



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**BUREAU OF CHILDREN AND FAMILY SERVICES  
WESTERN REGION**

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**REPORT ON THE NEAR FATALITY OF:**



**BORN: November 28, 2009**

**FAMILY KNOWN TO:**

**Crawford County Children and Youth Services**

**REPORT FINALIZED ON: May 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 been made regarding the report within 30 days of the oral report to ChildLine. Crawford County has convened a review team in accordance with Act 33 of 2008 related to this report. The review team did not meet until September 10, 2010 at the request of the Department.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	11/28/2009

- The mother had previously resided in Erie County where she gave birth to five children. The mother [REDACTED] to all five of those children and they have [REDACTED].

**Notification of Child Near Fatality:**

On 7/11/10 the mother brought the child [REDACTED] to Meadville Medical Center. [REDACTED] had a fever all day and was acting tired and was pulling on his left eye. The child had been home with the father and a babysitter. The father reported to the mother that the child had a seizure as his body went limp and eyes rolled back. The child had been left with a babysitter for part of the day. According to the local hospital the child had [REDACTED]. He had an [REDACTED].

The child was in serious condition but would survive. The child was transferred to Children's Hospital of Pittsburgh. Children's Hospital of Pittsburgh completed a skeletal survey of the child and found no fractures. He did not have a [REDACTED] as initially reported, but did have [REDACTED]. The initial report to [REDACTED] stated that the child suffered non-accidental trauma. An [REDACTED] had not been identified at the time of the initial report.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed the current and past reports on the mother from Crawford County Children and Youth Services. The mother's past file from Erie County Children and Youth Services was obtained and reviewed by the Department. A representative from the Department attended the Near Fatality Review Team meeting on September 10, 2010 at Crawford County Children and Youth Services.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:****Erie County Children and Youth Services Involvement:**

According to Erie County Children and Youth Service records; the mother had another family with her then husband. According to the case records the mother gave birth in 1997, 1998, 1999, 2001, and 2003. The family had a history of involvement with Children and Youth Service agencies in Warren, Crawford, and Erie Counties. The family established a pattern of moving to other counties and states. The first documented referral was to Warren County Children and Youth Services in 1999. The parents were unemployed with no money for formula for their children, the children were not receiving consistent medical care and the oldest child appeared to be delayed. The family left Warren County and went to live in Erie County. Erie County then received a referral on the family that they were without a source of income for food and necessities for the children. The mother appeared to be stressed and overwhelmed with child care responsibilities. The family then moved to Crawford County where again they were referred to the local child welfare agency in 2000. The identified problems were again that the parents had a lack of funds to provide necessities of life, including shelter for the children. The parents would not follow through with services. The oldest child was exhibiting behavior problems and the parents lacked parenting knowledge to deal with him. In addition there was a suspicion that the parents were [REDACTED]. During 2000 the family moved to Arkansas. By 2001 the family was back in Erie and another referral was made to Children and Youth Services. The family was having financial difficulties and had no money for food, diapers and other necessities. There were no noted safety concerns and the parents refused ongoing services.

On 7/25/2002 the oldest daughter, age 3, was almost hit by a car at 12:30am on a street in Erie County. She was only wearing a diaper. She was unable to tell the police her name and where she lived. The Police obtained an Emergency Custody Authorization and she was placed in a foster home. At approximately 7:25am the mother called the police to report her daughter missing. The mother had several explanations as to what happened. The child remained in foster

care and Dependency petitions were filed on the four children. The other three children were removed from the parent's care on 8/2/2002. On 8/20/2002, while the children were in out of home care, Erie County Children and Youth Service received a report of [REDACTED] on the three oldest children. These children were suffering from [REDACTED]

At the time of the referral, the children were found to be developmentally delayed. There were also concerns about the parent's drug use and domestic violence by the father. The parents stipulated to the Dependency finding for the oldest four children. The father left the area and did not visit the children or work with the agency.

The mother did cooperate with the agency and successfully completed court ordered services. The mother gave birth to her fifth child in 2003 and placed that child with relatives through guardianship. This was a private arrangement. The oldest four children were returned to the mother's care with the youngest of the four children being returned to the mother on 5/7/2003 and the other three children being returned to the mother on 6/12/2003. The agency provided the mother with supportive services and day care services. Soon after the children were returned home the agency began receiving reports from the day care provider that the children were being kept in day care for ten to twelve hours a day. On 8/7/2003 the mother requested that the children be placed in foster care because she was emotionally and financially overwhelmed with the care of the children.

