



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



DATE OF BIRTH: 06/24/2014
DATE OF INCIDENT: 09/16/2014
DATE OF REPORT: 09/18/2014

FAMILY NOT KNOWN TO
Armstrong County Children, Youth and Families

REPORT FINALIZED ON:
06/24/2015

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. Armstrong County did not convene a review team in accordance with Act 33 of 2008 related to this report because they determined the report to be "Unfounded" within thirty days of receiving the report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	06/24/2014
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	Father	[REDACTED] 1985

Non-Household Member:

[REDACTED]	Caregiver/Maternal Grandmother	[REDACTED]/1948
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Notification of Child Near Fatality:

On September 18, 2014 the Department received notification that this child was in critical condition due to suspected child abuse. According to the report, the parents were working on September 16, 2014 and the maternal grandmother was caring for the child. The grandmother propped the child up on a pillow while she went to use the restroom and when she returned, she found the child face down on the pillow and unresponsive. The grandmother immediately called 911 and the child was rushed to Children's Hospital of Pittsburgh (CHP). At the time of the report, the child had a strong heartbeat and was [REDACTED] after further precautionary testing.

This report was initially assigned to Allegheny County due to the location of the child at the time of the report; however, this office contacted Armstrong County and advised them that the report would be re-registered to them.

Summary of DHS Child Near Fatality Review Activities:

The Department reviewed the electronic record in Armstrong County Children, Youth and Families (CYF) case management system. Because the county determined prior to thirty days that the child's condition was accidental, no formal Act 33 meeting took place. However, due to the timing of the receipt of the report, the county was able to staff this at their regularly scheduled, monthly Multidisciplinary Team Meeting (MDT). A representative of the Department was present for this meeting.

Children and Youth Involvement prior to Incident:

At the time of the report, the family was not receiving any services. In addition to the family not receiving any services, there were no prior reports on the child and parents.

Circumstances of Child Near Fatality and Related Case Activity:

After learning of the report from the Department on September 18, 2014 and receiving the report [REDACTED] shortly afterwards, Armstrong County CYF contacted Allegheny County CYF to request a courtesy contact with the child, as the child was hospitalized at CHP. After contacting Allegheny County, the caseworker contacted the Pennsylvania State Police (PSP) to alert them to the report.

The caseworker also made contact with the mother to obtain more information about the maternal grandmother. In a conversation with the mother, she informed the caseworker that she was sure that this was accidental, as the grandmother was the only person the mother trusted to leave the children with. The mother also agreed to do whatever was required of her, but she expressed her frustration with having to be investigated by CYF and PSP.

PSP also contacted the caseworker back and advised that they will be in touch first thing the next morning (September 19, 2014) to begin their investigation.

Allegheny County CYF dispatched a worker to CHP to make contact with the child as requested by Armstrong CYF and saw the child at 7:30 PM on September 18, 2014. While at CHP, the Allegheny worker spoke with mom, who stated that the grandmother was caring for the child at the time of the incident. The grandmother was not feeling well and had to use the restroom, so she placed the child on the couch on a "boppy" pillow. When she returned from the restroom, she found the child face down and he went limp when she picked him up. The grandmother uses a "Trac Phone" but had no minutes on it, so she ran to several neighbors to see if she could use a phone, but no one was home. While outside, she observed Emergency Medical Technicians (EMT) go by and got their attention to help. The EMTs were unable to resuscitate the child, so he [REDACTED] and taken to Allegheny Valley Hospital. From there, he was flown via medical helicopter to CHP. Upon exam at CHP, the mother was told the child had [REDACTED] and had suffered a cardiac arrest. The child also had a seizure, so he was [REDACTED]. The mother reported that when he [REDACTED], he was moving and his eyes opened. He was reported at that time to have [REDACTED].

The mother provided some information about the family and denied any substance abuse issues with anyone, including the maternal grandmother. The grandmother was very upset about what happened.

