



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 08/22/2014
Date of Incident: 12/31/2014
Date of Report to ChildLine: 01/01/2015

[REDACTED]

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE:

Washington County Children and Youth Services (WCCYS)

REPORT FINALIZED ON:

07/01/2015

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. Washington County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 01/30/2015.

Family Constellation:

First and Last Name:

[Redacted]
[Redacted]
[Redacted]
* [Redacted]
* [Redacted]
* [Redacted]
* [Redacted]
* [Redacted]

Relationship:

victim child
mother
father
maternal grandmother
maternal great-grandmother
paternal grandmother
paternal grandfather
paternal uncle
maternal aunt
maternal uncle

Date of Birth:

08/22/2014
[Redacted] 1995
[Redacted] 1991
[Redacted] 1960
[Redacted] 1936
[Redacted] 1969
[Redacted] 1973
[Redacted] 1994
[Redacted] 1981
[Redacted] 1980

*not a household member at the time of the report.

Summary of OCYF Child Near Fatality Review Activities:

On 04/28/2015, the Western Region Office of Children, Youth and Families (WRO) received a copy of Washington County's report regarding the review team meeting they held on 01/30/2015. Washington County Children and Youth Services sent a written letter providing notice of the Act 33 meeting. Unfortunately, the letter was not received timely and the WRO was not in attendance for the Act 33 meeting. The WRO reviewed all current records pertaining to the victim child's family related to this incident. As a result of the record review, the WRO interviewed the intake supervisor on 06/25/2015.

Children and Youth Involvement prior to Incident:

The father reported that he was involved with WCCYS when he was 10 years old due to neglect issues. He reported being in and out of placement between the ages of 11-18. Washington County had no records to support this. He also reported that

he has had involvement with Juvenile Probation since he was 11 years old and when he turned 21 he was transferred to adult probation.

Circumstances of Child Near Fatality and Related Case Activity:

On 01/01/2015, WCCYS received [REDACTED] report at 3:47 AM initiated by [REDACTED]. It was reported that the parents had taken the child to Washington Hospital and the parents reported that the 4-month-old victim child had a seizure while the father was feeding him on 12/31/2014. The parents had described that the victim child started shaking his arms and legs bilaterally and arching back for about 10 minutes. The father has a prior history of seizures, but there is no history for the victim child. The victim child was transferred to CHP for further evaluation. [REDACTED]

[REDACTED] The skeletal x-rays were pending, but normal at the time of the report. The victim child also had a small abrasion posterior to the left ear. The victim child was admitted to the [REDACTED].

The father had reported to the [REDACTED] that approximately 2 weeks before the victim child was taken to the hospital, he tripped over the dog while holding the victim child to his chest. He described falling hard onto the floor but landing on his side and back so the victim child would not hit the floor. The maternal grandmother, who is a household resident, is the primary caretaker when the parents are not home. The CHP physicians do not believe that the fall as described by the father would have attributed to the victim child's current injuries. The CHP physician certified the victim child to be in critical condition as the report was registered as a near fatality case.

Upon receiving the [REDACTED] report, the agency contacted the [REDACTED] Police Department to report the incident in which they followed up by sending a written referral to law enforcement. The agency also contacted Allegheny County Office of Children, Youth and Families (ACOCYF) to request a courtesy visit of the victim child and initial interviews with the parents, who were at the hospital. The ACOCYF caseworker reported that the father self-reported he [REDACTED]

[REDACTED] The father provided the same story as he had relayed to [REDACTED] regarding tripping over the dog while he was carrying the victim child. Father was blaming the maternal grandmother as he stated that she cares for the victim child most of the time. According to the ACOCYF caseworker, the mother appeared to be limited and may be fearful of the father; however, she denied domestic violence. The mother reported that the father had [REDACTED] 8 months ago, but she allows him to be alone with the victim child, and is not concerned. The ACOCYF caseworker photographed the victim child.

On 01/02/2015, the WCCYS caseworker spoke with the parents and explained the allegations and the investigation process. The family identified the paternal grandmother as a resource for the victim child as she had not been with the victim child unsupervised over the past 2 weeks, and is not a household member. The

caseworker also learned that the victim child was [REDACTED] on or around 01/03/2015. The CHP physician reported that the victim child had [REDACTED] that were caused by impact. He also had [REDACTED] that were not from the impact. He is also suspected to have [REDACTED] that would be the result of shaking. The CHP physician also reported that the victim child would have had an immediate reaction to the event. It was also reported that the father told the night social worker that he used drugs and may have dropped the victim child, but does not know for sure. The maternal grandmother reported that the father had dropped the baby, but does not remember doing it. She stated that she did not witness it, but the father told her he did. The father reported that he was [REDACTED]

