



REPORT ON THE NEAR FATALITY OF:



Date of Birth: 10-24-2007

Date of Incident: 7-10-2012

Date of Oral Report: 7-11-2012

FAMILY KNOWN or NOT KNOWN TO:

The family was known to the Westmoreland County Children's Bureau prior to the incident.

REPORT FINALIZED ON: 10/31/13

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(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. Westmoreland County has convened a review team in accordance with Act 33 of 2008 related to this report on September 6, 2012.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	10-24-07
[REDACTED]	Half/Sibling	[REDACTED] 05
[REDACTED]	Natural Mother	[REDACTED] 79
[REDACTED]	Natural Father	[REDACTED] 66
[REDACTED]*	Cousin	Age 18
[REDACTED]*	Paternal Aunt (baby sitter)	[REDACTED]-69

*(not a household member)

Notification of Child Near Fatality:

On July 11, 2012, Westmoreland County Children's Bureau (WCCB) was notified that a four year old victim child was shot in the left eye. The ChildLine report was reported by [REDACTED]. The incident occurred on July 10, 2012. The child's paternal aunt was babysitting the child in her home. It was reported that due to the AP/caretaker's lack of supervision the victim child was able to find a gun and made it discharge with the bullet striking the child in his left eye. The child was immediately taken to [REDACTED] due to this injury. The victim child lost his eye due to injury.

Summary of DPW Child Near Fatality Review Activities:

The Western Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family on August 10, 2012. WCCB granted the Western Regional Office access to CAPS, their electronic case management system, in order to provide the Regional Office with the most up-to-date information related to the case. This access was provided immediately upon the registration of the fatality with Childline.

The reports that were obtained were the following: [REDACTED] Police Department, [REDACTED] Hospital [REDACTED] WCCB Child Protective Services Referral Form, [REDACTED] (forensic interview of the victim child's sibling), case notes, C-47, CY-48, and hospital photos of victim child.

The Regional Office also participated in the County Internal Fatality Review Team meeting that occurred on September 6, 2012.

Summary of Services to Family:

At the time of the child near fatality the family was known to Westmoreland County Children's Bureau. There was a prior GPS report dated February 4, 2010 made regarding [REDACTED] alleging that he had been [REDACTED] by the [REDACTED] who is the victim child's cousin. The child did not make a disclosure, so the case was closed on March 10, 2010. The [REDACTED] Police Department had made no determination on the case at the time of closure by WCCB. The parents were advised to [REDACTED]. There were no charges brought by the [REDACTED] Police Department against [REDACTED] for the [REDACTED].

Children and Youth Involvement prior to Incident:

The only history on this family was a GPS report involving the victim child's half sibling [REDACTED] age 6. There was no other involvement with the family and WCCB.

Circumstances of Child Near Fatality and Related Case Activity:

On July 11, 2012, WCCB received the referral on the victim child [REDACTED]. The victim child and his brother were dropped off by his father between 9 a.m. to 9:30 a.m. The children's paternal aunt was babysitting them for the day. The boys entered the home and began to play. They first went into her bedroom and then they went downstairs. The victim child and his brother found the gun on a night stand and began playing with the small-caliber handgun when [REDACTED] shot himself in his left eye.

The aunt stated that she was in her bedroom when the incident occurred. She stated that she heard a noise and went to investigate. She stated that she heard

crying and went down to the basement area. The child's aunt, [REDACTED] found the children in the basement and saw [REDACTED] with a gunshot wound. She tried to call 911, but realized that her friend [REDACTED] who she was talking to was still on the phone. She picked the child up and began to head outside when she saw her brother, [REDACTED] driving up the street toward the house. She got inside of the car and they went to [REDACTED] Pennsylvania which is an urgent care facility. They treated the child and then transported the child by ambulance to [REDACTED] Pennsylvania.

There were four other adults age 18 to 22 in the home at the time of the incident. None of the adults were in the area when the incident occurred. They were all in separate rooms throughout the home. It was reported that they were all sleeping at the time of the incident with the exception of [REDACTED] who was taking a shower. The [REDACTED] Police Department interviewed all of the people in the home after the incident.

The child's father stated that he had went home to do some things before going to work and was alerted by the aunt's friend [REDACTED] that something had occurred at [REDACTED] house and he needed to go there immediately. The child's father immediately went to the home and saw his sister carrying his son onto the porch and she jumped into his car and they took the child immediately to [REDACTED] Pennsylvania. Officials at the urgent care center notified [REDACTED] Police Department and called an ambulance to take the child to [REDACTED]

[REDACTED] The father reported that the victim child does not remember what happened during the incident.

The physicians at [REDACTED] later reported that if the child was not given immediate medical attention he could have died. He has some trouble seeing in his right eye, but his sight is slowly returning to that eye. The physicians reported that if the bullet would have entered an inch either way the child would have died from the gunshot.

On July 11, 2012, WCCB caseworker was able to meet with the family to assess the safety of the other child in the aunt's home and the child's sibling. A safety plan was established that stated that the victim child and his brother would remain in the care of their natural parents and would not have any contact with the AP until the completion of the investigation. [REDACTED] went to stay with his mother [REDACTED] shortly after the incident [REDACTED] was [REDACTED] on July 23, 2012 to the custody of his parents.

The victim child has been receiving [REDACTED] since his release from the hospital. His sight has improved in his right eye; however, the long term effects are still unknown.

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

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. WCCB has convened a review team in accordance with Act 33 of 2008 related to this report on September 6, 2012.

- **Strengths:**
The County was able to properly coordinate their efforts with law enforcement and medical professionals. The County also immediately ensured the safety of the child's sibling and conducted the safety and risk assessments in a timely manner.
- **Deficiencies:**
The County did not identify any weaknesses in the review of this case.
- **Recommendations for Change at the Local Level:**
The County will continue to educate their communities on the issues of proper care for firearms.
- **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 is in agreement with the strengths and recommendations made by the County.

Department of Public Welfare Findings:

- **County Strengths:**
There were several strengths identified in the review of this child fatality. The County was diligent in their investigation, and worked collaboratively with law enforcement and medical professionals. The case documentation completed by the County caseworker was very detailed and well organized. Safety and risk assessments were completed at the correct intervals, and the established safety plans for the child's sibling were thorough, detailed, and tailored to suit the safety and well-being of the child.

- County Weaknesses:
The Department did not identify any weaknesses in the review of this case.
- Statutory and Regulatory Areas of Non-Compliance:
There were no regulatory areas of non-compliance found by the Department in review of this child near fatality.

Department of Public Welfare Recommendations:

No recommendations regarding this report.