pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/09/2014
Date of Incident: 04/06/2016
Date of Report to ChildLine: 04/06/2016
CWIS Referral ID: [redacted]

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

Beaver County Children and Youth Services

REPORT FINALIZED ON:
September 1, 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.

Beaver County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/06/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/09/2014
[redacted] *	Biological Mother	[redacted]1994
[redacted]	Biological Father	[redacted]1995
[redacted]	Mother's Paramour	[redacted]1988
[redacted]	Maternal Uncle	[redacted]1993
[redacted] *	Paternal Grandmother	[redacted]1975
[redacted] *	Step-Paternal Grandfather	[redacted]1967
[redacted] *	Maternal Great Grandmother	[redacted]1953
[redacted] *	Maternal Great Grandfather	[redacted]1942

* 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 Western Region Office of Children, Youth and Families Services obtained and reviewed case records pertaining to the family. Follow-up interviews were conducted with the Beaver County Intake Caseworker and the previously assigned Beaver County Ongoing Caseworker. The Western Regional Office also participated in the Beaver County Act 33 meeting on 05/06/2016 where Beaver County Children and Youth staff, Beaver County solicitors, contracted agency providers, child advocate and law enforcement officials presented updated and historical information regarding the incident.

Children and Youth Involvement prior to Incident:

The family's first involvement with Beaver County Children and Youth Services (BCCYS) dates back to 07/30/2014. BCCYS received a General Protective Services (GPS) referral alleging biological mother would leave her son with multiple caretakers for days at a time. The mother was allegedly consuming drugs and alcohol while caring for her son and selling marijuana. Upon assessment the case was not accepted for services due to the paternal grandmother being an ongoing support. The caseworker did not observe any signs of drug and alcohol use and "believed that if mother used, child was in the care of the paternal grandmother". The mother was involved with the county's [redacted] Program. There is no information regarding mother's compliance with the [redacted] Program or if any other services were offered prior to closing the referral on 09/25/2014.

Another GPS referral was received on 11/17/2014 stating mother was involved in a car accident and allegedly did not have the child (who is the victim child of this report) properly secured in a car seat. The car seat was reportedly not in the base and the child was located on the floor of the truck after the accident. The child was examined at Children's Hospital of Pittsburgh (CHP) and no injuries were documented. However, on 12/07/2014 the child was taken to his Primary Care Physician (PCP) due to having a cold and small bruise in his ear. The PCP referred the child to CHP (the reason remains unclear) where it was discovered he had a [redacted] and the aforementioned bruise to his ear. According to documentation, the mother reported [redacted] was from the car accident. [redacted] was explained by the mother as a result of a fall while the child had a "binkie" in his mouth. During the investigation, BCCYS was unable to determine the cause of the bruising as there were multiple caregivers for the child prior to the injuries being noted.

Subsequently, the family, comprised of the mother and the child, was accepted for services and the case remained open from 01/12/2015 through 06/30/2015. During this time, BCCYS provided the family with [redacted] services [redacted] The services were in place to assist the mother with parenting, home maintenance and completing required appointments. BCCYS reports the services were initiated at an intensive level but did not state if the services remained at this level during the entire time of services. BCCYS also recommended the mother and the father complete [redacted] evaluations. There is no evidence that all of these evaluations were completed, however the case was closed due to the mother meeting the goals of her Family Service Plan.

During the above active case, a separate GPS referral was received 03/18/2015 stating the mother was avoiding [redacted] and BCCYS because the child had visible bruising on the right side of his head. The bruising was reportedly located "near where his [redacted] was" which was allegedly observed on 03/15/2015. BCCYS met with the child and paternal grandmother on 03/18/2015 and did not observe any bruising. It was also reported [redacted] had not met with the mother or the child since 03/09/2015. Five home visits were attempted during this timeframe. On 03/19/2015, the caseworker met

with the mother and discussed being more compliant with BCCYS and [redacted] This referral was closed on 04/13/2015.

Circumstances of Child Near Fatality and Related Case Activity:

BCCYS received a GPS referral on 03/29/2016 stating the mother had contacted the reporting source stating she had been in a car accident the previous night and due to being a little dizzy she requested the reporting source to check on her in the morning. The reporting source was very concerned because the mother was reportedly using heroin and [redacted] pills that [redacted] and in January and February of 2016 she had [redacted] The reporting source, prior to calling BCCYS, went to the mother's residence and found the home to be in reportedly deplorable conditions. The victim child was found to be locked in his bedroom in a soiled diaper, and allegedly he was left in this locked bedroom overnight, with the television left on while his mother slept all day into the afternoon.

BCCYS attempted home visits on 03/30/2016, 03/31/2016, 04/01/2016 and 04/04/2016. BCCYS left notes for the mother requesting she contact the caseworker; and on 04/04/2016 the mother did contact BCCYS stating she was out of town and would return on 04/06/2016.

BCCYS received multiple calls on 04/06/2016 with concerns the victim child had multiple bruises to his face that were observed while Skyping with [redacted] BCCYS contacted the [redacted] Police Department to conduct a joint home visit. At the time of the visit, the victim child, the mother, the mother's paramour and the mother's brother were at the home. It was noted the victim child had noticeable bruising to his face. It was also reported by the family that the victim child had been projectile vomiting overnight. The victim child was transported to the emergency room at Sewickley Hospital and subsequently transported to CHP where upon examination his injuries were qualified as being certified as a near-fatality incident. The injuries included bruising to the face, caused by being repeatedly grabbed, and [redacted] These injuries were classified as a near fatality by Dr. [redacted] of CHP. He was admitted [redacted]

Upon receiving this information, BCCYS closed the GPS case and opened a Child Protective Services (CPS) investigation. During the investigation, BCCYS was told [redacted] the victim child had hit his head while on a metal sliding board. BCCYS questioned the mother as to how there was bruising to both sides, a bruise above his left ear and cheek, on the right side of his neck, a bruise on his right leg and scratch marks to his face. The mother stated he scratches himself and the bruising was from the metal sliding board. The victim child reportedly had two episodes of projectile vomiting prior to going to the emergency room. The mother also provided multiple stories as to her and the victim child's whereabouts during the past week while BCCYS had been attempting to contact the family.

