pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/28/2015
Date of Incident: 09/24/2017
Date of Report to ChildLine: 09/24/2017
CWIS Referral ID: [redacted]

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

Butler County Children and Youth Services

REPORT FINALIZED ON:
May 22, 2018

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.

Butler 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 01/12/2018. The county review team meeting was held after the regulatory 30 days. This will result in a citation to the county agency.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	11/28/2015
[redacted]	Sibling	[redacted]2014
[redacted]	Mother	[redacted]1976
[redacted]	Father	[redacted]1972
[redacted]	Maternal Grandfather	[redacted]
[redacted]	Maternal Grandmother	[redacted]

* 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 (WRO) reviewed the case record pertaining to the victim child's family. The WRO staff participated in the county's Act 33 meeting. The Act 33 meeting occurred on 01/12/2018. During the meeting the Intake caseworkers presented the case information. The WRO also reviewed all information in Child Welfare Information System.

Children and Youth Involvement prior to Incident:

The family was not known to the Butler County Children and Youth Services (BCCYS). There are no records of any prior ChildLine reports or investigations.

Circumstances of Child Near Fatality and Related Case Activity:

BCCYS received a referral on 09/24/2017 after the victim child arrived at [redacted] for medical treatment.

The medical assessment of the victim child determined she had a skull fracture and as a result she was flown via medical helicopter to [redacted] for further evaluation and treatment.

The family resided at the Indian Brave Campground in Harmony, Pennsylvania during the summer months. On 09/24/2017 the victim child and the mother were traveling around the campground in a golf cart. The victim child fell from the moving cart.

Witnesses to the victim child's fall were interviewed, and denied that the mother was driving in a reckless manner nor did she appear to be under the influence of drugs or alcohol.

Emergency Medical Services were immediately called and the victim child was transported via ambulance to [redacted] for medical treatment. Upon arrival the victim child was assessed and it was determined by the treating physician that the child had sustained a skull fracture. A determination was made by the medical team to have the victim child transported via medical helicopter to [redacted] for further treatment.

The victim child remained under observation that evening at [redacted]. The physicians at [redacted] felt the explanation provided by the mother was consistent and plausible for the resulting injury. The victim child was discharged to her parents' care on 09/25/2017. The treating physicians do not suspect any lasting medical effects as a result of this fall.

BCCYS immediately responded to the referral. BCCYS requested that Allegheny County Children Youth and Family (ACCYF) complete the initial 24 hour visit to the victim child while at [redacted]. The ACCYF caseworker did respond and saw the victim child and the mother at [redacted]. The mother appeared to be appropriate and did not appear to be impaired.

BCCYS saw the victim child and the mother on 09/25/2017 at the hospital prior to the child's discharge. The mother was consistent with her statement on the incident. The mother appeared visibly upset over the incident. She stated she felt guilty the victim child fell as she usually places her on the seat next to her. Once the victim child fell out of the golf cart she immediately stopped the cart to retrieve the child who was bleeding. She was yelling for help and a person nearby called 911.

The BCCYS caseworker completed a home visit to the campground on 09/26/2017 and felt that a safety plan was not warranted. The sibling was also seen at this time. The BCCYS caseworker inspected the golf cart, and determined that the cart does not have the capability to go over 25 miles per hour. The family was able to discuss the discharge instructions from [redacted] and the mother took the week off of work to be with the victim child as she recovered from her injury. The victim child did attend follow-up medical appointments with her pediatrician. The BCCYS

caseworker did not identify any safety threats within the home. The [redacted], where the campground is located, did complete an investigation and chose not to file any criminal charges. On 10/24/2017, the BCCYS caseworker did submit the CPS report as "unfounded"; however, the BCCYS supervisor did not approve this report until 11/01/2017, seven days after the caseworker completed his investigation. Hence, the CPS report was not completed until day 39 resulting in the need to have formal Act 33 meeting.

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 investigation began within 24 hours of the report, while the child was still under observation at [redacted]. All interviews and collaboration with law enforcement occurred by 9/27/2017. Interaction with the Law Enforcement Office was appropriate and collaborative. On the day the child was released from [redacted], the CPS Caseworker made a visit to the home to interview identified collaterals, assess the scene of the incident (where the injury occurred), and assessed the safety of the children.

- Deficiencies in compliance with statutes, regulations and services to children and families; The County did not submit the CY-48 outcome within the 30-day timeframe and did not schedule a review team meeting within those 30 days.

- Recommendation for Changes: With any future near fatality/fatality reports received, a review meeting will be scheduled within 7 days of the report, no matter the projected outcome.
    - The Intake Case Manager will meet with the CPS Caseworker and CPS Casework Supervisor weekly to discuss the case details, progress, and outcome status.

- 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 made.

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

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

Department Review of County Internal Report:

BCCYS did submit a report to the regional office. The report was late due to the agency not completing a meeting within the required 30 days. The report was well written and contained all the needed information.

Department of Human Services Findings:

- County Strengths: BCCYS requested that ACCYF see the victim child within 24 hours of the incident and then BCCYS saw the child for themselves the following day. The sibling was seen during the home visit on 09/26/2017. They interviewed everyone involved in the case as well as the witness who called 911.

- County Weaknesses: The BCCYS caseworker did submit the report prior to 30th day of the investigation, but the BCCYS supervisor failed to approve the report prior to the 30th day. An Act 33 meeting should have been held prior to 30th day of the investigation.

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

  §6365 (d) (1): County agencies are required to convene a "Child Fatality or Near Fatality Review Team when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made within 30 calendar days. This meeting must occur by the county review team by the 31st day of the investigation.

  §6365 (d) (4) (v): The County shall submit a final written report on the child near fatality to the department within 90 days of the convening.

Department of Human Services Recommendations:

The Department recommends public service announcements to stress the importance of securing young children in any motorized vehicle including golf carts.