



**REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth:** 12/21/2013  
**Date of Incident:** 02/04/2016  
**Date of Report to ChildLine:** 02/05/2016  
**CWIS Referral ID:** [REDACTED]

**FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR  
WITHIN THE PRECEDING 16 MONTHS:**

Pike County Children and Youth Services

**REPORT FINALIZED ON:**

July 13, 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))

**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.

Pike County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 02/24/2016 and 03/16/2016.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Father	[REDACTED] 1982
[REDACTED]	Victim Child	12/21/2013
[REDACTED]	Brother	[REDACTED] 2000
[REDACTED]	Brother	[REDACTED] 2007
[REDACTED]*	Babysitter	[REDACTED] 1986
[REDACTED]*	Spouse of [REDACTED]	[REDACTED] 1983
[REDACTED]*	Child of [REDACTED]	[REDACTED] 2011
[REDACTED]	Child of [REDACTED]	[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 Fatality Review Activities:**

The Northeast Regional Office of Children, Youth and Families (NERO) obtained and reviewed all case records pertaining to the [REDACTED] families. All medical records pertaining to the incident were obtained and reviewed. NERO staff participated in the Act 33 meetings that occurred on 02/24/2016 and 03/16/2016. Law enforcement was also present at these meetings and provided information regarding their investigation.

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

Pike County Children and Youth Services (PCCYS) had prior involvement with the [REDACTED] families in December 2015 and January 2016. On 12/10/2015, PCCYS initiated a child abuse investigation regarding the victim child in response to a report that the victim child was [REDACTED] at Pocono Medical

Center for a broken arm. It was reported that the injury occurred while the child was in the care of a babysitter. The child had reportedly lost his balance while on the steps, the babysitter grabbed the child by the arm, and his left arm got stuck in the spindle. The child was brought to the Emergency Room the following day by the mother after she noticed the child's arm was swollen, painful, and he was favoring it. PCCYS responded to the hospital to see the child. The parents were interviewed. Another caseworker went to the home of the [REDACTED] [REDACTED] babysitter to interview the AP and assess the safety of her two children. PCCYS did not obtain medical consult. PCCYS also did not interview the verbal child who was witness to the referral incident. This incident was also investigated by Pennsylvania State Police. A County MDIT meeting was held on 12/14/2015. It does not appear that the Trooper attended this meeting. At that time, PCCYS reported that the incident appeared to be accidental. Case notes reflect that the caseworker contacted the PSP Trooper assigned to the case on 12/21/2015 and left a voice mail message asking that the trooper contact the worker with any concerns or the case will be closed. On that same date, the caseworker received the medical records from the child's ER visit which included [REDACTED] [REDACTED] recommending evaluation for non-accidental trauma. The child was taken for follow up [REDACTED] by the mother. However, PCCYS did not obtain these records, did not notify the [REDACTED] of the recommendation for evaluation for non-accidental trauma, and did not secure these medical records during the investigation. On 01/05/2016, PCCYS unfounded this report. The CY48 states "[REDACTED] injuries are accidental; there are no documented medical concerns and no previous injuries were found in the additional exams that the hospital did on [REDACTED]."

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

On 02/05/2016, Pike County Children and Youth Services (PCCYS) received a Near Fatality Report identifying [REDACTED] as the victim and the alleged perpetrator as babysitter, [REDACTED]. The report reflected that the child had been in the care of his babysitter on 02/04/2016 since 8:15am when the mother met the babysitter in a parking lot for her to pick up the child and the mother went to work. The mother reported that at about 3:15pm she was called by the babysitter and was told "I was freaked out by [REDACTED]. He had a little rice and the color flushed out of him and his lips turned blue. He had diarrhea in his diaper almost immediately and then said she took him upstairs to bathe him to see if he got better but didn't." The mother reportedly told the babysitter to take the child to the Emergency Room and the mother would meet her there. The child [REDACTED] due to the severity and life threatening injuries. [REDACTED]

[REDACTED] At that time, it was unknown if the child would survive his injuries.

