pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/13/2014
Date of Incident: 10/12/2016
Date of Report to ChildLine: 10/13/2016
CWIS Referral ID: [redacted]

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

Lawrence County Children and Youth Services

REPORT FINALIZED ON:
04/27/2017

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.

Lawrence 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 11/07/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	10/13/2014
[redacted]	Mother	[redacted]1992
[redacted]	Father	1991
[redacted]	Sibling	2012
* [redacted]	Maternal Great Aunt (kinship)	[redacted]1957

* 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 obtained and reviewed all information related to this incident from Lawrence County, including the initial notification form, the county report, the contact summaries, safety assessments, safety plans, risk assessments, and medical records. The Western Region also attended the Act 33 meeting that the agency held on 11/07/2016 in which law enforcement and medical providers attended. There was on-going contact with the manager during the investigation process.

Children and Youth Involvement prior to Incident:

Lawrence County Children and Youth Services (LCCYS) received a General Protective Services referral regarding the mother and children on 01/13/2015. The concerns within the referral included suspected parent substance abuse, poor home conditions, lack of supervision, and inadequate food. The investigation revealed that none of the allegations were substantiated. The family had recently moved into

new housing and there were no concerns noted in the new home. Case was closed at intake on 01/16/2015. No services were referred for the family at that time.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/13/2016, LCCYS received a report [redacted] stating that a 2-year-old child had suffered injuries [redacted] and scratches on her face. The child had been life flighted from Jameson Hospital in [redacted] Pennsylvania to CHP. While at CHP the child [redacted] The child was examined by the Children's Hospital of Pittsburgh's Child Advocacy Center. [redacted] Both parents were at CHP. The child's father explained that the injuries occurred when the child fell down the stairs in the home. The hospital has stated that this was not an adequate explanation for the serious injuries. [redacted]

LCCYS contacted Allegheny County Children, Youth and Family Services to request a 24 hour courtesy visit and a photo of the child and her injuries [redacted] The father reported that on the evening of 10/12/2016, the older sibling was in her bedroom playing, and the victim child was with him in his bedroom. The father stated that the child told him that she needed to use the restroom so he took off her clothing as he reported that she needed to be naked when she uses the restroom. He stated that he stayed in his room and he thought the child went to her bedroom where the potty-chair was located. He reported that he heard her falling down the steps and he found the child lying at the bottom of the stairs on her back, face up. He stated that there were no marks or blood; only a small scratch on her cheek. He stated at that point he found the child to be unconscious so he picked her up and carried her into the living room and got her dressed. He reported that he attempted to contact the mother, but the line was busy. He then contacted a maternal aunt, who occasionally watched the child, and she contacted the maternal grandmother who came to the home. Upon arriving and being at the home for approximately 5-6 minutes, the grandmother called 911. The mother stated that she was at work when the incident happened; that the father was the sole caretaker of the children at that time. The mother also reported that the child could not have fallen down the basement stairs as there are 2 doors blocking the basement stairs.

The agency coordinated investigation efforts with the [redacted] Police Department and made arrangements for a forensic interview of the sibling, who was currently in the care of her maternal grandmother. A joint home visit by LCCYS and [redacted] Police took place at the maternal grandmother's home on 10/14/2016. In regards

to the incident, the maternal grandmother reported that she was called and told that the child was unconscious, but breathing so she immediately went to the home and called 911 after seeing the child. [redacted] The maternal grandmother asked to be a caregiver for the sibling, which was taken into consideration. The grandmother completed the kinship paperwork on 10/19/2016. [redacted]

On 10/17/2016, the agency and law enforcement completed a joint home visit at the parent's residence. The mother reported that the father first attempted to contact her on 10/12/2016 at 7:30 PM but she did not call him back until 8:17 PM; at this point the father and child were in the ambulance in route to Jameson Hospital. The mother reported that she did not believe that the child was abused and believed the father's story about the child falling down the stairs; she was adamantly supporting the father. [redacted]

On 10/18/2016, the sibling's foster mother reported that the sibling told her that the father was at the top of the stairs when the victim child fell. [redacted] It was reported that the child was kicking her feet. She was described as being agitated [redacted] There was a discussion related to setting up visits between the victim child and the foster mother.

[redacted]

On 10/24/2016, the sibling had a forensic interview at CHP Child Advocacy Center (CAC). The sibling was difficult to keep focused and she was only able to speak briefly about the incident. She did state that her father was down stairs when the victim child fell down the steps.

[redacted]

On 10/26/2016, the caseworker completed a home visit and discussed the kinship care process to the maternal grandmother. There were no concerns noted with the

home, but there was a need for beds for the children. The grandmother works and was able to identify an alternate caregiver during that time.

[redacted]

[redacted]

On 11/07/2016, the agency had the Act 33 meeting in which law enforcement and a CHP physician presented information related to the child's injury and the law enforcement investigation. [redacted]

On 11/16/2016, the agency "Indicated" the CPSL report with the father as the perpetrator for causing a bodily injury to the child through a recent act or failure to act. The child [redacted] to the maternal grandmother's care on 11/17/2016. The mother was referred for parenting classes, and weekly supervised visits were scheduled. The mother continues to support the father stating that she does not believe that he did anything to harm the child, [redacted]

The [redacted] Police Department is continuing their investigation.

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 appropriate coordination with law enforcement and medical personnel. LCCYS Caseworkers promptly initiated the investigation. [redacted] A thorough investigation was conducted and appropriate documentation was created.

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

- None noted

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

- None noted

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

- None noted

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

- None noted

Department Review of County Internal Report:

The Department received the county's internal report on 12/21/2016. The county followed the protocol as far as the format of the report. Fortunately, the agency has not had many near fatalities or fatalities and is not very familiar with the requirements of Bulletin 3490-15-01, Child Fatality and Near Fatality Reviews. The county's internal report did not elaborate on the interviews and activities that occurred during the course of the investigation.

Department of Human Services Findings:

County Strengths:

- The intake investigation was very thorough and the worker completed detailed documentation of all interviews, phone calls, review of medical records, etc. The agency should maintain this level of investigation.

County Weaknesses:

- The agency needs to train all staff on Bulletin 3490-15-01 so there is a broad understanding related to what needs to occur when the agency receives a near fatality or fatality CPSL report.
- The administrator's need to review the Bulletin related to the required persons who are to be invited to the county internal review, as well as the details required in the county report.

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

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

Department of Human Services Recommendations:

- [redacted]The Department recommends that there are public service announcements related to shaken baby and child abuse [redacted]

- Since many county children and youth agencies do not have routine experience with child fatality or near fatality reports, it is recommended that county Act 33 Teams consider participation in the upcoming training currently being developed by the Department of Human Services, Office of Children, Youth and Families. This training will provide additional guidance beyond Bulletin 3490-15-01 to teams to ensure all Act 33 requirements are appropriately met. Until such time as the training is provided, counties are encouraged to utilize their assigned Human Services Program Representative for technical assistance as needed.