On September 19th, the caseworker accompanied the assigned Trooper from PSP to continue the investigation. The Trooper had begun to make phone calls in the evening of September 18th and had gathered good information from the parents. This information

was shared with the caseworker. According to the Trooper, the parents and grandmother/caregiver provided consistent accounts of what happened. The grandmother was caring for the child and had an urgent need to use the restroom, which was only approximately nine feet from the couch where she and the child were sitting. She placed the child on his side on the couch, with a pillow in front of him so he would not roll off of the couch. When she returned from the restroom, she found the child and said he "looked dead" when she turned him over. She had no minutes left on her Trac phone, so she ran outside for help. This was when she saw the ambulance and flagged them down for help.

The Trooper and caseworker went to the family home (where the incident took place) so that the Trooper could take measurements and photos of the scene. While there, they spoke with the paternal grandmother, who expressed no concerns with the maternal grandmother caring for the child. The grandmother showed the worker and Trooper a video of the child that was filmed on September 15th and sent to her via cell phone. The child appeared to be healthy and normal in the video.

After leaving the home, the Trooper and caseworker made contact with the Emergency Medical Services (EMS) personnel that were on scene for the incident. The EMS recalled their involvement in the incident, which was consistent with what was already provided.

On the evening of the registered report, CYF made contact with CHP. A message was left for the physician [REDACTED], who was consulting due to the nature of the incident being listed as a near fatality. On September 22nd the physician returned the call and reported that [REDACTED]

[REDACTED] As a precaution, the child had a skeletal survey completed, but the doctor did not suspect any intentional harm to the child. Her only concern was what she described as "unsafe sleeping arrangements" with the maternal grandmother. She also informed the caseworker that it was hospital policy to report all cases of unexpected cardiac arrest. This information was also provided to the caseworker in a typed report received on September 22, 2014.

On September 24th, the caseworker staffed this incident during the county's regularly scheduled MDT meeting. The investigating Trooper was also present, as he is a regular member of the MDT. After reviewing the facts of the case and the preliminary medical report, the team recommended not substantiating the report pending the upcoming skeletal survey.

On September 24th, the caseworker completed a Safety Assessment Worksheet (SAW) and identified no threats that needed to be mitigated. As a result, the child was deemed safe and no plan was required.

On two occasions after September 24th, the caseworker attempted to reach the [REDACTED] physician for an update on the child's skeletal survey, but she was unavailable. However, on September 30, 2014 the physician returned the caseworker's phone call and informed the caseworker that the child's skeletal survey came back normal. This information was relayed to the investigating Trooper. A written, final report was also received from CHP

regarding this child. The written report also included information that the child's [REDACTED] was normal. No major follow-up recommendations were required.

On October 3, 2014, the caseworker completed a final home visit with the child and mother. The child appeared to be fine and the mother was cooperative, but described as "not friendly" with the caseworker, as she was upset that the incident had to be investigated. The worker informed the mother that the report was not substantiated and the family's involvement with the agency was over at that time.

On October 6, 2014 the caseworker completed the investigation into the incident by submitting an "Unfounded" status. In addition, a closing SAW and Risk Assessment were both done. As was the case with the first SAW, no threats were identified. In addition, the overall risk for this child was rated "Low" based on the information gathered during the assessment. The family's involvement with CYF was officially closed with supervisory approval on October 10, 2014.

Current Case Status:

The family's case remains closed with the agency at this time. No other reports have been received on the child.

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

Because the county made an unsubstantiated determination within 30 days of receiving the report, an Act 33 meeting was not convened.

Department Review of County Internal Report:

As stated above, no internal report was required.

Department of Human Services Findings:

- **County Strengths:**
 - The county responded quickly to the report and contacted Allegheny County CYF for a courtesy contact with the child and PSP so that a joint investigation could be completed.
 - The assigned caseworker and Trooper worked collaboratively during the investigation and shared information efficiently with each other.
 - Although not required to do so, the county presented this case as part of their regularly scheduled MDT meetings. These regularly scheduled meetings are beneficial in cases such as this.
 - The caseworker kept in regular contact with medical staff to gather the necessary information to make the proper determination.
 - The report was submitted to ChildLine as soon as enough information was obtained to do so.
 - The worker was sympathetic to the parents' anger and frustration with the system's involvement.

- County Weaknesses:

None identified in for this report.

- Statutory and Regulatory Areas of Non-Compliance:

None identified

Department of Human Services Recommendations:

The county should continue to utilize this same approach in dealing with serious incidents such as this. It is beneficial for all parties involved.