As with the previous removal, the mother was cooperative with the agency and was able to successfully complete court ordered services. This time, the mother and the children were involved with the Collaborative Visitation Services. It was observed that the mother was unable to control and discipline the children during a visit. She was unable to provide structure to the children during a visit and could not implement the suggestions of the observer. The visits would become chaotic with the mother becoming overwhelmed. By the end of 2003 the mother told the agency that she was unable to parent all of her children. She ended her visitation with the youngest of the four children and requested that [REDACTED]

[REDACTED] In December of 2003 the father told the agency that he wanted [REDACTED]. On 8/2/2004 the mother [REDACTED]

**Crawford County Children and Youth Services Involvement:**

The mother gave birth to a male child on 1/17/2007. The mother and this child were referred to Crawford County Children and Youth Services in July of 2008 due to allegations that the mother was [REDACTED] when the child was present. The caseworker made an unannounced home visit to the maternal grandparent's home where the mother and the child were living. During this visit the mother [REDACTED]. She did not want the caseworker to tell her parents about the [REDACTED]. The mother was in agreement with the plan that her parents supervise her contact with the child. The next day the mother was admitted to a [REDACTED]. The mother gave the grandmother guardianship of the child while she was in [REDACTED]. The grandparents told the caseworker that they were willing to care for the child. The mother was in the [REDACTED] for approximately three weeks. Upon her release from the facility the mother returned to her parent's home. The record indicates that the caseworker made two more home visits in September of 2008. The mother was attending [REDACTED]. The record states that the mother was [REDACTED] and that the child was being cared for by the mother and her parents. No child welfare concerns existed at this time. Risk Assessment was completed and a decision was made to close the case; as the overall severity and risk were rated low.

The next referral the agency received was in January of 2009. The mother had [REDACTED] in December of 2008 and the grandparents had kicked her and the child out of their home. At this time the mother and child moved into a shelter. They then moved into an apartment together. The mother was working and the child was in Daycare. Before the caseworker made a home visit to the mother's apartment the child was back in the maternal grandparent's care. The grandmother agreed to notify Children and Youth Services if the mother attempted to remove the child from the grandparent's home. The mother had lost her job and was going to [REDACTED]. The mother agreed that the child would stay with her parents until she completed a [REDACTED], and the grandparents agreed to supervise mother's contact with the child.

The agency was in contact with Crawford County Adult Probation who was supervising the mother for Erie County Adult Probation, where she had been convicted for passing bad checks. One of the mother's probation requirements was to complete a [REDACTED] and [REDACTED]. The Adult Probation office agreed to contact the agency if they had any concerns regarding the child. Again a decision was made at intake to close family for services. A Risk Assessment was completed and overall severity and risk were rated low.

In May of 2009 the family was again referred to the agency, this time by [REDACTED] when the mother who was pregnant [REDACTED] again. The mother, who had remarried, [REDACTED] at the time of the referral and was concerned that her husband would find out about her [REDACTED]. Her husband also [REDACTED].

Prior to the referral, the mother had resumed parenting the child in April of 2009. The child had been ill and had suffered a seizure. The mother had been able to meet the child's medical needs, however, the grandmother came and assumed care of the child. The child was to remain in the grandparent's custody until the mother completed a [REDACTED]. The case was accepted for service on 7/17/2009. A family service plan was completed with the family on 7/29/2009. During the summer of 2009 the agency did file a dependency petition on the child. This petition was withdrawn because the mother was compliant with the [REDACTED] and was cooperating with the agency. The case was closed in October of 2009 after the mother had successfully completed [REDACTED]. A closing Family Service Plan was completed. Three Risk Assessments were completed during the agency's involvement with the family. The Risk Assessments completed in May and July of 2009 rated the overall severity as low and the overall risk as moderate. The Risk Assessment completed in October of 2009 had the overall severity and risk rated as low.