The mother reported the bruising to his left cheek had been there since Easter and the bruising to his jaw line occurred as a result from the fall from the slide. [redacted] the bruising to his face was less than ten days old and [redacted] injuries occurred within twenty-four hours of being admitted to the hospital.

The victim child [redacted] on 04/20/2016 to the care of his paternal grandparents. BCCYS scheduled supervised visitation for the mother and the father. The father stated he was not interested in working with BCCYS and had been minimally involved in the victim child's life. BCCYS provided the mother and the father with a Family Service Plan, which recommended both parties to complete [redacted] evaluations as well as obtain secure housing.

On 04/27/2016, BCCYS determined [redacted] caused bodily injury to a child through a recent act of physical abuse and indicated the case. [redacted] who was also listed as a perpetrator, was determined to be unfounded for allegations of physical abuse as there was no evidence to support he was responsible for causing the injuries. [redacted] has been criminally charged with Simple Assault, Endangering the Welfare of a Child (Felony) and Obstruction. The charges have been waived and [redacted] is currently awaiting trial. No charges have been filed against [redacted]

[redacted] The victim child remains in the care of his paternal grandparents, and is reported to be recovering well from his injuries.

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: Beaver County Children and Youth Services collaborated with Ambridge Police Department, Beaver County Detectives Bureau and Children's Hospital of Pittsburgh to conduct a thorough investigation. The agencies were all quick to respond.

- Deficiencies in compliance with statutes, regulations and services to children and families: Beaver County has limited resources in regard to [redacted] for families. There is also an issue in communication with [redacted] providers which can cause the services to be less effective.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse: No recommendations provided.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: No recommendations provided.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: The review committee discussed possible ways to improve communication with providers such as changes in release of information forms. It was also discussed that some forms of [redacted] should be supplemented with other forms of [redacted]

Department Review of County Internal Report:

The County Internal report was received and reviewed with in the timeframe established in Act 33. The report was somewhat lacking specific details of prior case history. The extent of the prior case history was minimally summarized allegations of contact reports.

Department of Human Services Findings:

- County Strengths: The current County Intake Caseworker completed a thorough investigation. BCCYS had multiple agencies represented and present for the Act 33 meeting.

- County Weaknesses: BCCYS utilizes the teaming structure of the county MDIT team to review county Act 33 cases; however the structure of the meeting appeared to still mimic a proposed MDIT meeting. BCCYS was not prepared to review any of the mandated review points and presented an MDIT based agenda on the active CPS/criminal case as opposed to a full Act 33 meeting. The Intake Caseworker was given the responsibility of preparing the report and co-facilitating the Act 33 meeting with no prior experience or knowledge as to the mandates to follow in a review.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no statutory or regulatory areas on non-compliance.

Department of Human Services Recommendations:

1. Per Act 33, the county review team is responsible for reviewing (not limited to):
    - The circumstances of the child's fatality or near fatality resulting from suspected or substantiated abuse.
    - The delivery of services to the child, the child's family and/or the (alleged) perpetrator provided by the county agency in each county where the child resided within the 16 months preceding the near fatality/fatality.
    - The services provided to the child, the child's family and the (alleged) perpetrator by other public and private community agencies or professionals (these services include services provided by law enforcement, behavioral health services, programs for young children,

programs for children with special needs, drug and alcohol programs, local schools and health care providers).

- Relevant court records and documents related to the child and child's family, as well as the (alleged) perpetrator when they are not a family member.
- The county's agency compliance with statutes and regulations and with relevant policies and procedures of the county agency.

The Act 33 review failed to have substantial documentation and historical information related to the past involvement of the county agency. A prior supervisor who was active in the prior opening of the case was in attendance; however she was not able to answer a majority of the questions presented by the Department as it related to the case history. Additionally, although a provider who was involved in the past active case opening was present for the review, he believed his only focus was the current involvement. He was not prepared to answer any questions about past service activity with the family and appeared to be uninformed prior to the review that this information would be necessary.

As a part of the local review, the team must discuss the following points in order to formulate an appropriate county report:

- Deficiencies and strengths 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 child abuse and neglect;
- 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 and neglect.

The County meeting was coming to a close when the Department had to intervene and suggest the above points be discussed. It would be recommended that Beaver County reiterate the full requirements of the county Act 33 review team. Additionally, it would be recommended that all providers and members with a direct relationship to the case be prepared in advance regarding necessary documentation and historical details in order to conduct a more successful meeting.

2. This case has a history of substance abuse allegations and behavior in regard to the primary caretaker/alleged perpetrator. However, when the injuries to the child were identified, no drug screen was completed on the caregivers. It would be recommended when there are concerns regarding possible

substance abuse the County would request a urine screen from the caregiver. If necessary, this request would be made while parties are present at court.

3. When service providers have been requested to provide services to the family and the family is not compliant with appointments, or the service array it is recommended the service provider notify the local children and youth services agency to notify them of the no compliance so appropriate actions can occur.