pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/15/2016
Date of Incident: 09/15/2016
Date of Report to ChildLine: 09/15/2016
CWIS Referral ID: [redacted]

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

Washington County Children and Youth Services

REPORT FINALIZED ON:
03/19/2017

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (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 (CPSL) 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.

On 10/14/2016, Washington County Children and Youth Services (WCCYS) convened a review team related to this report as required by the CPSL.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/15/2016
	Sibling Child	[redacted]2011
	Sibling Child	2009
	Biological Mother	1985
	Biological Father	1983

Summary of OCYF Child Near Fatality Review Activities:

As part of the review for this near fatality, the Department attended WCCYS' review meeting held on 10/14/2016, as well as a review of the electronic record and the county's report.

Children and Youth Involvement prior to Incident:

WCCYS had no prior involvement with this family. This was the agency's first contact.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/15/2016, WCCYS received a report that the subject child had been taken to Washington Hospital, [redacted] According to the family, the child fell off of a changing table when her mother left her unattended, so the child was taken to Washington Hospital. [redacted] physicians at Washington Hospital believed that the child was in serious condition due to her

injuries, so the child was transferred to Children's Hospital of Pittsburgh (CHP) [redacted]

Also on 09/15/2016, the WCCYS caseworker on-call contacted Allegheny County Children, Youth and Family Services to request a courtesy contact with the child at CHP. Later that same evening, an Allegheny County caseworker made contact with the child at CHP.

The following day, the assigned caseworker from WCCYS completed a home visit with the parents and siblings to conduct interviews and assess safety. As part of the home visit, the caseworker measured the height of the changing table and took photos of the environment where the incident allegedly occurred. Both parents reported that they had a memorial service for the mother's grandmother at 11:00 AM, which they were preparing for when the incident occurred.

According to the mother, she had showered, woke the two older children up, bathed and fed them breakfast. At around 9:15 AM, the victim child began fussing, so the mother checked on her. The mother noticed that the child had urinated, so she placed the child on the changing table without strapping her in and then left the room to go run the child's bath in the bathroom at about 9:20 AM. While in the bathroom, the mother said that she heard a "thud" from the child's bedroom. When she went to examine where the noise came from, she saw the child face up on the hardwood floor, next to the changing table. She immediately screamed for her husband, who was downstairs. He immediately came to the room and the parents called the child's pediatrician and explained what happened. The pediatrician's office advised them to take the child to the nearest Emergency Room, which was located at Washington Hospital. The mother took the child to the hospital by herself because the father was performing the memorial service for her grandmother. She reported leaving for the hospital at approximately 9:45 AM.

When the father was interviewed, he re-iterated the account given by his wife. Since about 6:30 AM, he had been in his downstairs office working on the memorial service for her grandmother, as he was the person performing the service. The father said that at approximately 9:20 AM, he heard his wife "calling for him loudly" from upstairs. When he went upstairs, he said the child was "screaming." He and his wife called the pediatrician's office, who directed them to take the child for medical treatment. The father said the mother took the child to the hospital at approximately 9:45 AM while he remained home with the two other children. He then took the children to the memorial service for 11:00 AM.

WCCYS staff made collateral contacts to the pediatrician's office and CHP. The pediatrician's office verified that the parents contacted them at approximately 9:30 AM on the day of the incident and informed the agency that the children receive routine medical care. A physician at CHP was consulted and believes the mother's explanation of the injury to be a "plausible explanation." [redacted] The physician informed WCCYS that she educated

the mother on the risk of leaving a child unsecured in that situation and the mother informed the physician she would take steps to prevent such incidents in the future.

WCCYS requested the medical records from Washington Hospital. When they were received and reviewed, it showed that the mother arrived at the Emergency Room at approximately 9:45 AM.

Due to the seriousness of the injury, the police were notified of the incident, however, they did not pursue criminal charges.

The assigned WCCYS caseworker found the parents were appropriately meeting the children's needs and that there were no safety concerns in the home. The family was offered voluntary parenting education services, to which they agreed and completed. On 10/14/2016, the county submitted an unfounded determination in regards to the allegations of causing serious physical neglect of a child. As a result, the agency determined that there was no need to accept the family for services and they closed their assessment on 11/04/2016.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

The following strengths, deficiencies and recommendations were taken directly from the county's full internal report.

- Strengths in compliance with statutes, regulations and services to children and families;
  The child, family and home were seen throughout the agency's involvement in accordance with DHS regulations. Timely interviews were conducted with the child's parents and siblings to determine what occurred. Hospital medical personnel were consulted to determine the cause, extent, and impact of the child's injuries. Ongoing communication occurred with law enforcement. Releases of information were obtained to gather collateral and related information from the child's pediatrician, school, and hospitals. Photographs were taken of each of the children and the scene.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  None noted in the 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;
  The team expressed concern that this incident was considered a "Near Fatality." Although a Washington Hospital physician indicated the child was "critically ill with a high probability of imminent or life threatening deterioration" due to [redacted], the child required little treatment either at Washington Hospital or Children's Hospital of Pittsburgh.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  It is unlikely that any changes at either the state or local level would prevent similar incidents since this case was not known to the child welfare system prior to this incident.

  Because this family was not known to the agency, it is doubtful that any changes in monitoring or inspection would have served to prevent this incident or similar ones from occurring.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  No recommendations noted in the report.

Department Review of County Internal Report:

The Department found the county's report to be clear and complete, as well as in compliance with the law. It was done timely and provided to the Western Region on 11/29/2016.

Department of Human Services Findings:

- County Strengths:
  - WCCYS completed a thorough and timely assessment of this family and the incident.
  - On the day of the incident, they contacted Allegheny County CYF to request a courtesy visit to CHP to make contact with the child, as required by the CPSL.
  - The assigned worker made a home visit the day following the report to assess the safety of the two other children in the home, as well as document the environment where the incident occurred. The worker photographed the changing table and floor, as well as measured the height of the table.
  - Collateral contacts were made with the pediatrician's office, CHP, and the police department. Information was obtained from pediatrician's office CHP, and Washington Hospital to help confirm timelines and verify what was stated by the parents.
  - It appears that the agency met the requirements of the CPSL and Chapter 3490 Regulations for this report.

- County Weaknesses: and
  - No weaknesses were identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - As previously stated, there are no regulatory or non-compliance issues noted.

Department of Human Services Recommendations:

The Department does not have any recommendations given this appears to have been an unintentional accident and the mother was provided safety education by hospital staff.