pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/26/2006
Date of Incident: 10/02/2016
Date of Report to ChildLine: 10/04/2016
CWIS Referral ID: [redacted]

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

Indiana County Children and Youth Services

REPORT FINALIZED ON:
03/23/2017

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.

Indiana County has not convened a review team in accordance with the Child Protective Services Law related to this report. The county submitted an unfounded status determination within 30 days.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/26/2006
	Mother	[redacted]1980
	Father	1977
	Sibling	2001
	Sibling	2009

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 10/14/2016 based on their investigation concluding that the incident was accidental.

Children and Youth Involvement prior to Incident:

Indiana County had no prior involvement with the family.

Circumstances of Child Near Fatality and Related Case Activity:

Indiana County Children & Youth Services (ICCYS) was notified by [redacted] on 10/02/2016 regarding a General Protective Services (GPS) referral regarding an accidental shooting involving a 15- year-old that accidentally shot his 9-year-old brother in the head, stating that the bullet grazed the top of the skull above the right ear. The events of the shooting were reviewed. The father was working at the time of the incident. The victim child's older sibling and his 15-year-old friend had been target shooting in the back yard with a single action barrel 22 pistol. The sibling had completed a hunter safety course and had been target shooting and

hunting with his father for years. The family is a "family of hunters". The sibling and his friend came into the house and went to the living room. The mother had stepped out to burn the garbage. The sibling was holding the weapon on his lap while he was sitting on the gaming chair across from a recliner chair where the victim child was curled up playing video games. The sibling's friend was standing behind the recliner chair where the victim child was sitting. The sibling and his friend were watching what the victim child was doing on the video game. The sibling reached around behind himself to retrieve the gun cleaning kit to clean the 22 before he put it away. The sibling did not realize that the 22's hammer was pulled back and that there was still a bullet in the barrel of the gun. The sibling's finger hit the trigger while he was turning around and the gun went off. The bullet entered in the side of the victim child's head. After the shot, the victim child jumped up and started to walk to the kitchen at the same time that his sibling went running to get their mother. The mother ran into the home. The victim child was standing in the kitchen holding his head. The mother grabbed a dishtowel, and held pressure on the wound, and had the sibling call 911. The ambulance arrived and transported the victim child to the local hospital. The victim child was later flown by medical helicopter to Children's Hospital of Pittsburgh (CHP) [redacted]

On 10/04/2016, ICCYS contacted CHP to gather more information regarding the health of the victim child [redacted] It was at this time that ICCYS was informed that the treating physician was calling the report into ChildLine as a Near Fatality as the physician felt the incident could have been prevented with supervision. This decision was made even though Law Enforcement closed their case indicating the incident was accidental. Once ICCYS received the report they began the Child Protective Services (CPS) investigation. ICCYS contacted the Allegheny County Office of Children, Youth and Families to conduct a courtesy interview and to see the victim child. ICCYS engaged the parents, who entered into a safety plan stating that both children would have supervised contact with one another when the victim child was returned home until the completion of the investigation.

On 10/06/2016, ICCYS contacted CHP to inquire about [redacted] the victim child and was told that due [redacted] the victim child received from the injury, the hospital would be keeping him for a few more days and would contact ICCYS [redacted] CHP did notify ICCYS of the victim child's [redacted] four days later.

On 10/10/2016, ICCYS received a call from the mother stating that the victim child returned home on this date and that the sibling would be staying at a friend's house to give the victim child some time home without the sibling's presence since this is the first time the victim child has been home since the incident. ICCYS arranged to come to the home the following day.

On 10/11/2016, went to the home to conduct a home visit with all of the family members. The home was a little messy but all of the children were clean and there were no safety concerns; all of the guns and ammunition were locked up and not

accessible to the children. The family was still shaken-up over the incident and was agreeable to any assistance from ICCYS. All of the children were interviewed separately and there were no concerns with the safety and well-being of any of the children.

On 10/14/2016, ICCYS intake manager, casework supervisor and caseworker discussed the case and determined that the allegation of causing bodily injury to a child through a recent act would be unfounded. The case was closed and no additional services were provided to the family; however, ICCYS provided the family with brochures for [redacted] services which the family could contact on their own.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report: NONE

The county was not required nor did the county submit a county internal report as the status determination was submitted as unfounded within 30 days of the date of the report.

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

Department Review of County Internal Report:

The county was not required nor did the county submit a county internal report as the status determination was submitted as unfounded within 30 days of the date of the report.

Department of Human Services Findings:

- County Strengths: The county conducted a complete and thorough investigation and made collateral contacts and constant contact with the police and family.
- County Weaknesses: None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  No areas of non-compliance noted

Department of Human Services Recommendations:

It would be recommended to improve hunter safety courses to include a stronger emphasis on gun handling and safety.