REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/14/2017
Date of Incident: 11/10/2017
Date of Report to ChildLine: 11/11/2017
CWIS Referral ID: [REDACTED]

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

Cambria County Children and Youth Services

REPORT FINALIZED ON:
6/5/2018

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.

Cambria County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/08/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1995
[redacted]	Mother's Paramour	[redacted]1992
[redacted]	Victim Child	[redacted]2017
[redacted]	Sibling	[redacted]2014
[redacted]	Maternal Aunt	[redacted]1997
[redacted]	Cousin	[redacted]2017

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYF, reviewed the Cambria County Children and Youth Services, CCCYS, child protective service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed [redacted] [redacted] and [redacted]. The CROCYF also attended the Act 33 Child Near-Fatality Review Team meeting on 12/08/2017. The CROCYF is currently working with CCCYS to obtain a copy of the record.

Children and Youth Involvement prior to Incident:

CCCYS had no prior involvement with this child and the family had no involvement with the agency within the preceding 16 months of the date of the incident; however, the mother had prior involvement with the agency as a child and with another of her children.

08/04/2011 to 01/19/2013: The mother was in the care and custody of CCCYS as a child. Her placement was necessary due to transiency, lack of supervision, and poor living arrangements. The mother left the agency's care and custody on her 18th birthday.

O4/23/2014 to 06/05/2014: CCCYS received a General Protective Services report that the mother was smoking marijuana before she was pregnant with the child's sibling. Reportedly the mother quit smoking when she learned she was pregnant. A drug screen completed on the mother at the sibling's birth was negative and the GPS assessment was rejected/screened out.

08/28/2015 to 10/27/2015: CCCYS received a referral that the mother was smoking marijuana in front of her child, the child's sibling.
The mother recently had completed a drug screen for her employer which showed negative results. The assessment concluded that the child's basic needs were met and the GPS assessment was rejected/screened out.

Circumstances of Child Fatality and Related Case Activity:

CCCYS received this Child Protective Services report of physical abuse from ChildLine on 11/11/2017. There was no alleged perpetrator, AP, identified in the report. The mother reported that on 11/10/2017, she was not feeling well and went to lay down. Later that evening the mother's paramour went to check on the child and found "limp and not breathing normal". The mother then went into the child's room and discovered that the child was vomiting. The child was then transported to Following the child's examination and CT scan the child was diagnosed with three skull fractures, a fracture of the right temporal bone, hemorrhaging on the frontal brain as well as areas of old bleed. Due to the child's injuries was air lifted to Following examination there by , reported that the child suffered both chronic and acute subdural hematomas. Dr. noted that the fresh blood could have been caused as recent as the day the child was taken to the hospital. Dr. stated that there was retinal hemorrhaging in all 4 quadrants of both eyes. Dr. further indicated that this is "diagnostic of abusive head trauma". Dr. classified the child's injuries as a near fatality on 11/15/2017. CCCYS then contacted ChildLine to update the report as a Near Fatality.

The child was discharged from on 11/15/2017, into the care of a family friend. CCCYS developed and implemented an immediate Safety Plan with the mother and the child's caregiver. The safety plan provided that the mother cannot have any unsupervised contact with the child. The mother agreed to this plan.

On 11/10/2017, upon receipt of this report, CCCYS immediately ensured the safety of the child's sibling, who the mother had left in care of her maternal aunt, while she and her paramour traveled to to be with the child. That child also had a physical exam which confirmed that she had no physical injuries. The sibling remains in the care of the maternal aunt with a safety plan in place which provides that the mother will have no unsupervised contact with that child. The mother is cooperative with the safety plan.

On 11/27/2017, the child was readmitted to for surgery to install a shunt in the child's head to alleviate pressure on the child's brain and to assist with blood drainage. Upon discharge the child returned to caregiver with the safety plan remaining in place.

CCCYS also verified that that the mother's sister had her child examined for any injuries as recommended by Dr. [redacted] of [redacted] as she resided with her child in the mother's home. Documentation of the exam performed by [redacted] verified the exam was completed and there were no findings of any injuries.

The child's father had little to no contact with the child since birth and was incarcerated at the time of this incident. The father currently remains in the [redacted] for charges unrelated to this incident.

CCCYS and the Johnstown Police Department conducted many interviews in an attempt to determine an AP. The child's mother, her sister and paramour denied harming the child in any manner. Interviews with other individuals who were in the home also failed to produce an AP. On 01/04/2018, in collaboration with the Johnstown Police Department, CCCYS determined this case as "Pending Criminal Court" and submitted the CY-48 on the same date naming the perpetrator as unknown. On 01/29/2018 at a Juvenile Court hearing, the Judge issued the following finding: "The court hereby finds that the child is a victim of child abuse as per 23 Pa.C.S. 6303, in that the Court finds that the Child [redacted], is a victim of physical child abuse as per 23 Pa.C.S. 6303 with the Perpetrator of the child abuse being unknown."

CCCYS opened the family for ongoing services effective 01/10/2018. Supportive services include case management, in-home counseling and parenting education.

The child currently remains with the family friend caregiver with a safety plan in place. The mother continues to have supervised visitation with the child. All medical care for the child continues to be provided and monitored by CCCYS.

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 team felt that all county agencies acted in compliance with statutes, regulations and procedures.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  There were no deficiencies 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:
  There were no recommendations made.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  There were no recommendations made.

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

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting Report was received by CROCYF on 05/07/2018. The CROCYF attended the Act 33 Child Near-Fatality Review Team meeting on 12/08/2017 and was aware of the discussion, recommendations and outcome. CROCYF finds the county's report content and findings are representative of what was discussed during the meeting on 12/08/2017.

Department of Human Services Findings:

- County Strengths:
  CCCYS conducted the investigation in cooperation with law enforcement and medical services/providers. The record was comprehensive; including medical reports, interviews, risk and safety assessments, and case dictation.

- County Weaknesses:
  Documentation of the Act 33 Meeting was not submitted timely.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  There were no areas of non-compliance noted.

Department of Human Services Recommendations:
CCCYS should continue to conduct thorough and timely investigations in collaboration with law enforcement, the court and medical and service providers CCCYS should continue to work on timely submission of documentation as required by OCYF 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.