pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/21/2016
Date of Incident: 08/24/2016
Date of Report to ChildLine: 08/24/2016
CWIS Referral ID: [redacted]

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

Mercer County Children and Youth Services

REPORT FINALIZED ON:
02/06/2017

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.

Mercer 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 10/25/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	[redacted]2016
[redacted]	Mother	1994
[redacted]	Father	1989
[redacted]	Maternal Grandfather	1952
[redacted]	Maternal Grandmother	1958
* [redacted]	Father's Ex-Wife	1990
* [redacted]	Half-Sibling	2012
* [redacted]	Half-Sibling	2008

*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 all information related to this incident from Mercer County, including the initial notification form, the county report, the contact summaries, safety assessments, safety plans, risk assessments, and medical records. This information was reviewed as well. The Western Region also attended the Act 33 meeting that the agency held on 10/25/2016 in which law enforcement and medical providers attended. There was on-going contact with the supervisor during the investigation process.

Children and Youth Involvement prior to Incident:

The only information available related to prior involvement with CYS are three separate Child Protective Services Law investigations in which the mother was a victim of abuse, at the time she was a child. The cases were never accepted for services.

Circumstances of Child Near Fatality and Related Case Activity:

On 08/24/2016, at 11:09 AM, Mercer County Children and Youth Services (MCCYS) received a report of suspected abuse [redacted] stating that the child is a patient of CHP [redacted] The child was found to have [redacted] which was highly concerning for physical abuse. There was no history for trauma and [redacted] were being completed. At the time of admission, the alleged perpetrator was unknown. [redacted] certified the victim child to be in serious or critical condition based on suspected abuse or neglect; therefore, the report was registered as an Act 33 report.

At 11:16 AM, MCCYS call screener contacted [redacted] CHP to gather additional information. It was reported that the victim child was originally transported by her parents to Grove City Medical Center around 6:30 PM on 08/23/2016. The child was then transported by Life Flight to CHP. It was reported that [redacted] physician suspected abusive head trauma as the child [redacted] it was not known whether the child would survive.

MCCYS then contacted the [redacted] Police [redacted] and the Mercer County District Attorney's (DA) office. [redacted] advised the caseworker not to go to the hospital to see the child. The agency supervisor spoke to the [redacted] to explain agency policy related to an Act 33 case, and that the caseworker is supposed to see the child as soon as possible after the report comes into the agency. [redacted] actually threatened that charges of obstruction would be filed if the agency interfered in the [redacted] investigation in anyway.

At 3:10 PM on 08/24/2016, the agency spoke to [redacted] It was also reported that on 08/23/2016 at 2:03 PM the mother contacted the hospital to report that the child was breathing funny and not eating more than 4 ounces in a 13 hour period; that the child was wetting his diaper and spitting up more than usual; and that his arms and legs were twitching. The mother was advised to take the child to the nearest Emergency Room. The mother had also called the physician on 08/22/2016 regarding dark bowels and fussiness so the formula was changed.

At 4:45 PM on 08/24/2016, [redacted] reported that [redacted] were at the hospital interviewing the parents. [redacted]

At 7:52 PM on 08/24/2016, MCCYS made a referral to Allegheny County Office of Children Youth and Families to see the child and to photograph the child. It was explained to Allegheny County that [redacted] did not want a Children and Youth agency interviewing the parents. Allegheny County agreed to go to CHP and see the child.

[redacted]

At 8:48 PM on 08/24/2016, [redacted] notified MCCYS that [redacted] had put a block on the biological father's contact with the child, which meant he was removed from the hospital and was forbidden to have any contact with the child. The child's condition had not changed.

At 7:30 AM on 08/25/2016, the MCCYS caseworker made an unannounced home visit to assure the safety of the father's other children. No one answered the door. On this same date, the caseworker visited the child at CHP. [redacted] The caseworker observed that the victim child [redacted] The caseworker photographed the child. The caseworker met with [redacted] in the hospital lobby. [redacted] The mother reported that her parents found steroids in the father's things last evening and that they notified [redacted]. The mother was not interviewed [redacted]

On 08/25/2016, the father's ex-wife contacted the caseworker and a home visit with the victim child's half-siblings was set up for later that day. There were no concerns related to these children's safety and their mother agreed not to allow the father to have contact at this time. A safety plan was established.

A supplemental report from an anonymous person was received on 08/25/2016 stating that the father was telling people that the victim child died and that he brought him back to life. [redacted] It was also reported that there was a Protection from Abuse Order against the father. The report noted concerns that the father may hurt someone as he was speeding on the roads, going in and out of traffic and had violations on the forklift at work.

On 08/26/2016, the caseworker obtained an update [redacted] related to the child's condition. [redacted] Later that day, the caseworker was able to reach the father [redacted] The agency also received the courtesy information from Allegheny County Office of Children, Youth and Families on this date.

