



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



BORN: March 10, 2010
NEAR FATALITY: May 11, 2011

FAMILY NOT KNOWN TO:

Erie County Office of Children and Youth

REPORT FINALIZED ON: August 17, 2011

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 [REDACTED]. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	March 10, 2010

*Not a household member; however plays a pivotal role in the current status of the case.

Notification of Child (Near) Fatality:

Erie County Office of Children and Youth (OCY) received a call on May 11, 2011 that a one year-old male child was being transported via ambulance to [REDACTED] hospital due to a [REDACTED]. The mother's paramour, who was caring for the child at the time of the incident, reported that the child had been sitting on his lap and then the child jumped off and ran into a door frame. The paramour called the mother at work and when the mother arrived home, the child was unresponsive on the floor. The paramour also called 911 to report the child's condition prior to the mother arriving home. At the time when emergency personnel arrived on the scene, the child was still unresponsive and therefore transported to the hospital. Upon medical examination, the child was diagnosed with a [REDACTED] and was air lifted to [REDACTED].

Upon admission to [REDACTED], the child received [REDACTED]. The child was found to have additional [REDACTED]. A [REDACTED] was completed after [REDACTED] and found no [REDACTED].

Through the course of interviews, the paramour's story changed in regards to how the child received the injuries. There was a second story that reported the child ran out of the bedroom he and mother's paramour were in and into the kitchen after the mother left for work. The paramour heard a "bang" and ran into the kitchen to find the child on the floor and believes the child ran into the metal table and chairs in the

kitchen. The attending physician at [REDACTED] indicated that the explanation of the injury provided by the paramour is not consistent with the level of injuries. The physician strongly believed at the time of the initial examination that the child was a victim of [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed the current intake records pertaining to the [REDACTED] family. Regular communication and updates were provided by the intake worker, [REDACTED].

During the course of the review, it came to the attention of the Department that the mother's paramour had three children (ages 2, 14, 16) to three separate women, none of whom is the mother to the subject child of this report. In reviewing the histories, it was discovered that [REDACTED] had two separate prior involvements with the agency regarding his two oldest daughters. The Western Region reviewed the contents of both the June 2010 [REDACTED] report regarding the then 13 year-old and the January 2011 [REDACTED] reports involving the 16 year-old.

The regional office also participated in the County Internal Fatality Review Team meetings on July 13, 2011 and July 29, 2011

Summary of Services to Family:

At the time of the near fatality, the family was not receiving any services from Erie County OCY.

Children and Youth Involvement prior to Incident:

The mother and her children had no previous involvement with Erie County OCY as a family. The mother was however known to the agency as a child between the years of 1989-2008 due to allegations of [REDACTED] [REDACTED] in the family setting. The specific details of some of the [REDACTED] are unknown due to expungement laws. The agency closed the allegations of [REDACTED]. There is no previous involvement with the child's father or the sibling's father, neither as adults nor as children.

The mother's paramour does have a history with the agency regarding allegations toward his biological daughters. The mother's paramour has two daughters, ages 14 and 16, each to a different mother, neither of whom is the mother to the subject child of this report. The following is a brief summary of those reports:

➤ June 2010

Erie County OCY received a report alleging [REDACTED] of [REDACTED] daughter, who at the time of report was 13 years old. [REDACTED] was the [REDACTED] on the report, which was [REDACTED]. There were no bruises to the child and no evidence to support [REDACTED] had occurred.

➤ January 2011

Erie County OCY received a report regarding allegations of [REDACTED] involving the mother of [REDACTED] 16 year-old child, and the child's half siblings who were living with their mother. [REDACTED] was only involved as the primary caregiver of the 16 year-old daughter at that time and no allegations were being made regarding his care of the child.

