



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/22/2012
Date of Incident: 01/02/2015
Date of Report to ChildLine: 01/03/2015
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT
OR WITHIN THE PRECEDING 16 MONTHS:**

Mercer County Children and Youth Services

REPORT FINALIZED ON:
09/28/2015

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. 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Mercer County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 01/28/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
* [REDACTED]	Victim Child	07/22/2012
* [REDACTED]	Biological Mother	[REDACTED] 1990
[REDACTED]	Biological Father	[REDACTED] 1981
[REDACTED]	Step-Mother	[REDACTED] 1989
[REDACTED]	Step-Sibling	[REDACTED] 2008
[REDACTED]	Step-Sibling	[REDACTED] 2010
* [REDACTED]	Biological father of step-siblings	[REDACTED] 1988

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Department of Human Services, Western Region Office of Children, Youth and Families (The Department) obtained a copy of the near fatality investigation file and access to the electronic version of all updated case records. The record was reviewed in its entirety. The Department attended the Act 33 meeting on 01/28/2015. Regular communication through the investigation of the case occurred between the Department and Mercer County Children and Youth's director.

Children and Youth Involvement prior to Incident:

There was no prior involvement with the family and Mercer County Children and Youth Services.

Circumstances of Child Near Fatality and Related Case Activity:

Mercer County Children and Youth Services (CYS) received a referral on 01/03/2015 that a child was admitted to a local hospital [REDACTED] after being transported by her stepmother. The victim child was unresponsive. The referral indicated that the stepmother reported the victim child had fallen out of her booster seat on 01/02/2015. The stepmother reported that upon waking on 01/03/2015 the child was not acting normal and appeared unresponsive. The initial exam of the victim child upon admission found bruises on her arms, legs and face. The victim child was diagnosed with a [REDACTED] that appeared older than 24 hours. [REDACTED] physician certified the child to be in critical condition from suspected abuse and transferred the victim child to Children's Hospital in Pittsburgh (CHP).

Upon arrival at CHP, the victim child was [REDACTED] [REDACTED] indicated the child to be suffering from a [REDACTED]. The victim child had exceptionally high levels of sodium in her blood, was very cold in body temperature and was determined to be malnourished for her age. The victim child was in a life-threatening condition. The physical exam confirmed the bruising noted by the local emergency room and indicated that the victim child's nose was swollen with blood on her right nostril and an area of broken and scabbed skin over her left wrist. The victim child appeared to have what looked like a human bite mark on the back right calf area. [REDACTED] physician [REDACTED] [REDACTED] consult indicated the injuries to be very concerning for physical abuse.

Upon receipt of the report, Mercer County CYS requested a courtesy assessment of the victim child at CHP by Allegheny County Office of Children, Youth and Families. Additionally, Mercer County CYS received information that when the stepmother arrived at the local hospital with the victim child, she also had her two biological children in her custody. The stepmother had called her children's father and he arrived at the hospital to take his children to his home in [REDACTED] County. Mercer County CYS requested a courtesy visit by [REDACTED] County CYS to assess the safety of the other children at the father's home. There were no concerns with the stepmother's other children while in the father's care.

The report was immediately called into law enforcement officials upon the victim child's admission to the local hospital. Mercer County CYS communicated with investigating detectives and arranged for the father of the stepsiblings to bring the children to the local CAC for interviews that same day. The sibling interviews resulted in some concerning details regarding the victim child's father and stepmother spanking and biting the victim child. Additionally, it was said that the stepmother dropped the victim child and that the victim child fell out of her time out chair. Following the interviews, the father to the stepsiblings communicated to Mercer County CYS that he was taking his children home and would not be returning them to their mother.

While at CHP, interviews were conducted with the victim child's father and stepmother by the consulting CAC physician. During the interviews, it was reported that the victim child had been in the care of her biological father and stepmother since August 2014. The biological mother had been living in [REDACTED], where the family was originally from. The parents used to have share custody with a month on/off until the biological mother moved to [REDACTED]. The biological mother and father were never married and the pregnancy was a result of a "fling" according to the father. The biological mother has an older child who was in her custody and also moved to [REDACTED]. The mother moved out of state due to losing her housing, so the custody of the victim child remained with the father.

The victim child had allegedly been ill, with what resembled the flu, in November of 2014. The parents reported that they had to carry the victim child often and that she was refusing to eat or walk during the illness. The illness did resolve itself; however the victim child continued to refuse to walk and began walking in "crab-like" walk. The victim child had reportedly not been eating normally for approximately a month prior to the incident. The stepmother reported she would just constantly chew her food and would not swallow.

In regards to the day of the incident, the stepmother reported to CHP that on 01/02/2015 the victim child was sitting at the dining room table, on a booster seat, eating her lunch. The stepmother walked out of the room to attend to her own children and heard the victim child fall and start to cry. She responded and asked the victim child what had happened and she stated she fell out of her chair. The stepmother stated she noticed swelling on the victim child's forehead and applied ice to the injury. The stepmother denied there was any loss of consciousness and denied vomiting. The victim child took a nap and woke up later in the day acting "fine".