[redacted]

[redacted]

On 08/29/2016, the caseworker interviewed the father [redacted] The father reported that the only people who care for the victim child besides himself are the mother and maternal grandparents. The father reported that the first time he noticed that something was wrong was on 08/22/2016 around 7:00 PM. He stated that the victim child was upstairs with the maternal grandparents so he went upstairs to feed him around 6:00 PM; he stated the victim child was fussy so he took him downstairs and around 7:00 PM the victim child started choking on formula. The father then picked him up and patted him on the back. He reported that the victim child spit up some formula and cried for a while but fell back to sleep. Around 10:40 PM, he stated that the victim child's head collapsed into his left collar bone. He stated that the child's mother arrived home and the victim child's breathing was shallow so he began giving him chest compressions. He stated that the mother decided not to call an ambulance, so he went to the gym to work out around midnight because the victim child seemed fine. On 08/23/2016, while at work, he received a call from the mother stating the victim child needed to be taken to the emergency room. [redacted] reported to the caseworker that the father was manipulative, that his affect appeared to be off, as he would laugh inappropriately, and that his story continually changed.

On 08/31/2016, the caseworker met with [redacted] who was a household member at the time of the incident. He stated that about a month ago the victim child's left eye was bloodshot and he had a bruise on his left temple. He stated that the father told him the injury was from bouncing, tossing and catching the child and that the father missed him and caught him hard.

On 08/31/2016, the caseworker also met with [redacted] at the hospital to gather additional information. The mother reported that at least ten times during their relationship she had to ask the father to leave her residence due to his anger issues. [redacted]

In regards to the incident, on 08/23/2016, she reported that she was at work and the father was watching the victim child; she arrived home around 10:00 PM and the father was at the door holding the victim child. She stated that it took 10-15 minutes to convince the father to give her the baby and once he did she described that the victim child was staring off into space, and his arms were limp. She stated she touched his face and he was acting normal; she thought he was tired. Around

12:30 AM on 8/24/2016, the victim child woke up crying and she stated that the father became very frustrated and went to sleep on the couch. The mother rocked the baby back to sleep and he again woke up at 2:00 AM crying, and she again got him back to sleep. He woke up crying again around 3:30 AM and ate 4 ounces of formula. Around 6:00 AM she put the child in the bouncer and he fell asleep until noon. At this point, he refused to eat. The maternal grandmother came home from an appointment around 1:00-1:30 PM and when she picked up the victim child she told the mother that something was seriously wrong and she needed to call the hospital. The mother called her pediatrician who advised her to go the emergency room. The father and mother drove the victim child to Grove City Medical Center where he was [redacted] transported by Life Flight to CHP. It was at this point the mother stated she learned that the father reported that he had done chest compressions on the victim child. She stated that at least 10-12 times she had to take the victim child away from the father due to his appearing to be extremely frustrated.

The caseworker also spoke to the maternal grandmother at the hospital who reported that she had heard the victim child screaming several times in the past and when she would check on him the father would say that he had everything under control. She also described that the father often times had a look of frustration on his face when he was holding the child.

During this hospital visit, the caseworker visited the victim child and obtained an update regarding his medical condition. [redacted]

[redacted]

the mother stated that on three separate occasions, she noticed bruising to the child's buttocks after being with his father. She noticed minor swelling to the child's eye which later turned black and blue.

On 09/01/2016, the agency had a team meeting regarding placement of the child with the maternal grandparents. All parties expressed concerns related to what the grandparents reported as well as what the mother has recently reported, given the fact that the grandparents were household members. There were concerns for all three related to their protective capacity.

On 09/02/2016, [redacted] reported to the caseworker that the mother admitted to witnessing the father shake the victim child on more than one occasion, including the night of 08/23/2016. Based on this information, the father was arrested on 08/29/2016, and charged with Aggravated Assault-Victim less than 13

and defendant older than 18 (F1), Endangering the Welfare of Children (F3), Simple Assault (M1), and Recklessly Endangering Another Person (M2). Bail was initially set at $250,000 but was lowered to $150,000 on 08/29/2016. On 11/14/2016, at the arraignment hearing, all charges were ordered to proceed to court. A court date has not yet been set.

On 09/06/2016, the caseworker [redacted] to watch the video interviews [redacted] stated that on 08/23/2016 she was awakened around 1:00 AM to the father picking up the victim child shaking him and dropping him face down onto the bed. The father was cussing at the child calling him derogatory names. Then she witnessed the father sit on the bed and he began to shake and toss the victim child onto a pile of blankets on the floor. She admitted that this has been going on since the victim child was three weeks old. She stated that there were a least five different incidents in which the father shook and threw the victim child. Based on this information, the caseworker contacted ChildLine to register the father as perpetrator by commission for causing bodily injury through a recent act, and causing physical neglect through failing to provide medical treatment. The mother was registered as perpetrator by commission for causing physical neglect through failing to provide medical treatment and omission for causing bodily injury through a failure to act. The Child Protective Services (CPS) referral had initially been registered with an unknown alleged perpetrator.