On 01/02/2015, the WCCYS caseworker ran clearances on the paternal grandparents and their adult son. The parents were also interviewed by the WCCYS caseworker at CHP on 01/02/2015. The mother stated that it seemed like her son had an ear infection three days before the hospital visit. She also stated that her son had been constipated for five days so she contacted the doctor's office and was told to give the victim child prune or apple juice in his bottle. The mother reported noticing on Monday that the victim child was tugging on his ear. She reported at that time she tried calling the doctor's office around 5 PM that day and at 6:30 PM she talked to the doctor on call. The mother said that she was directed by the doctor to take and lay the victim child on a blanket or towel. The mother reported that he slept about three hours (normal for her son is 30 minutes to 2 hours). After the child woke up, he was fussy and he would only eat half of his bottle. The victim child continued sleeping on and off after that. The mother reported he woke up at 4:00 AM on Tuesday and finished a whole bottle and then went back to sleep and woke up again at 8:30 AM. The mother stated that she was at home on Tuesday stating that the victim child slept a lot and he was laughing and playing but took long naps. She reported that his father was also there all day on Tuesday, and they watched the baby except when they went to smoke and then the maternal grandmother and maternal great grandmother took care of him. The mother reported that she did not notice any changes with the baby and that he was sleepy and playful. The mother stated that the dog tripped the father and he was holding the baby. This happened approximately 2 to 2 1/2 weeks prior to the hospitalization. She stated that the victim child saw his PCP on 12/22/2015, and the doctor said that the victim child appeared to be fine. The mother reported leaving for work on Wednesday 12/31/2014 at 1:30 PM and stated that her son was laughing and playing after he woke up from a nap at 12:50 PM.

The father stated that he was [REDACTED]

[REDACTED] The father described the fall as happening when he was letting the dog back inside of the home and he was burping his son and the dog went between his legs and he lost his balance. He said that he fell onto his right shoulder and then landed on his back but his son was secured to his chest. The father said that the victim child was seen by his PCP and was checked

out and he was advised that no further testing was needed. The WCCYS caseworker asked if the doctor was told about dropping the baby and the father stated that no one was told about the drop. The father said that he does not remember doing it; that the maternal grandmother told him it happened.

The father reported that the victim child had a seizure a few days ago when he was feeding the baby and when he burped him at 7:00 AM, he had a seizure and it lasted for 10 minutes. He described the seizure as the baby was shaking and his back was arching and the baby did not open his eyes and he was weaker. The mother walked in about 7 minutes into the seizure and that is when they took him to Washington Hospital.

[REDACTED]

The decision was made to place the victim child in foster care until further assessment of the paternal grandparent's home could be completed. A maternal aunt had also come forward requesting to be a caregiver for the victim child. The agency assessed both families.

On 01/05/2015, CHP stated that the victim child was [REDACTED]. The WCCYS caseworker completed a home evaluation of the maternal aunt's home, and obtained clearances for the aunt and uncle. The paternal grandparents were ruled out for custody due to [REDACTED] regarding the paternal grandfather; as well as the fact that there was a recent domestic dispute between the grandparents. The maternal aunt and uncle were approved as Emergency Caregivers and picked the victim child up from the hospital. They were subsequently approved as kinship foster parents.

[REDACTED]

On 01/12/2015, the caseworker interviewed the maternal grandmother and maternal great-grandmother separately to gather information regarding what they knew regarding the injuries. The maternal grandmother was also listed as an alleged perpetrator due to the fact that she assisted in caring for the child. The maternal grandmother described two separate incidents in which the father dropped and/or fell with the victim child. The first time the father reported that he dropped the victim child but the victim child did not hit the floor because the father fell with him in his arms. This was around the beginning of December. The second incident was the one where the father stated that he tripped over the dog and fell, which was two weeks before Christmas. The maternal grandmother stated that she kicked the father out of her home after that report. She believed that the victim child fell between the wall and the couch and landed on dumb bells, but did not witness this. At some point, the father returned to the home. She also stated that

she checked the victim child out and did not believe he needed medical attention at that time. The maternal grandmother also stated that the victim child cries a lot when he is with the father. On 12/31/2105, the father brought the baby into the maternal grandmother's room and left him with her; she stated that the victim child was crying a lot. The father returned later in the evening, and this is when he was feeding the bottle and the victim child had a seizure.

The maternal great-grandmother picked the mother up from work the evening of 12/31/2015 and they went to [REDACTED]. While there, they received a call from the father reporting that the baby was having a seizure. They left the store and when they returned home the baby was lying on the couch and looked like he was not breathing, and he was not making noises so the maternal great- grandmother told them to wrap the baby in a blanket and take him to the Washington Hospital [REDACTED]. The maternal grandmother drove the parents and the baby to the hospital.

On 01/02/2015, the case was accepted for services and transferred for on-going services. [REDACTED]

[REDACTED] The victim child was referred as he is not able to hold his head up when he is in the prone position. [REDACTED]

[REDACTED] It is believed that the victim child suffered a hard impact and shaking for these injuries to occur. He is being seen by [REDACTED] at CHP to address his medical needs. [REDACTED]

[REDACTED] The mother is also allowed to visit supervised by the kinship foster parents in the kinship foster parents home.

The father was arrested on 02/10/2015 for failure to appear at court for an unrelated aggravated assault charge against the maternal grandfather. He was sentenced to 1-3 years and is currently serving his sentence in SCI [REDACTED].

