



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]
Date of Birth: 08/10/2015
Date of Incident: 9/30/2015
Date of Report to ChildLine: 09/30/2015
CWIS Referral ID: [REDACTED]

**FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF
INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Blair County Children, Youth and Family Services

**REPORT FINALIZED ON:
February 5, 2016**

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Blair County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/21/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	08/10/2015
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Father	[REDACTED] 1989
[REDACTED]	Sibling	[REDACTED] 2014

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYP) reviewed current case records pertaining to the [REDACTED] family. A CROCYP representative engaged the following Blair County Children, Youth and Family Services (BCCYFS) personnel to discuss the incident: Director [REDACTED], Caseworker Supervisor [REDACTED], and Caseworker [REDACTED]. A CROCYP representative attended and participated in the Act 33 meeting that occurred on 10/21/2015, in which medical professionals, social service professionals, legal professionals, and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

On 02/25/2014, BCCYFS received a report two days after the birth of the victim child's sibling, [REDACTED]. It was reported that mother was planning on giving the child up for adoption and that she had changed her mind. The reporting source stated that the mother did not have supplies for the child and that she is "immature". BCCYFS called the mother who had supportive family and stated they will be obtaining proper supplies. The report was screened out on 02/26/2014.

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

On 09/30/2015, BCCYFS received a report that the victim child was brought into the Doctor's office, [REDACTED], by his mother for odd marks on his ribs. The doctor's office is integrated with Nason Hospital. Upon examination and X- rays, it was determined the child had [REDACTED]. The victim child's mother had no explanation for the injuries but stated the child had been in the care of his father, maternal grandparents, and a private childcare provider.

The victim child was transferred to Children's Hospital of Pittsburgh of UPMC for further evaluation. On 10/01/2015, BCCYFS received notification that the victim child had [REDACTED]

To ensure the safety of the victim child's sibling, BCCYFS placed him with a resource family. The sibling received a bone survey at Nason Hospital [REDACTED]

On 10/03/2015, the victim child [REDACTED] the hospital. Follow up skeletal surveys at Children's Hospital of Pittsburgh of UPMC [REDACTED]. He and his half sibling [REDACTED] currently reside in the same resource family.

[REDACTED] Police Department was contacted at the time of the report. The case was assigned to Detective [REDACTED]. On 10/14/2015, [REDACTED], father of the child, was charged with aggravated assault, endangering the welfare of children, simple assault, obstruction, recklessly endangering another person, and harassment. The father waived his charges to [REDACTED] Court of Common Pleas on 10/21/2015. He remains incarcerated at the [REDACTED] Prison due to his inability to post \$50,000 bail. There are currently no criminal charges filed against the biological mother. On 11/25/2015, BCCYFS indicated the father and mother for the abuse of their son.

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

BCCYFS abided by the safety and risk assessment protocols.

- Deficiencies in compliance with statutes, regulations and services to children and families

The Act 33 Team did not reference any specific recommendations.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse

The Act 33 Team did not reference any specific recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies

The Act 33 Team did not reference any specific recommendations.

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

The Act 33 Team did not reference any specific recommendations.

Department Review of County Internal Report:

The CROCYP received BCCYFS Child Near Fatality Report on 01/05/2016. Upon review of the report, CROCYP assessed that the documentation efficiently described the incident, the actions taken by the agencies involved, and the current status of the case.

Department of Human Services Findings:

- County Strengths:

BCCYFS was expedient in informing CROCYP of the near fatality of the victim child.

BCCYFS abided by the In Home Safety Assessment and Management requirements by ensuring the safety of the victim child and his sibling in the home where the incident occurred. Both children [REDACTED] [REDACTED] reside together in a resource home.

The agency utilized an effective community Multidisciplinary Team (MDT); members of which represent a wide array of community services, medical and law enforcement. The MDT team was supportive of the agency's response and actions to the report of the near fatality.

- County Weaknesses:

CROCYP has not identified areas on non-compliance. A recommendation will be forwarded to the Director of BCCYFS in relation to the flow of the agency's Act 33 meeting. The agency is effective in communicating the history of the case and current case status, but there is no direction offered to the participants to discuss recommendations at the State and/or Local level.

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

At the time of this report, CROCYP has not identified areas on non-compliance.

Department of Human Services Recommendations:

CROCYP completed interviews and obtained records as required. The agency provided appropriate services to the family during the investigation and ensured the safety of the other child relevant to the case. The case is currently active with BCCYFS. CROCYP reviewed the near fatality and subsequent involvement by BCCYFS. The only recommendation is to offer direction to the agency concerning the flow of their respective Act 33 meeting to ensure that participants are asked for and afforded the opportunity to offer recommendations at the State and Local level.