After initial evaluation [REDACTED] at Pocono Medical Center, the child was transferred to Lehigh Valley Hospital for more advanced care due to his life threatening condition. [REDACTED]

[REDACTED]

Although the child presented to the Emergency Department on 02/04/2016 at approximately 4:25pm, the report was not registered [REDACTED] until 02/05/2016 at 11:20am. PCCYS initiated their investigation on 02/05/2016 and also notified Pennsylvania State Police via phone on that date of the report. The caseworker had contact via phone [REDACTED]

Due to the delay in receiving a report, the PCCYS director contacted [REDACTED] who reported that they contacted ChildLine twice to make a report.

The babysitter was interviewed by PSP at their barracks on that date. She has two children of her own who were present at the PSP barracks at the time of the interview. The babysitter denied injuring the child and offered no plausible explanation for the child's injuries.

In the afternoon on 02/05/2016, a meeting was held with Pike County District Attorney's Office, Pennsylvania State Police and PCCYS staff at which time the current and prior incidents were reviewed. The babysitter's prior conviction for aggravated assault in New Jersey was also reviewed. The babysitter had assaulted her biological mother causing the mother's retinas to become detached. While this meeting was being conducted, the babysitter was completing a polygraph examination which she failed. The babysitter's children remained at the police barracks during the day while the investigation was being completed.

On that date, PCCYS developed a safety plan with the father of the babysitter's children. The children's father is married to the mother and is a household member. A plan was developed that he would not leave the children alone with the mother and the maternal grandmother would come to stay with the family to assist. Also on that date, PSP executed a search warrant on the residence of the babysitter.

On 02/07/2016 the four-year-old child of the babysitter was interviewed at CAC-Northeast Pennsylvania. The child described physical discipline by the babysitter of her younger sister. The child reported that when her sister gets in trouble, her butt is pink and her mother's hand is red. The child was non responsive when asked questions regarding the victim child. Concerns for adult influence upon the four

year old were noted as the child was brought to the CAC by her father who told the PCCYS caseworker that he believed everything was being pinned on his wife.

A full skeletal scan of victim child was completed after his admission to Lehigh Valley Hospital [REDACTED]

The victim child remained hospitalized [REDACTED] The child [REDACTED] returned to his parents' home on 03/11/2016. He was unable to eat solid foods and received total parenteral nutrition. [REDACTED]

On 03/23/2016, PCCYS indicated the babysitter for the abuse of the victim child. On 04/08/2016, Pennsylvania State Police charged the babysitter with six counts of Aggravated Assault, multiple counts of Endangering the Welfare of a Child, Reckless Endangerment, and two counts of Intimidation, Retaliation or Obstruction in Child Abuse Cases. The babysitter was incarcerated for several days and then posted bail. The conditions of her bail preclude her from having any contact with children under the age of 18. The charges related to abuse suffered by the victim child while in the care of the babysitter from the Fall of 2015.

The children of the babysitter were placed in the custody of PCCYS on 03/01/2016 after PCCYS determined that they could not monitor the safety plan as the family had fled out of state. [REDACTED]

[REDACTED] The family has been offered parenting services.

On 03/22/2016, PCCYS opened the case of the victim child's family for services to provide supportive services and to assist the family in accessing additional community services. The victim child continues to improve [REDACTED] He is now able to eat solid food. The criminal prosecution of the babysitter is pending.

**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 agency responded immediately to the call [REDACTED] on 02/05/2016 prior to the formal report being obtained through the ChildLine system.

- The agency coordinated the investigation into the near fatality with the Pennsylvania State Police and completed interviews using a team approach. Communication and sharing of information between the agency and other agencies following February 5, 2016 is seen as a strength.

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

- The failure to appropriately investigate the injury suffered by the victim child in December 2015. Specifically, assessment based on individual impression rather than review of evidence; providing the mother of the victim child with information suggesting the injury was accidental; failure to isolate and interview individuals involved, including child eyewitness; failure to obtain and understand medical records prior to making case determinations; developing a case determination based on a lack of a return call from law enforcement rather than actual communication; relying too heavily on the investigation of law enforcement or lack thereof; failure to utilize the structure of the county's MDIT to allow full review and discussion of the case.
- Interview with victim child while in the hospital was inappropriate, suggesting and leading, and not necessary.
- The safety plans and assessments created for the babysitter's family failed to fully appreciate the risk posed to the children by the babysitter, included the risk of flight to another jurisdiction where minimal authority and supervision existed, and reflected a disconnect between information available and that which was considered when making safety determinations.