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

On July 11, 2010 Crawford County Children and Youth Services received a report of [REDACTED]. The child had been brought to a local hospital in serious or critical condition as a result of [REDACTED]. The child would survive. The mother brought the child to the hospital because he had a fever and was not acting right; the child was also noted to have a rug burn or rash on back of his head. The child appeared to be tired and he was pulling at his left eye. The child had been home in the morning with his father. The father reported to the mother that the child had a seizure, he had become limp and his eyes had rolled back. The mother did not know how the child had gotten the rug burn or rash on the back of his head. The child had also been in the care of a babysitter that day. When the hospital staff informed the mother of the severity of the child's injuries she called home. The mother reported to the hospital staff that the father told her that his four year old son must of have done something to the child. The child was transferred to Children's Hospital of Pittsburgh, the mother went with him. At the time that the [REDACTED] an [REDACTED] was not identified.

A Social Worker from [REDACTED] interviewed the mother upon her and the child's arrival at the hospital on July 11. The mother reported that she was not at home that morning, as she had been working at a flea market. The father

was at home with the child as well as his 4 year old child from another woman. The father did call the mother to tell her that he thought the child had had a seizure. The mother reported that when she returned home she tried to feed the child but he vomited. The mother noticed the abrasion on the left side of the child's head. The father told her that he thought his four year old child caused the injury. The mother reported during this interview that her three month old child has a history of seizures; as well as a history of weak neck muscles for which he is to receive [REDACTED] from Shriners' Hospital. The mother told the social worker that five of her children from a previous marriage [REDACTED]. According to the social worker that [REDACTED] was not fearful and the mother was upset that [REDACTED] was suspected as the cause of the injuries. The [REDACTED] was aware that there were [REDACTED] on three of the children who had [REDACTED] and that the mother and her then husband were the [REDACTED].

Later that evening an agency caseworker and supervisor went to the family home. The father along with his son and a family friend were at the home. The family lives on a farm with multiple buildings. There are different families that live in the different buildings on the farm. Some of these individuals are the father's relatives. The father reported that he had just obtained full custody of his 4 year old son. The child was watching TV during this visit.

The father reported the events of the day as follows: The mother left for the flea market around 6:00am. He said that he woke up round 7:30am and that he heard the child crying in his crib. When he went to the crib the child was in a different part of the crib than where he had been placed. The father picked him up and as he took him downstairs the child stiffened up like a board. The father called his Aunt but she wasn't up. He called the mother who told him to give the child a bottle and to snuggle with the child. That did not work, so he called the mother again, she told him to give the child a breathing treatment. When he gave the child the treatment, he threw up yellow stuff. When he reported this to the mother, she told him she was on the way home. When the mother arrived home she took the child to the hospital. The father reported that the child had a seizure and that he knew that the mother's other child had seizures. The father's extended family members, who also live on the property in a separate building, stopped by the house prior to the agency workers leaving the home.

On July 13, 2010 [REDACTED] informed the agency of their finding that the child was a victim of [REDACTED]. The child had [REDACTED]. The hospital said that the injury would have occurred sometime between Saturday and Sunday. The child had had a MRI and did not have any other fractures. The agency spoke to the mother by phone since she was still in Pittsburgh. The mother was quite upset when she was told of the hospital's findings. The agency told the mother that it was the agency's priority to keep the other children safe. Arrangements were made for the father's 4 year old child to stay with his maternal grandparents. The

mother's other child was already staying with his maternal grandparents. The father called the agency and told them that the child had multiple caregivers on Saturday when he had experienced the seizure. The agency also received reports from the adults involved in the case that it was the father's 4 year old son who shook the child. The Pennsylvania State Police were notified of the hospital findings.

Once the child was released from the hospital back into the mother's care, the maternal grandmother of the victim child and his sibling informed the agency that because of other family obligations she could no longer have the mother and the two children stay in her home. At this time, the mother and the two children returned to the family home. The father's 4 year old child also returned to the family home. In order to assure safety, the father's aunt, who was not in the home the morning of the incident, moved into the home to provide supervision.

The father was offered a polygraph by police, which he failed. The father admitted that he was one that shook the child. At this time the father was told that he had to leave the family home, which he did. The safety plan with the father's aunt remaining in the family home to supervise the mother and the children remained in effect until the mother returned to her parent's home after the child's discharge from the hospital. A Family Group Decision making conference was held and it was agreed upon by participants that when the maternal aunt could not be in the home another family member would take her place.

During the investigation the workers found it frustrating that the mother would not accept the fact that the father was the one who caused the child's injuries. The mother would make excuses for the father and said that the child's injuries were caused by one of his half-siblings pushing him too vigorously in the swing. The mother frequently expressed her concern that she needed the father in the home to support her.

