



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF



Date of Birth: 11/19/2013
Date of Near Death: 03/15/2014
Date of Oral Report: 03/15/2014

FAMILY KNOWN TO:

Centre County CYS

REPORT FINALIZED ON:

03/06/2015

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, 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. Centre County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	11/19/2013
██████████	Mother	██████████ 1993
██████████	Father	Unknown

Notification of Child Near Fatality:

On March 15, 2014, the agency received a report of a child near fatality as the child was present at the Mount Nittany Medical Center ██████████ and had a large ██████████ on the right side of her head. A ██████████ also showed a ██████████ (right eye-socket) and an ██████████. The child was certified to be in critical condition by a physician on-duty.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth, and Families (CYS) obtained and reviewed all current and past case records pertaining to the Victim Child and her family. Medical records were also reviewed. Conversations and interviews were conducted with the Caseworker ██████████, Supervisor ██████████, Ongoing Worker ██████████, and Administrator, ██████████ throughout involvement but specifically on March 19, 2014 and November 13, 2014.

Children and Youth Involvement prior to Incident:

The agency received a report of suspected child abuse on February 3, 2014 regarding the victim child. According to the report, the child had a red mark on her cheek and some bruising. This occurred after she was left in the care of mother's paramour. The doctor that assessed the child did not suspect any trauma, but rather that the child may have not been properly supervised. The paramour was listed as the alleged perpetrator

(AP). The mother reported that she threw him out of the home because he could not explain the bruising and ended her relationship with him. The AP could not be found during the course of the investigation as he was homeless. The agency did make some attempts to find him. The child received medical care and the bruising was gone within 9 days. The agency unfounded the report on February 28, 2014, and closed the case with no additional services. The agency reported that Mother had stable income and housing and appropriate supports to help her with the child.

Circumstances of Child Fatality and Related Case Activity:

On March 15, 2014, the agency received a report of a child near fatality as the child was present at the Mount Nittany Medical Center [REDACTED] and had a large [REDACTED] on the right side of her head. [REDACTED] also showed a [REDACTED] (right eye-socket) and an [REDACTED]. The child was certified to be in critical condition by a physician on-duty. The mother told the EMS worker that the child had fallen out of her stroller. She had also told the police officer, who was present at the hospital, that she was walking down the stairs with the child while talking on her cell phone and dropped the child.

The child was life-flighted to Geisinger Medical Center in Danville, PA due to the nature of her injuries. Further x-rays at this medical facility showed that the [REDACTED] of the eye-socket was not present. When Centre County CYC visited with her on March 15, 2014, she was eating and cooing. The CYC worker interviewed the mother on March 15, 2014, and she was adamant that she had not been on her cell phone. She stated that she placed the stroller on the stair landing, heard a thud, and saw the child laying on the floor. She picked her up and called for an ambulance. The agency was able to observe the stroller and determined that it was an inappropriate stroller for a 4 month old as the waist strap was too big and there were no shoulder straps to hold the infant. Centre County CYC took custody of the child on March 15, 2014 and she [REDACTED] a Centre County foster home on March 18, 2014. The child had a follow up appointment with [REDACTED] to determine that the [REDACTED]. Her eyesight was checked and there were no problems. She also showed no signs of [REDACTED]. A full recovery was expected. The agency received a [REDACTED] report from Dr. [REDACTED] at the Geisinger Medical Center which stated that this injury was non-accidental; that there is no way that it happened as the mother described due to the nature of the injuries. The mother was cooperative with the investigation.

The agency completed their investigation on March 28, 2014 and indicated the mother for physical abuse. There were many conflicting stories given by the mother as to how the injury occurred. Medical professionals continued to say that the injury was inconsistent with her explanation. [REDACTED]

[REDACTED] The mother began to work with [REDACTED]

Current Case Status:

The mother of the child has been working with Centre County CYS and [REDACTED] since March 2014. She has continued to show improvement in her supervision and attention to her child. She has shown some instability in maintaining a job and providing proper income and housing, but continues to work with local case management. There has been some concern that she enters into new friendships/relationships quickly and does not always understand how that may affect her child or her ability to parent her child. She has received parenting instruction and help with [REDACTED] and visitation. The foster mother for her child works closely with the mother to allow her maximum amount of time with the child.

[REDACTED] Her goal is still reunification with her mother. The agency has recently begun to explore unsupervised visitation for the mother and child. The agency expects to hold a 3 months hearing in January to see if the mother has progressed enough for successful reunification.

The agency has also reported that the mother did [REDACTED] The agency may file for Aggravated Circumstances which will not hinder reunification, but recorded should reunification not be successful.

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 April 10, 2014 in State College. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff. The team came up with several recommendations/next steps to make sure that the investigation continued appropriately. These included providing reunification services to the mother and conferring with all previous services available to the child.

• Strengths:

The agency's response to the situation was immediate and appropriate. Information was gathered from all medical professionals and others working with the mother and child.

• Deficiencies:

None were noted by the team in regards to the handling of the case by the agency.

• Recommendations for Change at the Local Level:

No recommendations were made.

• Recommendations for Change at the State Level:

None noted.

Department Review of County Internal Report:

Centre County CYs provided a report on the Near Fatality of the Victim Child to the Regional Office on April 10, 2014. The report contained all required information and a summary of agency findings. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on July 10, 2014.

Department of Public Welfare 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 full collaboration with local police and medical professionals.

- County Weaknesses:

While some efforts were made to locate Mother's paramour in the prior CPS investigation, it appeared that a more concerted effort could have been made to find and interview the alleged perpetrator.

- Statutory and Regulatory Areas of Non-Compliance:

None noted

Department of Public Welfare Recommendations:

None noted at this time.