Circumstances of Child (Near) Fatality and Related Case Activity:

On May 11, 2011 Erie County OCY received a referral that a one-year old child was being transported via ambulance to [REDACTED] hospital due to a [REDACTED]. The mother's paramour, who was caring for the child at the time of the incident, reported that the child had been sitting on his lap and then the child jumped off and ran into a door frame. The paramour called the mother at work and when the mother arrived home, the child was unresponsive on the floor. The paramour also called 911 to report the child's condition prior to the mother arriving home. At the time when emergency personnel arrived on the scene, the child was still unresponsive and therefore transported to the hospital. Upon medical examination, the child was diagnosed with [REDACTED] and was air lifted to [REDACTED]. During the first forty hours of being in [REDACTED], the child required [REDACTED] w [REDACTED]. During the medical examination in [REDACTED], the child had a [REDACTED] that revealed an [REDACTED]. The child remained in the [REDACTED] until June 6, 2011 when he was transferred to a rehabilitation facility in [REDACTED]. During the child's stay at [REDACTED], regular communication occurred between the agency and [REDACTED]. The treating physician reported the injuries were as a result of being [REDACTED].

The child's safety was assured at the hospital, ceasing all contact between the child and the mother's paramour who was identified as the [REDACTED] after the physician's finding of abuse. The child's sibling went to stay with his father and paternal grandmother. [REDACTED]

[REDACTED]. In fact, the father took significant steps to be available and supportive to his son.

The mother's paramour continues to deny [REDACTED] of the child. As previously noted, he has reported varying stories that resulted in the injuries. The mother continues to support the paramour and does not believe that he caused the injuries to her child.

During the course of the investigation, criminal histories were obtained for both of the children's fathers, the mother, and the mother's paramour as well as significant others that may be involved with the child or the sibling. Criminal histories were significant for both the child's father and the mother's paramour. The child's father, who has been significant in the child's life, was found to have a prior criminal history of *Simple Assault (2007, M2)*, *Carrying a Firearm without a License (2007, M1)* and *Disorderly Conduct Engaging in Fighting (2008, M3)*. No [REDACTED] record was found for the child's father. The mother's paramour was found to have a prior criminal history that included *Simple Assault (1999, M2)*, *Criminal Mischief (1999, S)*, *Disorderly Conduct Engaging in Fighting (1999, M3)*, *Recklessly Endangering Another Person (2000, M2)*, *Criminal Mischief (2000, S)* and *Burglary (2000, F1)*. It was also learned that the mother's paramour had a Protection from Abuse order placed against him by his youngest daughter's mother. The PFA was ordered May 10, 2011 for an incident that allegedly occurred on April 2, 2011. The agency had no prior knowledge of the PFA and only became aware during the near fatality investigation. There were no [REDACTED] records regarding the mother's paramour.

Based on the finding [REDACTED] from the physician at [REDACTED], the agency completed the [REDACTED] investigation on May 26, 2011, [REDACTED] the mother's paramour of [REDACTED]. The Erie Police Department has filed criminal charges on the mother's paramour, consisting of *Aggravated Assault (F1)*, *Endangering the Welfare of Children (M1)* and *Recklessly Endangering Another Person (M2)*. The criminal arraignment was held on July 25, 2011 holding the charges over for trial. The trial has been scheduled for September 12, 2011. The [REDACTED] is currently still incarcerated in Erie Prison.

Current Case Status:

The agency accepted the family for services on May 26, 2011. The child remains in [REDACTED] at the [REDACTED] of the hospital. The child is reportedly responding well to his mother, tolerating liquids and pureed foods well and has been seen laughing and giggling at times. He appears much calmer and has noticeable minor visual tracking. Although outcome predictions can not be made at this time, hospital staff is optimistic about his recovery. [REDACTED] has been scheduled for September 2011 and it is anticipated that he will remain in the rehabilitation center for another four to six weeks.

The mother continues to visit very regularly and has gained employment in [REDACTED] in order to meet her financial responsibilities while staying in [REDACTED] during the child's recovery and rehabilitation. Significant support and guidance has been offered to the mother by hospital staff. The only concern the agency and staff continue to present in regards to the mother is her continued support for her paramour, who has been charged with [REDACTED] of her child. The mother consistently reports that she does not believe her paramour could do such a thing and has been researching other plausible causes for the injuries. She has been heard stating that she will continue to believe her paramour until he is either convicted or acquitted of the charges. The mother continues to maintain a residence in Erie and does visit with her other son on a consistent basis.