Both the mother and father have histories of [REDACTED]. The mother has been diagnosed as [REDACTED] as well as having a [REDACTED], for which she was receiving treatment from a [REDACTED]. The mother also has a past history of [REDACTED]. The mother's [REDACTED].

The father is also diagnosed as being [REDACTED]. He also has [REDACTED] that manifest themselves as [REDACTED]. The father has a history of [REDACTED]. The father was [REDACTED]. Both parents were receiving [REDACTED].

Prior to the incident the child had been seen at Shriner's Hospital in Erie and diagnosed as having [REDACTED]. The

child was referred for physical therapy and [REDACTED]. [REDACTED] had not started when the incident occurred. The child had had a cookie swallow test at [REDACTED] in June of 2010. The child was seen again in August of 2010 at the [REDACTED] in Erie. Again he was diagnosed as having [REDACTED] which was causing [REDACTED].

The child was also noted to have mild developmental delays. He was not able to sit on his own, but with weekly physical therapy the child was showing improvement. A referral was made again to [REDACTED] for him. The two older boys were referred to the [REDACTED] program. The family was receiving in home services focusing on parenting skills. A referral was made to Family Group Decision Making and a conference was held.

During the Intake investigation the agency obtained the past medical records on the child, the medical records for [REDACTED] the mother's child to a previous partner, the parent's [REDACTED], and Erie County Office of Children and Youth case file. The agency had multiple home visits to the family home. The agency completed the In-Home Safety Assessment Worksheet, a Safety Plan, and a Risk Assessment. The [REDACTED] was completed on 8/10/2010 with a status of [REDACTED]. The father was identified as the [REDACTED] of the [REDACTED].

### **Current Case Status:**

Case was accepted for service on September 3, 2010 and transferred to on-going services. Case remains open with the agency. The primary concern of the agency and other parties involved with this case has been the mother's refusal to believe that the father caused the child's injuries. This fact influenced the safety planning for the family. The mother remained in the family home with the child, her child and the father's child until the end of October of 2010. The father's aunt moved into the family home to supervise the mother and the children. When the father's aunt was not available, other family members who were not in the family home the morning of the incident did the supervision of the mother and children. By the end of October of 2010 the mother informed the agency that she could no longer care for the father's child and he returned to the care of his biological mother.

The mother, victim child and the child's half-sibling went to live with the maternal grandparents. When the mother was preparing for the move the child accidentally fell down some steps. He was playing with his brothers when the fall occurred. The mother took him to a local hospital because he had five red bumps on his head. The injuries were consistent with the explanation and he was released to his mother's care. The maternal grandparents were incorporated into the safety plan to ensure that the father does not have access to the children.

The family was involved with Family Group Decision Making. The initial Family Service Plan was completed as part of the Family Group Decision Making process. The mother has cooperated with the services provided which include a Parenting program and [REDACTED] for her. She remained active with Adult Probation as a result of charges related to passing bad checks. The mother ensured that the child attended all of his medical appointments and followed up on the recommendations made as a result. The child was seen for follow up medical appointments by Children's Hospital of Pittsburgh and Shriners Hospital in Erie until his discharge in December 2010. The child successfully completed [REDACTED] in January of 2011. At the time of this report, the child is attending an [REDACTED] Program. The child continues to receive services from the Gertrude Barber Center. The mother's other son is on a waiting list for a [REDACTED] program. The mother has been working with a parenting educator and has also applied for housing.

The father has been charged with one count of Aggravated Assault, one count of Simple Assault, one count of Endangering the Welfare of Children, and one count of Recklessly Endangering a Child. On October 6, 2010 the Criminal Court Judge informed the agency that she was issuing a no contact order for the father and the mother and child. On April 4, 2011, the criminal court judge changed the conditions of the father's bond so that he could have agency supervised visitation with the child. The father's trial has been postponed again and is not scheduled to be heard until the end of April or the beginning of May.

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of [REDACTED] 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. Crawford County has convened a review team in accordance with Act 33 of 2008 related to this report. Crawford County review team met on September 10, 2010. The meeting was scheduled for this date in order for the Department to attend the meeting.