[redacted]

On 09/14/2016, the agency accepted the family for ongoing services to assure the ongoing safety and well-being of the victim child, to assess and address the parents [redacted] issues, improve the parents parenting knowledge, skills and motivation, and to assess the need for additional services.

On 09/14/2016 the agency also indicated the report of abuse with father as perpetrator by commission for causing bodily injury through a recent act and causing serious physical neglect through a failure to provide medical treatment. Additionally, the mother was indicated for causing serious physical neglect through a failure to provide medical treatment and as perpetrator by omission for causing bodily injury through a recent failure to act. A foster home was identified and the foster family started visitation with the victim child [redacted] to bond and learn about his medical needs.

On 09/26/2016, the child [redacted] the foster family. MCCYS also identified a respite foster parent to assist in caring for the child. [redacted]

[redacted]

At this point, the victim child is spending half the week with the foster family, and the other half with the respite family who is willing to provide him with permanence.

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:

> [The Western Region staff] stated that a strength of the agency was that they checked on the father's other children immediately.

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

> None were 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 were noted.

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

> None were noted.

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

The agency will continue to work on collaborative efforts between the various child serving systems.
The agency will work with the District Attorney's office to coordinate meetings between local law enforcement and the agency to ensure continued communication.

Department Review of County Internal Report:

The report submitted by the county to the region on 12/02/2016 did not follow the required format as established in Bulletin 3490-15-01, Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014, issued July 15, 2015 and effective December 30, 2008 and December 31, 2014. Despite this, the report did contain detailed information of the intake investigation related to this incident. The agency also had representation at the meeting from the CHP, PSP, the DA's office, Department of Health, the County Commissioners, Mercer County [redacted], the child's [redacted], the Coroner's office, the intake caseworker and supervisor, the on-going caseworker and supervisor, the Assistant Administrator and the Administrator of Mercer County.

Department of Human Services Findings:

County Strengths:

The intake assessment was extremely thorough and well documented.

The agency made efforts to collaborate their investigation with PSP.

The agency maintained constant contact by phone and by visiting with the CHP medical personnel related to the victim child's progress.

The agency obtained all the medical records related to the victim child's birth, pediatrician appointments, and hospital records [redacted]

The agency placed the child in foster care which was least restrictive at the time of placement as no immediate kin were identified.

The agency immediately set up a visitation schedule with the mother to allow her frequent visits and transportation for her to attend all medical appointments.

The agency completed the investigation within 30 days of the CPS report date.

The agency has a permanent home identified for the child as his concurrent goal is adoption. The agency has engaged this family in the care and medical treatment of the child.

The agency continues to make efforts to keep the mother engaged despite the fact she is not responding well to parenting issues and she is argumentative and not accepting of help; and very negative about the foster parent's care of her child.

County Weaknesses:

The county internal meeting was held on 10/25/2016 which is outside of the timeframe set in in Bulletin 3490-15-01, Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014, issued July 15, 2015 and effective December 30, 2008 and December 31, 2014. This also impacted the fact that the county report was not submitted within the time-frame required.

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

There are no regulatory areas of non-compliance based on the information provided below. Communication did occur with the County regarding the timeframe requirement of the local review meeting. The county response was accepted by the Department and is found below in the recommendation section; therefore a citation was not issued.

Department of Human Services Recommendations:

Per Bulletin 3490-15-01, Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014, issued July 15, 2015 and effective December 30, 2008 and December 31, 2014, The agency shall schedule all internal meetings within 30 days of the date of the report if the finding has not been determined or if the finding is indicated.

Mercer County did not conduct the local meeting within the 30 day timeframe as the report was received on 08/24/2016 and the meeting was conducted on 10/25/2016. On 11/15/2016, the assigned Western Region Human Services Program Representative to Mercer County held a meeting with the agency administrator and the meeting facilitator regarding the requirements of the bulletin. In response to this, on 11/29/2016 the agency administrator sent a plan of correction that includes the following:

> This was the agency's third internal meeting and unfortunately they were using the draft bulletin from 2008 as guidance.
>
> Since that time, the agency administrator has reviewed the correct bulletin as well as the Child Protective Services Law and there is a clear understanding of the requirements.
>
> The agency is in the process of updating their current policy.

The Department recommends that the agency's intake practices continue to the level that this case was investigated. The Department also recommends that the agency administrator ensure future compliance with Bulletin 3490-15-01, Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 of 2014, issued July 15, 2015 and effective December 30, 2008 and December 31, 2014.

The Department also recommends that a hospital staff be present while new parents are shown the video related to the effects of shaken baby to assist the parents in understanding and absorbing the potential consequences.

The Department recommends that there be more billboards and public service announcements related to the negative and long-term effects shaken baby can have on children.

The Department recommends the creation of a hotline for parents who are feeling overwhelmed which can link them to community resources to assist them when feeling overwhelmed.