pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 9/26/13
Date of Incident: 7/18/14
Date of Oral Report: 7/18/14

FAMILY NOT KNOWN TO:

Montgomery County Office of Children and Youth

REPORT FINALIZED ON:
7/7/15

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)

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. Montgomery County has convened a review team on August 11, 2014 at 2 pm in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim child	9/26/13
	Mother	[redacted]/89
	Maternal Grandmother	[redacted]/61*
	Father	[redacted]/79**

* [redacted] does not live in the home but had extensive caretaking responsibilities for the child as babysitter.
** [redacted] does not live in the home and has had little contact with the child up until the time of the incident.

Notification of Child Fatality:
The Montgomery County Office of Children and Youth received a report [redacted] on 7/18/14 with the following information: The child, [redacted], was brought to the [redacted] Pottstown Memorial Medical Center by her mother, [redacted], on 7/18/14. It was reported that the child appeared lethargic and had numerous unexplained injuries. The child was diagnosed with an [redacted]. The child had bruises to the face. The child was transferred to Children's Hospital of Philadelphia (CHOP) and admitted to the [redacted]. Previous to the child's hospitalization the mother had picked the child up from the maternal grandmother, [redacted], and stated that the child had bruises at that time. Mother did not get a clear explanation for the injuries. The child was determined to be in serious condition and was certified a Near Fatality by [redacted] at CHOP.

Summary of DHS Child Fatality Review Activities:
The Southeast Regional Office of Children, Youth and Families obtained and reviewed current Child Protective Services (CPS) investigative information including the CY-48 as well as written case documentation from the Montgomery County Office of Children and Youth. Included in the packet of information were medical records from the CHOP as well as investigative information, including transcripts from the polygraph given to [redacted] and [redacted]

conducted by the [redacted] Police Department. The Southeast Regional Program Representative also reviewed information from the Act 33 meeting which was held on August 11, 2014 where a thorough case presentation was completed. The Program Rep. also periodically communicated with [redacted], the Quality Assurance Administrator at the Montgomery County Office of Children and Youth for case updates.

Summary of Services to the Family:

Children and Youth Involvement prior to the Incident:
The mother [redacted] does not have a history with the Agency with respect to parental concerns.

The maternal grandmother, [redacted], has had extensive involvement with the Agency (2001-2010) stemming from allegations of physical abuse and neglect, chronic drug abuse and [redacted] issues. [redacted] was placed in foster care in March of 2003. Later after [redacted] was returned to the home, the Agency's involvement continued due to adolescent issues and a high level of parent/child conflict.

Circumstances of the Fatality and Related Case Activity:
As stated earlier, the child was seen [redacted] at Pottstown Memorial Medical Center and was later transferred to CHOP on 7/18/14. In addition to the child having a [redacted] which is a life threatening injury, the child had other concerning medical issues. The child had bruising under her chin, bruising on her collarbone on both sides, an abrasion on her left shoulder blade on the child's back, a bruise on her right thigh and a faint spotty bruise on her chest bone.

At first, both the mother and grandmother were considered to be alleged perpetrators as it could not be determined who caused the child's injuries. The mother is employed as a residential advisor at [redacted] (2 years) and works different shifts, even within the same week. When the mother works, she depends on family members including the child's grandmother and aunt, to care for the child. After a thorough investigation conducted by the [redacted] Police Department, including polygraphs given to both alleged perpetrators, it was determined that the grandmother, [redacted], was the sole perpetrator. The alleged perpetrator has a long history of Agency involvement which includes allegations of physical abuse and neglect with her own daughter, the victim child's mother. The alleged perpetrator failed to pass the polygraph test. The alleged perpetrator had unlimited access to the child at the time it was calculated that the child received the injuries, which was determined through a medical examination, police interviews and a re-constructed times line indicating the grandmother to be the primary caretaker for most of the time prior to the incident. The grandmother continued to deny causing injuries to the child or knowing how the injuries occurred. Suspicion regarding the mother and other family members was ruled out by the [redacted] Police.

It should also be noted that the child had been taken to the Doctor for a sick visit (Wednesday 7/16/14) shortly before the incident occurred. The child has a history of [redacted] Follow up contact with the

child's physician indicated that the child did not have any injuries related to the [redacted] or bruising on any other parts of her body at the time of the visit.

The child's 7 year-old cousin admitted to dropping the baby and there was an investigation as to whether that could have caused the child's injuries. This was ruled out by the police and medical staff at CHOP, that dropping the child would not have caused injuries to this extent.

During the child's stay at CHOP a skeletal survey was performed with negative results, indicating no other fractures were found. [redacted] was also ruled out.

The child remained in the hospital until 7/24/14 at which time the child was [redacted] to her maternal aunt, [redacted] is a married, stay-at-home mother with 3 young children of her own. The parents were anxious to care for the child. Both [redacted] were cleared as suspects, passed ChildLine and criminal checks and agreed to strict safety and supervision requirements set by the Agency to maintain the child in their home.

A CPS investigation was completed by the Montgomery County Office of Children and Youth on 8/12/14 and resulted in an "indicated" finding on the grandmother as it was felt that the severe pain and serious injuries suffered by the child were as a result of an intentional attempt to harm the child by the AP.

A safety assessment completed at the conclusion of the investigation on 8/12/14 found [redacted] the victim child's mother, to have appropriate parental capacities and her daughter, [redacted], to be safe in her care. A closing risk assessment completed on 8/13/14 found the overall severity to be low, provided the grandmother does not become a household member and is not utilized for babysitting functions.

Current Case Status:
According to the case documentation from Montgomery County Children and Youth noted at the conclusion of the investigation, [redacted] (the victim child) was found to be safe in the home of her mother, [redacted], and the Agency did not accept the family for services. Montgomery County did confirm that the family was receiving the necessary [redacted]. A closing visit and follow-up phone call occurred with the family on 8/6/14 and 8/12/14 which indicated that Agency intervention was no longer warranted. A police investigation is continuing concerning the grandmother; however, she has not been charged.

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

Strengths:
The County conducted their investigation collaboratively with all Multi-Disciplinary Teams (MDT) members and assured the safety and well-being of the child at all times.

The Team felt that a competent CPS investigation was completed by the Montgomery County Children and Youth caseworker which included numerous contacts with the family, medical information from the Children's Hospital of Philadelphia and a police investigation conducted by

the [redacted] Police Department. The mother was cleared of all allegations and the child was ultimately returned to her care.

The Team felt that case documentation was thorough and that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

Deficiencies:
The alleged perpetrator has not been criminally charged at the conclusion of the CPS investigation.

Recommendations for Change at the Local Level:
The team recommended that all of the children, including the victim children, have no further unsupervised contact with the alleged perpetrator.

Recommendations for Change at the State Level:
There were no recommendations for change at the state level.

Department Review of County Internal Report:
The Department has received the County's report dated 11/13/14 and is in agreement with their findings.

Department of Human Services Findings:
All indications regarding the County's CPS investigation, medical reports and a police investigation state that the injuries to the child occurred as a result of non-accidental trauma with the grandmother being the primary caretaker responsible for the child at the time that the injuries were sustained. The results of the CPS investigation were determined to be "indicated."

County Strengths:
The Montgomery County Office of Children and Youth conducted and completed an appropriate CPS investigation within 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

County Weaknesses:
The Department identified no weaknesses.

Statutory and Regulatory Areas of Non-Compliance:
A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:
The Department has no further observations or recommendations other than those already contained in the report.