMILY NOT KNOWN TO:

York County Office of Children, Youth and Families

### REPORT FINALIZED ON:

April 17, 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))

**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 convened a review team beyond the 30 day time frame which was not in accordance with Act 33 of 2008. A team meeting was scheduled prior to 30 days but had to be cancelled due to inclement weather.

**Family Constellation:**

<b><u>Name:</u></b>	<b><u>Relationship:</u></b>	<b><u>Date of Birth:</u></b>
██████████	Victim Child	04/16/2013
██████████	Mother	██████████ 1995
██████████	Father	Unknown
██████████	Mother's Paramour	██████████ 1992

**Notification of Child Near Fatality:**

York County Office of Children, Youth and Families (YCOCYF) was contacted by ██████████ regarding the victim child. He was transferred to the facility on October 28, 2014, from Holy Spirit Hospital with suspected non-accidental trauma. The child was ██████████ and unconscious. The ██████████ called the report into ChildLine. YCOCYF then called ██████████ to retrieve the report.

**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 ██████████, ██████████ Supervisor ██████████, Agency Quality Manager ██████████, and Agency Administrator ██████████ throughout involvement but specifically on October 29, 2014, November 5, 2014, and November 12, 2014, and December 17, 2014. The agency conducted an Act 33 meeting on December 17, 2014.

**Children and Youth Involvement prior to Incident:**

There was no prior agency involvement in this case.

**Circumstances of Child Near Fatality and Related Case Activity:**

On the morning of October 28, 2014, the mother left for work at 5:30 am, leaving the victim child in the care of her paramour. Normally the maternal grandmother or

maternal great-grandmother would care for the child while she was at work but neither caretaker was available that day. The first time the paramour cared for the child, one week prior to this incident on October 22, 2014, the child had a bump and bruise on his forehead and bruises on his back, as well as what looked like bite marks on his arm. It was reported by the paramour that he had fallen out of his crib. The maternal great-grandmother stated that she had seen these marks but did not make any calls at that time.

On October 28, 2014, the mother called from work during her 1:00 pm break and spoke to her paramour and to the victim child, and at that time everything was fine. She then missed three calls from her paramour. When she called him back at 2:30 pm, he stated that he was taking the child to the hospital because he was unconscious and vomiting. He took the child to Holy Spirit Hospital in Camp Hill. From there he was taken to Penn State Hershey [REDACTED]. When questioned about the child's injuries the paramour stated that he had laid the child down for a nap, but then got him up 15 minutes later because it was so nice outside. He laid him down to change him and the child began to vomit and became unconscious.

The child was [REDACTED] and unconscious at Holy Spirit Hospital. He was transported via ambulance to Penn State Hershey [REDACTED] where he was having frequent [REDACTED] and there was [REDACTED]

[REDACTED] Additional testing revealed [REDACTED]. The child was [REDACTED] to the [REDACTED]. While hospitalized, his mother stayed in Hershey and visited regularly. It was reported that she would often become upset and had to be calmed by hospital social workers. They provided supportive services to help her understand what was happening to her son. The child began to show improvement and was removed from [REDACTED]. He also started to talk and was able to remember people.

After spending one month in the [REDACTED], the child [REDACTED] to the Penn State Hershey [REDACTED] in November 2014 and was there for two weeks. He was [REDACTED] in early December and went to live with his maternal grandmother and paternal grandfather, who are husband and wife, under an informal plan. The child's mother also moved into the home to spend time with her child and work on agency recommendations. The child was required [REDACTED].

During the course of the investigation, the agency learned that the mother was pregnant with the child of the paramour. His family reported that he had made statements about not wanting the victim child around. The mother had a miscarriage with this pregnancy in November 2014.

The paramour was arrested on November 5, 2014, and was detained in the [REDACTED] Prison. He was charged with two counts of aggravated assault and endangering the welfare of children.

The agency completed the investigation and on December 23, 2014, and indicated the paramour as the perpetrator of child abuse as he was the sole caretaker of the child at the time of the incident.

**Current Case Status:**

The case was opened for [REDACTED] services to monitor the mother's progress and to ensure the safety of the child. The mother attended [REDACTED] courses through [REDACTED] and the agency reported that she had been fully cooperative. The child continues to make progress and is enrolled [REDACTED]. The long-term effects of the child abuse are unknown at this time. As the child grows he may always be weak on the left side of his body, as if he had a stroke. He continues to improve and is mobile, verbal, and breathing on his own. He receives weekly [REDACTED] sessions. [REDACTED]

The child's father lives in Cumberland County and visits him at the grandparents' home.

The mother participated in parenting programs and accepted the services and support provided to her. As a result of her progress, the agency made the decision to close this case in February 2015.

The paramour was arraigned on January 2, 2015, and is awaiting a pre-trial conference. He remains incarcerated at the [REDACTED] Prison.

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on December 17, 2014, at the York Hospital Pediatric Unit. The team was comprised of local CYD professionals, medical professionals, law enforcement, and regional staff. The original meeting was scheduled for November 26, 2014, but had to be cancelled due to inclement weather. The team was not able to meet again until December 17, 2014.

- **Strengths:**
  - The MDT worked well together to complete the investigation and share information.
  - There are numerous family supports in place for the mother and child.
  - The child's prognosis has progressed better than expected and he was able to be discharged to family.
  - Penn State Hershey Children's Hospital completed an extremely thorough evaluation including imaging tests and evaluations which provided the MDT clear evidence of abusive head trauma.
  
- **Deficiencies:**
  - None Noted.
  
- **Recommendations for Change at the Local Level:**

- Child welfare professionals should consider bruises on a child's back or the trunk of the child's body red flags. Also, if a child has a human bite mark, compare the size of the bite mark to the child's mouth. Consider the location of the bite mark—is the mark located somewhere the child could reach or not? These are important factors in differentiating between a self-inflicted bite or a bite caused by someone else. Consider a forensic dentist as a resource for examining bite marks in CPS Investigations.
- Recommendations for Change at the State Level:
  - None Noted.

**Department Review of County Internal Report:**

YCOCYF provided a report on the Near Fatality of the Victim Child to the Regional Office on February 20, 2015. 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 February 24, 2015.

**Department of Human Services Findings:**

- County Strengths:
  - County response to 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 agency was able to work with the mother to identify family resources that could help her with her child and allow her to complete agency recommendations.
  - The agency was able to engage the mother to help her understand the need for agency intervention and encourage her to be cooperative with services.
- County Weaknesses:
  - None Noted.
- Statutory and Regulatory Areas of Non-Compliance:
  - None Noted.

**Department of Human Services Recommendations:**

The agency should follow through with discussing ways of alerting the community of appropriate numbers to call, or other ways to contact child welfare services when they observe unexplained marks on young children.