- **Strengths:** Twenty-three people attended this meeting. In addition the treating physician from Children's Hospital of Pittsburgh participated by speaker phone. There were representatives from County Human Service programs, Law Enforcement, Education, Domestic Violence, Drug and Alcohol, CASSP Coordinator and other Medical Providers. The treating physician from Children's Hospital of Pittsburgh clarified that even though this case had been registered as a child near fatality case and the child had suffered a serious bodily injury; the child was never near death. The child was never intubated and was released from the hospital after a short stay. Even though the child did suffer from [REDACTED] it was not severe enough to be near death. His long term prognosis could not be

made at the time of the meeting. The review team as asked to consider three questions:

1. Was there a premature closing of the case at the last referral?
2. Should the family have been referred to Family Group Decision Making sooner? Did the review team have suggestions for Family Group Decision Making and case planning? There was much conversation about the timing of the closing of the case after the last referral. The participants stated that they could argue the point of keeping the case open. Since the mother had just resumed parenting of her son from her parents. However at the time of the closing the mother had successfully completed her Family Service Plan and there were no identified safety concerns. The review team did not believe that the family should have been referred to Family Group Decision Making sooner. The review team did recommend that the Family Group Decision Making process be used to determine how long the extended family members were committed to supervising the mother and children to ensure that the father does not return to the family home. Secondly, could the Family Group Decision Making process identify potential long term care givers for the children in case the mother and father could not or would not parent the children?

- Deficiencies: The review team did not identify deficiencies.
- Recommendations for Change at the Local Level: The review team did not recommend changes at the local level.
- Recommendations for Change at the State Level: The review team did not make recommendations for change at the State Level.

### **Department Review of County Internal Report:**

The Department received a copy of the review team's report on October 7, 2010. The report was well written and well organized. The report discussed the mother's prior history with the agency and their current involvement with the family. The report focused on case strategies to help the mother successfully parent the children. The Department was in agreement with the review teams recommendations.

### **Department of Public Welfare Findings:**

- County Strengths: The agency responded to each report it received in a timely manner. The agency completed each assessment with in sixty days of receiving the report. The agency engaged extended family members as part of safety planning. The father's aunt moved into the family home. The extended family members who were part of the safety planning were not in the family home at the time of the incident. The

agency was in contact with service providers. The agency made unannounced and announced home visits. Case documentation supports the agency's contact with service providers as well contacts with the family. The case file contained the records of service providers. The case file contained copies of completed In-Home Safety Assessment Tool, Safety Plan, Risk Assessment, and Family Service Plan. The agency used Family Group Decision Making in Safety Planning and Service Planning.

- County Weaknesses:

One issue that remains unresolved is that this report was identified as a child near fatality report. The initial report of [REDACTED] was filed by [REDACTED] on July 11, 2010. The first sentence stated that "the child was a victim of a serious or critical condition as a result of a non-accidental trauma due to possible [REDACTED]. The victim child will survive [REDACTED].

[REDACTED]. The child was never intubated during his hospital stay. Even though the child did suffer from [REDACTED] it was not severe enough for the child to be near death. The child's hospital stay was brief. His long term prognosis could not be determined. The county should have identified this issue when completing its initial assessment of the report.

- Statutory and Regulatory Areas of Non-Compliance:

None

**Department of Public Welfare Recommendations:**

This case illustrates the problems that county agencies encounter when they have history on one parent and the other parent is not known. The agency had not received a past referral on the father. Once the father was identified as the [REDACTED] during the incident the agency intervened for the family. The agency assessed the father and recommended that he have a [REDACTED]. The father went on his own for [REDACTED] after the incident. The mother was already in [REDACTED]. Both parents were referred to Brief services for parenting. Both parents continue to receive parenting services. The child successfully completed [REDACTED] and has been enrolled in an [REDACTED] Program. The mother's son is on a waiting list for a [REDACTED] Program. The child continues to receive Physical Therapy from the Gertrude Barber Center for the [REDACTED]. The mother has been referred to Housing programs to obtain her own housing.

Based on the Department's review of this case and participation in the Crawford County's near Fatality Review team the agency's involvement with the family was appropriate. During the course of the agency's involvement the father was identified as the [REDACTED] to the child. The agency took appropriate steps in developing a safety plan for the children. The safety plan developed by the agency for the father that he would not have contact with the child was supported by a Criminal Court Order which also stated that the father was not to have contact with the child. Both parents complied with this court order. On April 4, 2011, the terms of the father's bond was changed to allow him to have agency supervised visitation with the child. The father's criminal hearing was postponed again and is not scheduled to be heard until the end of April or the beginning of May.