On 02/19/2015, the agency submitted the CY 48 to ChildLine with an indicated status against the father, as the medical evidence supports that the injuries occurred while the victim child was in his care.

The victim child continues to receive [REDACTED]. He also has [REDACTED] in which he receives [REDACTED].

[REDACTED] The mother is having unsupervised visits with the victim child in the community for four hours a week and continues to visit the victim child in the aunt and uncle's home. She also is receiving parenting

education through [REDACTED] as she works towards reunification. The agency also made arrangements for the paternal grandparents and other maternal relatives to visit with the victim child in the community or at the kinship foster parents home.

The criminal investigation regarding this incident is still being investigated. There have been no charges filed to date.

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

WCCYS Child Fatality Team convened on 01/30/2015 for a review.

Strengths:

- The child, family and home were seen throughout the agency's involvement in accordance with DHS regulation.
- Interviews were conducted with the victim child's parents and household members to determine what occurred.
- Collateral contacts were made with the hospital medical personnel, the victim child's Primary Care Physician, and other medical providers.
- Services were arranged to assess and address any deficits in parenting skills.
- The parents were referred for additional assessments.
- The victim child was referred for appropriate medical and developmental services.
- Each parent was scheduled for four hours of visitation with their child weekly, and the mother is permitted additional visits in the foster home.

Deficiencies:

- No deficiencies were noted by the Child Fatality Review Team.

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 is unlikely that any changes at either the state or local level would prevent similar situations as the family was not known to the agency prior to the incident.

Recommendation for changes at the state and local levels on monitoring and inspection of county agency:

- Since the family was not known to the agency prior to this incident, it is doubtful that any changes in monitoring or inspection would have served to prevent this incident or similar ones from occurring.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- The hospital personnel expressed concern that law enforcement had not conducted interviews with the parents in the hospital. Although the local police department was notified of the incident immediately by the WCCYS

caseworker and informed of the interviews scheduled, it is believed that many Law Enforcement Departments in Washington County are small and often do not have the capacity to send an officer or detectives to the hospital to conduct interviews.

- Photographs of the home where the incident occurred may have been helpful in determining what happened to the victim child. Taking photos of the home environment and/or site where the incident occurred would help those investigating better understand the scene and could be helpful in determining mechanism of injury.
- After reviewing this incident it is clear that timely law enforcement interviews and a thorough understanding of the scene where the injuries occurred are important components of an investigation. Discussion ensued regarding areas where teaming could be enhanced. Possibilities for caseworkers and law enforcement responding in tandem and caseworkers taking additional photographs will be revisited for potential change.
- The agency purchased 1200 DVD's of "When Babies Cry" to give to new mothers who give birth at Washington Hospital to increase their education about newborn care.

Department Review of County Internal Report:

WRO received the WCCYS child fatality team report on 05/04/2015. OCYF finds the county internal report as an accurate reflection of the Act 33 meeting, and concurs with the findings and recommendations made. Verbal feedback was given to WCCYS program specialist on 06/24/2015.

Department of Human Services Findings:

County Strengths:

- The agency responded immediately to the report by contacting law enforcement to notify them of the report, and followed up by sending the CY 104. The agency made efforts to coordinate the interviews with law enforcement. The agency had on-going attempted communication with law enforcement
- The agency went to the hospital to interview the parents within hours of receiving the report.
- The agency quickly teamed with medical and community service providers in assessing the needs of the family, and ensuring the appropriate services were set up.
- The agency immediately spoke to the parents regarding identifying a relative caregiver, and completed the background checks and home evaluation timely so when the victim child was discharged from the hospital he was immediately placed with kin. They complied with the Fostering Connections requirements.

- The agency also made efforts for other extended family members to maintain on-going contact with the victim child.
- The agency immediately established a visitation plan so the parents could continue to have contact with the victim child that also ensured the safety of the victim child.
- WCCYS was in compliance in meeting the time-frames and requirements for service plans and court reviews.
- The caseworker did an excellent job documenting the details of all of the interviews conducted during the investigation.
- The supervisory logs were completed timely and contained specific details as to where the agency was in the investigation process, as well as next steps for the caseworker in completing the investigation.
- The fatality review team that the agency convened is consistent and productive as the report reflects a lot of discussion regarding the components that need to be addressed.

County Weaknesses:

- Law enforcement did not collaborate with the agency regarding the investigation. The law enforcement interviews did not happen immediately after the incident, but were several weeks later. The criminal investigation is on-going at this time.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

- There are no areas of regulatory or statutory non-compliance identified.

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings in this review:

- WCCYS needs to continue the current practice utilized for intake investigations/assessments, as the protocols established ensure timely response and thorough investigation.
- WCCYS and the District Attorney's office need to continue to reach out to local law enforcement departments to educate them on the importance of collaboration during Child Protective Services investigations.
- WCCYS needs to continue its practice in complying with Fostering Connections requirements.
- There needs to be consideration for a public service announcement that details the risk and signs of abuse related to infants and small children in hopes that relatives will take a more active role in ensuring the child's safety.
- Pediatricians need to be educated regarding the importance in completing a thorough exam of infants so if abuse is occurring, it is identified more quickly.