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

- Review leadership of the county agency to ensure it is providing training, guidance, and support to case workers involving serious incidents of child abuse.
- Ensure staffs have appropriate sources of information before approving a case for unbounding/closure.
- Ongoing training for caseworkers in the area of physical abuse and medical records so that information can be sought, obtained and reviewed in a timely fashion to determine safety and case planning.
- The agency should develop a relationship with a board certified child abuse expert.
- The failure of the state reporting system caused a delay in proper investigative authorities securing the crime scene and taking steps to protect other children in the household. The Child Abuse Hotline system needs to be repaired not only for convenience of reporting but also to avoid becoming a hindrance to swift action by child abuse investigators.

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

- None

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

- The agency should utilize an MDIT approach for child abuse cases to include a thorough case review as expeditiously as possible.
- A broader, more encompassing review team which includes individuals of varying levels of experience and background should be developed for child fatality / near fatality review team meetings.

**Department Review of County Internal Report:**

The Pike County Child Near Fatality Review Team convened on 02/24/2016 and 03/16/2016 to review this case. NERO received the Pike County Child Near Fatality Team Report on 05/24/2016. The report content and findings is representative of what was discussed during the meetings on 02/24/2016 and 03/16/2016. NERO notified the PCCYS director on 06/28/2016 of receipt and acceptance of the county report.

**Department of Human Services Findings:**

County Strengths:

- PCCYS initiated the investigation immediately upon receipt of a report regarding the referral incident despite the fact that they had not yet received a registered child abuse report certified as a near fatality.
- PCCYS immediately collaborated with law enforcement upon receipt of the Near Fatality report.
- The county was compliant in convening the Child near Fatality Review Team Committee on two occasions within the required time frame.
- The county submitted a thorough and complete internal review report within the required time frame.
- Interviews conducted during the investigation were completed in collaboration with law enforcement.

County Weaknesses:

- During the December 2015 investigation, PCCYS and law enforcement failed to clearly communicate the findings of their investigative efforts. There was no joint collaboration in the investigation of the abuse report received at that time.

- PCCYS failed to communicate directly with medical professionals during the December 2015 investigation and determined that the injury was accidental based on personal opinion.
- During the December 2015 referral incident, the child who was an eyewitness to the event was not interviewed nor was medical information pertaining to this child requested or exams conducted.
- The assessment of safety during the December 2015 incident did not include history gathering in all six domains and was allegation based.
- During the February 2016 incident, the county developed a safety plan that was not manageable or feasible for the county to ensure safety of the perpetrator's children.
- The Community Review Team is in need of additional community representation.

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

- As noted in the prior section, areas of regulatory non-compliance were noted pertaining to the CPS investigation of December 2015 as well as application of the safety assessment and management process in both the near fatality and prior incidents. A licensing inspection summary will be issued outlining the citations in Chapter 3490 and 3130 and requiring the development of a corrective action plan.

**Department of Human Services Recommendations:**

- Staff training is recommended regarding investigation and interviewing techniques as well as the review of medical records and physical abuse.
- Assessment of the county agency protocol as it pertains to the training, guidance, and support of front line and supervisory staff in the investigation, review, and approval of outcomes.
- Staff training is recommended regarding the safety assessment and management process with specific attention to the following: interview protocol, information gathering, safety plan development and monitoring.

[REDACTED]

[REDACTED]

[REDACTED]

It is therefore recommended that the county solicitor become more active in the review of case information and investigation findings.

- It is recommended that the county expand its community review team membership to include more community service providers including educational and medical personnel.
- Further review on the state level of the efficiency of the ChildLine as related to the finding that [REDACTED] reportedly made 2 reports to ChildLine that were never processed and referred to the county agency.