



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 05/25/2012
Date of Date of Incident: 04/06/2016
Date of Report to ChildLine: 04/06/2016
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Fayette County Children and Youth Services

REPORT FINALIZED ON:
09/22/2016

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.

Fayette County has not convened a review team in accordance with the Child Protective Services Law related to this report. The county completed the investigation within 30 days and UNFOUNDED the report, therefore a review was not required by Fayette County.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	05/25/2012
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Sibling	[REDACTED] 2014
[REDACTED]	Sibling	[REDACTED] 2015

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all records pertaining to the [REDACTED] family. The County Unfounded the report on 05/06/2016 based on their investigation concluding the father did take the victim child for medical treatment and was not refusing treatment.

Children and Youth Involvement prior to Incident:

There is no history with the family prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

Fayette County Children and Youth Services (FCCYS) received a report on 04/06/2016 regarding the victim child. The report stated the victim child reportedly fell two feet off of a swing while playing at a playground. The incident was reportedly witnessed by a bystander at the park. The father and the victim child returned home when the child began to show signs of an altered state; hence, an

ambulance was called and the child was transported to Uniontown Hospital. Upon admission at the Uniontown Hospital [REDACTED], the father was present; however, the mother was not initially available. The victim child presented with an altered level of consciousness after hitting his head in the fall. The father was reportedly belligerent and refusing for the victim child to be transferred to Children's Hospital of Pittsburgh stating he wanted to wait until the mother arrived. Based on the physician's assessment, the victim child required a heightened level of care that the father was not permitting. The father was threatening to leave with the victim child; [REDACTED]

The Emergency Room doctor contacted Children's Hospital of Pittsburgh (CHP) and requested the victim child be transferred for further observation, he stated that the child needed to be seen at the trauma center. CHP agreed to accept the transfer and the request was sent in. During this time, the doctor reported that when he addressed the situation with the father that the father became irate and stated that he felt the victim child should be evaluated at the local hospital. The doctor stated that due to the injury and that time was of the essence the victim child should be evaluated at CHP. The father began swearing and became threatening towards the doctor. [REDACTED]

[REDACTED] Two and a half hours later the victim child was transported to CHP.

FCCYS responded to hospital at the time of the report and assessed the victim child as he had not been sent to CHP as of yet. The victim child was verbal and spoke to the caseworker. The victim child reported he was playing on the swing and jumped off the swing and did not land on his feet, but hit his head.

The caseworker also attempted to go to the home to see the other children, but no one was home. The mother stated to the worker at the hospital that her children were safe and that she was not going to give them the address to where they were.

The victim child [REDACTED] to the parents at 3:00 AM on 04/07/2016 from CHP, where the child [REDACTED]. There were no other medical concerns noted.

On 04/07/2016, the county conducted their home visit at the family residence. They were met at the door by the mother who refused to allow them into the home to see any of the children. The caseworker did see the sibling from the doorway, and she appeared to be fine and there were no concerns noticeable. The parents refused the caseworker entry and also refused to allow the caseworker to take any pictures. The caseworker contacted the police and when the [REDACTED] Police arrived the father became agitated and still would not allow entry. The mother who had left the residence had returned and had the other sibling in the car and the caseworker was able to see this child and noted there were no concerns. The mother stated that the baby was with her mother. The caseworker went to the grandmother's home to see the baby, who refused access to the child unless the caseworker presented a court order. The caseworker contacted the Supervisor,

Director and Solicitor to see what he should do and was instructed to come back to the office.

On 04/08/2016, another home visit was attempted and the mother would not allow the second caseworker to enter the home either; the mother continued to refuse and the worker left.

[REDACTED] The mother did not understand why this was occurring and the caseworker explained how they need to see all of the children in order to ensure all of the children were safe. The mother reported that she was taking the victim child to the doctor on this date. The caseworker was able to see the victim child and noticed the scar on the forehead seemed to be healing and that the child was actually picking at the scar. The caseworker reported no concerns for the safety of the victim child at that time. The mother stated she would be [REDACTED] and the worker left the home. The County Manager contacted the mother and explained that if she was willing to allow the caseworker to assess the home and the children that day [REDACTED]

[REDACTED] The mother agreed and stated she would contact the caseworker. The caseworker went to the home that afternoon and completed the assessment. The caseworker reported the home was safe, clean and had all working utilities. The home had appropriate sleeping space for all of the children and the caseworker was able to photograph all three children. The children appeared safe and clean and there were no concerns noted. The parents did sign releases for the caseworker to obtain medical records. The county received the records and after a review found no concerns reported medically. The county unfounded the investigation on 05/06/2016 based on the finding that the father was only asking to wait until the mother arrived to transfer the victim child. He was not refusing medical treatment. The case was closed upon submission of the unfounded report.

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; There was no county report
- Deficiencies in compliance with statutes, regulations and services to children and families; There was no county report
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; There was no county report
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; There was no county report

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. There was no county report

Department Review of County Internal Report:

No report required as county submitted an unfounded report within 30 days of the date of report.

Department of Human Services Findings:

- County Strengths:
 - The County responded in a timely manner and conducted their investigation thoroughly.
 - The County made significant attempts, to include possible court intervention, in order to assess and ensure safety of all children in the home.
- County Weaknesses: No weaknesses were noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. No statutory or regulatory areas of non-compliance noted by the Department.

Department of Human Services Recommendations:

It would be recommended that Fayette County continue to complete their investigations in a thorough manner and to continue to complete collateral contacts during these investigations. Fayette County exerted diligence in gathering all pertinent information and went to all necessary means to ensure safety was assessed for all the children.

It would be recommended that communication with local hospitals occur regarding consideration of statements made by parents as to why they may be preventing treatment to their children. In this case the father stated to the county during their investigation that he wanted to wait until the mother arrived at the hospital before transferring the child to the specialized pediatric hospital. The physician was unable to effectively communicate with the father as to his reasoning for wishing not to transport the victim child to Children's Hospital of Pittsburgh. A social worker was not contacted to assist in exploring the father's reasoning. [REDACTED]

[REDACTED] Based on the emotional status of the father at the time of the incident, a more understanding approach by the hospital staff/social worker may have resulted in a less threatening and traumatic outcome for the family.