



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

BORN: November 29, 2013
DATE OF INCIDENT: March 26, 2014
DATE OF ORAL REPORT: March 26, 2014

FAMILY WAS NOT KNOWN TO:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:

6/23/15

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

Family Constellation:

Name:

Relationship:

Date of Birth:

[REDACTED]

child
mother
father
sibling
sibling

11/29/2013
[REDACTED] 1988
[REDACTED] 1988
[REDACTED] 2008
[REDACTED] 2009

Notification of Child (Near) Fatality:

On March 26, 2014, the child was transported via ambulance to Westmoreland Regional Hospital in Greensburg, Pennsylvania due to the child having difficulty breathing. [REDACTED] was performed and it was determined that the child had [REDACTED]. The father was watching the child and could not explain the [REDACTED] or child's condition. [REDACTED] physician at Westmoreland Regional Hospital was suspicious of physical abuse, and certified that child was in critical condition as a result of suspected physical abuse. The child was subsequently transported to Children's Hospital of Pittsburgh via medical helicopter.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families reviewed the case file regarding this family's case. In addition, the Regional Office participated in the Westmoreland County Multi-Disciplinary Team Meeting on April 23, 2014. The caseworker and supervisor were interviewed regarding their investigation at various points of their investigation.

Summary of Services to Family:**Children and Youth Involvement prior to Incident:**

According to Westmoreland County Children's Bureau, the family had no prior involvement with the family.

Circumstances of Child (Near) Fatality and Related Case Activity:

On March 26, 2014, the father reported that he had to call an ambulance to the family's home because the child was having difficulty breathing. The child was transported to Westmoreland Regional Hospital in Greensburg, Pennsylvania. The child underwent [REDACTED] and it was determined that the child had [REDACTED] physician at Westmoreland Regional Hospital had concern for physical abuse.

The child was life-flighted to Children's Hospital in Pittsburgh, Pennsylvania. The child was accompanied by his grandmother and his mother and father arrived at the hospital later. Upon arrival at the hospital the child was determined to have sustained [REDACTED]

[REDACTED] The child was observed to have bruising to his anterior shoulders, right shin and calf. Through additional testing it was determined that the child had [REDACTED]

While hospitalized the child endured multiple seizures, and [REDACTED] The physicians at Children's Hospital of Pittsburgh stated that they are unable to tell if the child [REDACTED]

The child was [REDACTED] Children's Hospital of Pittsburgh on April 23, 2014 and [REDACTED]. He was [REDACTED] on May 29, 2014 and placed into his mother's care.

The mother reported that on the day of the child's initial hospitalization, she had left for work around 1:30 pm. When she left the home, the father was feeding the child a bottle. At approximately, 5 pm she received a phone call from the paternal grandmother that something was wrong with the child. She immediately left work and went home. By the time she arrived at her home, the child had already been transported to Westmoreland Regional Hospital. She then went to

the hospital to be with her child. The mother admitted that she was [REDACTED]

The father also explained that he was feeding the child when the mother left for work around 1:30 pm. According to the father, the child began to fuss and was not willing to finish his bottle. The child's sister then commented that she wanted to take a nap and the father sent both of the child's siblings upstairs to take a nap. After taking the siblings upstairs for their nap, the father tried to feed the child again. The child ate a little bit more and both the father and the child laid down for a nap. The father woke around 3:40 pm and claimed that the child was smiling and appeared to be happy. He then chose to go upstairs to check on the child's siblings. When he returned downstairs began to watch television while holding the child. He attempted to feed the child again, and he was able to eat 3 ounces. After eating the child began to vomit, defecate and went limp, and then began to gasp for air. The father stated that he attempted to bounce the child and slapped him on his foot, but the child continued to have problems with his breathing. At that time, he decided to contact the paternal grandmother to get her opinion on what to do in this situation. The grandmother advised the father to call 911. The father attempted CPR until the ambulance arrived.

The child's sister was interviewed and expressed fear of her father. She reported that he was mean and yells a lot. She expressed that she saw her father be rough with the child and force the bottle into his mouth. She also mentioned that the father is often angry with the child. She went on to say that her father yells and screams at her and has smacked her on her butt on different occasions. The sister also claimed to have witnessed the father push the mother forcefully. The child's brother would not leave his mother's side and was not interested in being interviewed.

Both of the siblings were seen medically at Children's Hospital of Pittsburgh on March 28, 2014 and no injuries were identified. In addition, both siblings had a forensic interview on April 2, 2014. Both children reported that their father has hit them with a belt, but were not willing to say anything more about their parents.

A safety plan was established that the father was to have no unsupervised contact with any of the children.

The Pennsylvania State Police arrested the father on April 10, 2014 and charged him with three counts of felony aggravated assault and endangering the welfare of a child. He was unable to post bail in the amount of \$20,000 and remains in the [REDACTED] Prison awaiting his criminal trial.

On May 1, 2014, Westmoreland County Children's Bureau indicated the father for physically abusing the child.

Current Case Status:

The case was opened for ongoing services on May 1, 2014. The child was [REDACTED] on May 29, 2014 and placed back into the mother's care due to her demonstrating that she was able to meet the medical and basic needs of her child. The mother was to continue [REDACTED] and the follow-up medical appointments for the child.

In July of 2014, the mother decided to move back to Kentucky where all of her supports were located. The mother moved into her parents' home. The Westmoreland County Children's Bureau closed their case and made a referral to Kentucky Social Services to assess the mother and children to determine if services were warranted in Kentucky.

The father remains in the [REDACTED] Prison and is waiting for his criminal trial.

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

- Strengths: None noted
- Deficiencies: None noted
- Recommendations for Change at the Local Level: The need for increased funding streams to pay for child care for working parents at the local level.
- Recommendations for Change at the State Level: The need for increased funding streams to pay for child care for working parents at the state level.

Department Review of County Internal Report:

The County's Internal Report does not show any analysis as to the strengths and deficiencies with the case investigation. There were a lot of various strengths that were not highlighted in this report.

Department of Human Services Findings:

- **County Strengths:** Immediate follow by the county in response to the child line and the near fatality of the child. This included the In-Home Safety Assessment and Safety Plan as a result of the child's injuries and the services provided by the county to the parents.
- **County Weaknesses:** The County Internal Report provides very little information. The multi-disciplinary team meeting is an opportunity to conduct an analysis of the case and to devise methods or suggestions on how to prevent any future child abuse. It appears as though this meeting based on the report is to report out on the case instead of analyzing what led up to the event and how it could have potentially been prevented. In addition, could have anything been different in the course of the investigation.
- **Statutory and Regulatory Areas of Non-Compliance:** No areas of non-compliance.

Department of Public Welfare Recommendations:

The county should also be looking for strengths and weaknesses within their own system and high light them in the report. This would also include any recommendations for change at the state or local levels.