The child's current permanency goal is reunification with the mother. Continued visitation at the rehabilitation center is encouraged and supported by the agency and hospital staff. The agency has prepared a safety plan that will ensure safety at the time of discharge. As long as the mother's paramour remains incarcerated, the child's mother appears to be a safe discharge resource. Daily review of the inmate list and regular communication with the probation office regarding [REDACTED] incarceration status is occurring to better prepare for any changes in safety threats or required safety planning. The sibling's father has expressed a desire to move forward with custody arrangements and has verbally agreed to keep the child in his care.

As mentioned above, the Erie Police Department has filed criminal charges on the mother's paramour, consisting of *Aggravated Assault (F1)*, *Endangering the Welfare of Children (M1)* and *Recklessly Endangering Another Person (M2)*. The criminal arraignment was held on July 25, 2011 holding the charges over for trial. The trial has been scheduled for September 12, 2011. [REDACTED] is currently still incarcerated in Erie Prison.

At the time of discharge, the agency will work with the hospital staff to better assess the level of services required for the child upon his return home. Supportive services, such as Mother to Mother, are also being considered as a resource for the mother upon the child's discharge. Ongoing agency monitoring will continue to be in place.

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

County agencies are not always required to convene a review team – if a review team was not convened, note the reason in this section

- Strengths:
None were identified in the report.

- Deficiencies:

At the time the review team convened, a formal safety plan had not been established for the child since his current status in the hospital was assessed as safe and the [REDACTED] was incarcerated. The team viewed this as a concern and suggested that a plan be developed to clearly outline the participants' expectations and to ensure that safety would be preserved at the time of discharge. A recommendation was made to accomplish this task immediately.

- Recommendations for Change at the Local Level:

The local team contributed the following recommendations:

- (1) Better effort should be made by caseworkers to review all prior histories and intakes on a family when a new referral has been accepted. It was suggested that a search be conducted to see how often intake workers are reading the histories of newly assigned referrals.
- (2) A review of the screening process should occur to determine the level of referrals coming from the Court in regards to PFA orders where children are identified to be present in the setting. If referrals are being made by the Court, it is recommended that the process be reviewed to determine if acceptable screening actions are occurring (i.e. are referrals being accepted or screening out).
- (3) It was recommended that new mothers and their families be shown a video, prior to leaving the hospital, on the effects of Shaken Infant Syndrome. It was also suggested that public broadcasting and school channels be encouraged to show the video.
- (4) Better education for teen and young adult parents (mothers and fathers) could be streamlined through the schools, community providers and Probation systems.
- (5) Although the father has been active in the child's life and recovery, the agency should be working better to encourage the child's father to be more involved in the training and rehabilitation of the child while he is in the [REDACTED]. This could prevent future delays if the father becomes a necessary resource upon discharge.

- Recommendations for Change at the State Level:

None were identified in this report.

Department Review of County Internal Report:

The county finalized the internal report on August 12, 2011 and the Department received the report on August 17, 2011. The Department reviewed the report and concurs with the findings and recommendations made by the review team. The Department had representation on the review team and was already familiar with the substance of the report. The agreement with the team's findings was made known at the time of the final review meeting.

Department of Public Welfare Findings:

- County Strengths:

The Department felt that the agency conducted a thorough assessment and displayed positive collaboration with hospital and law enforcement staff. Significant interviews and correspondences took place during the investigation process, which openly supported the final determination [REDACTED]

- County Weaknesses:

The Department concurs with the above findings of county weaknesses, which were made known in the county's internal report. Some of the weaknesses identified were mentioned by Regional representatives at the time of the review meeting.

- Statutory and Regulatory Areas of Non-Compliance:

No findings of statutory and regulatory non-compliance.

Department of Public Welfare Recommendations:

In addition to the mentioned above deficiencies, the Department recognizes some areas of county practice that may benefit from suggested recommendations. The Department makes the following recommendations:

Per Act 33, a local review meeting must be conducted within 30 days of the start of the child death investigation unless the case was ██████████ and ██████████ received the ██████████ within 30 days of the date of the ██████████ referral. The date of the ██████████ report to the county was May 11, 2011 and the first local review was not conducted until July 13, 2011. It is recommended that Erie County review current policies and procedures in place regarding the commencement of local review meetings.