The stepmother reports that on the morning of 01/03/2015 she was preparing to take her children to their father's home. She left the three children alone for a few minutes to put the car seat in the car. When she came back inside, she took her two children and strapped them in the car, leaving the victim child alone in the house. She then returned to the house to get the victim child. She stated that the victim child was doing her "crab walk" when she fell backwards. The stepmother picked the child up under her armpits and there was no response by the victim child. She reported that the victim child was still breathing, but could not hold up her head. She took the victim child to the car, strapped her in the car seat and transported her to the local emergency room. The father arrived at the local emergency room after receiving a call from the stepmother. While at the emergency room, they were interviewed by the Pennsylvania State Police.

Review of medical records indicated that after custody was obtained by the father in August, there was a 4 pound weight loss when the victim child was seen in November by her pediatrician. Upon admission to CHP the child began gaining weight. The doctors could not determine a medical reason why the victim child had lost the weight over the three months, besides the reported "illness" that was described by the stepmother and father.

The biological mother arrived the day following the admission and was interviewed by CHP. The mother reported the victim child to be a normally, well developed child who was able to run, walk and speak when she left her in the father's home in August 2014. The mother reported that she did not know the victim child's stepmother very well. She stated that the father also has other children in [REDACTED], who live with their mother.

The victim child received additional [REDACTED] at CHP. A skeletal survey indicated no fractures or dislocations. [REDACTED] showed no evidence of additional traumas. The source of the [REDACTED] was not able to be explained by a minor impact (the alleged fall from the seat). The combination of bruising, [REDACTED], reported change in mental status and the appearance of the [REDACTED] suggested to [REDACTED] team the victim child sustained a brain injury shortly before presenting to the local emergency room and the injury was diagnostic for physical abuse.

Additionally, the victim child's weight loss suggested possible food restriction and the highly elevated sodium level suggested she was restricted fluids or was given inappropriate, salt-containing fluids over a long period of time. [REDACTED] physician unequivocally and without doubt indicated that the victim child was not thriving in her current home setting and the need for an alternate setting was necessary after hospitalization.

Upon hearing the details of the victim child's injuries, the father to the stepmother's children sought custody and enrolled the children in school in [REDACTED] County. The victim child's mother immediately filed a Protection from Abuse order on behalf of the victim child. The mother was a willing and able parent for the victim child and began procedures to secure custody. The victim child was released to the care of her mother and returned to [REDACTED] in her mother's custody on 01/30/2015. The victim child's follow up care was transferred to Medical University of [REDACTED].

The father and stepmother consulted with their attorney and were advised not to provide a statement to CYS. In collaboration with law enforcement and medical records/interviews, Mercer County completed the investigation on 03/04/2015 with an indicated status on both the father and the stepmother. The report was indicated for physical abuse for causing bodily injury with an [REDACTED]. Mercer County also followed through with an assessment of the father's level of contact and access to his other children in [REDACTED]. The father and the stepmother were both charged with one count of Aggravated Assault-Victim less than 13 years old (F1), two counts of Aggravated Assault-Victim less than 6 (F2) and three counts of Endangering Welfare of Children (F3). Both perpetrators were released on bond and charges were held over for court.

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

- Strengths in compliance with statutes, regulations and services to children and families: Report did not contain county strengths.
- Deficiencies in compliance with statutes, regulations and services to children and families: Report did not contain county deficiencies.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse: It was recommended that Mercer County CYS offer a collaborative training on recognizing the signs of abuse.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: No recommendations offered.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: No recommendations offered.

Department Review of County Internal Report:

The Department reviewed the County Act 33 Internal Report. The Department does recognize that the date of this report precedes the finalization of the Act 33 Bulletin, which requires specific findings to be documented in the report. Although a thorough report to the specifics of the near fatality investigation, the report lacks any finding regarding strengths, deficiencies and recommendations.

Department of Human Services Findings:

- County Strengths: The Department recognizes several strengths regarding the management of this investigation.
 - Mercer County CYS's response to assessing safety of the victim child and the step-siblings was immediate and collaborative. The agency requested assistance from resident counties to ensure the children were seen and safe.
 - The collaboration between the county, law enforcement and medical professionals was exemplary. Interviews were conducted with subjects as soon as possible and details were able to be shared in order to make well informed decisions.
 - The communication between the county and the medical professionals in regards to the victim child's treatment was commendable. The relocation of the victim child to [REDACTED] resulted in a change of medical providers. Immediate referrals and follow up services were initiated prior to the victim child even being discharged.

- Mercer County CYS assisted the mother with the physical relocation of the victim child [REDACTED] to ensure that all services were in place upon the victim child's arrival in [REDACTED].
 - Instant engagement with the step-siblings' father quickly ensured an alternate and safe setting for the children.
 - Mercer County CYS was able to complete a comprehensive and thorough investigation on a very difficult situation in a timely manner. The Act 33 Review and status determination were completed within 30 days.
 - Mercer County CYS is recognized for the diligence in keeping the Department apprised of this investigation due to the certification of the near fatality.
- County Weaknesses: None noted.
 - Statutory and Regulatory Areas of Non-Compliance by the County Agency. No areas of non-compliance were noted.

Department of Human Services Recommendations:

It would be the recommendation of the Department that Mercer County CYS become familiar with the required outline of the County Act 33 Internal Report. The report must contain the following:

- Strengths in compliance with statutes, regulations and services to children and families.
- Deficiencies in compliance with statutes, regulations and services to children and families.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.