



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

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

11 Stanwix Street, Room 260
Pittsburgh, Pennsylvania 15222

REPORT ON THE NEAR FATALITY OF:



Date of Birth: April 26, 2010

Date of Near Fatality Incident: September 16, 2010

**The family was not known to
Washington County Children and Youth Services**

The family was not known to other public/private social service agencies

Date of Report: June 14, 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. 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. Washington 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	04/26/10
[REDACTED]	Sibling	[REDACTED] 05
[REDACTED]	Mother	[REDACTED] 85
[REDACTED]	Father	[REDACTED] 85

Non Household Member

[REDACTED]	Siblings Father	Unknown
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Notification of Child Near Fatality

Washington County Children and Youth was notified by [REDACTED] on September 16, 2010 (date of incident) that the victim child was brought into their emergency room by both parents at approximately 9:15a.m. Father, who was the caretaker at the time, called mother at work, and waited until she returned home before bringing child to the ER. Child was limp and not breathing at the time of ER admission. After breathing was restored, child was flown to Children's Hospital, Pittsburgh. Child presented there with several [REDACTED] (in various stages of healing) and a [REDACTED]. As of September 17, 2010, child's condition was unstable and he remained on a ventilator.

Documents Reviewed and Individuals Interviewed

The OCYF Regional Program Representative reviewed the case file provided by Washington County CYS. The file included the investigation summary, demographic information, risk/safety assessment, permanency plans and progress notes. Interviews were also conducted with the CYS caseworker and supervisor. Additionally, medical

records from Children's Hospital of Pittsburgh were reviewed. The Washington County Review team met on October 15, 2010.

Case Chronology

Prior to the near death of [REDACTED] on September 16, 2010, the family was not known to Washington County Children and Youth Services. A search of agency records revealed no prior history with the family.

September 16, 2010: [REDACTED] was carried into [REDACTED] Emergency Department by his father, accompanied by the child's mother. The child was not breathing and was limp at the time. The father stated that he was sleeping on the couch with the child; the child started to cry and there were bloody bubbles around his nose. It was noted that father then called mother at work and waited for her to return home before taking child to the hospital. The child's breathing was subsequently restored at the [REDACTED] and [REDACTED] was life-flighted to Children's Hospital, Pittsburgh later that same day. When the child was admitted to that hospital, an examination revealed he had several [REDACTED] in various stages of healing, and a [REDACTED]. Eighty percent of child's [REDACTED]. Child was in critical condition and was placed on a ventilator. The father was jailed pending criminal charges.

September 17, 2010: [REDACTED] investigations were initiated against both parents. CYS took custody of child's sibling and placed her in foster care.

October 7, 2010: [REDACTED] and his sibling sister were [REDACTED].

October 19, 2010: [REDACTED] was [REDACTED] and placed in foster care.

November 3, 2010: [REDACTED] investigations were concluded. Both parents were [REDACTED].

November 9, 2010: Child's sibling transferred to same foster home as victim child. The mother was engaged in supervised visitation with both children.

February 18, 2011: Child's sibling was returned to mother's care. Child's visitation changed to unsupervised with mother. The father, who was arrested and charged with aggravated assault and child endangerment, remained incarcerated.

April 4, 2011: [REDACTED]

April 19, 2011: [REDACTED] was returned to mother's home. CYS services continue.

Children and Youth Involvement prior to Incident

The family had no prior involvement with Washington County CYS.

Circumstances of Child (Near) Fatality and Related Case Activity

Washington County CYS received a call on September 16, 2010 reporting that the victim child, who was limp and not breathing, was brought to the [REDACTED] emergency room at about 9:15a.m. After being transferred to Children's Hospital of Pittsburgh that same day, the child's injuries, identified as several [REDACTED] [REDACTED] (in various stages of healing), and a [REDACTED], were determined to be the result of [REDACTED]. Additionally, it was reported that 80% of the child's [REDACTED] and that he had been placed on a ventilator. Upon the child's admission to the hospital, father stated that he had been sleeping on the couch with the child and noticed bloody bubbles around the child's nose. The father said that he then called the mother at work and waited for her to return home before proceeding to the hospital. [REDACTED] investigations were then commenced by Washington County naming both the father and the mother as [REDACTED]. These investigations were concluded on November 3, 2010, and resulted in both the father and the mother [REDACTED]. The mother appealed the [REDACTED] report as it relates to identifying her as [REDACTED] and a hearing was held on April 4, 2011. No decision has yet been issued. The father was criminally charged with Aggravated Assault (F-1), Recklessly Endangering Another Person (M-2), and two counts ([REDACTED]) of Endangering the Welfare of Children (M-1). He remains in the Washington County jail at this time.

Child was released from the hospital on October 19, 2010 and placed in foster care. His sibling, [REDACTED] was transferred to the same foster home [REDACTED] on November 9, 2010. At that time, the physicians treating [REDACTED] did not believe he would survive; it was noted that the child's medical condition precluded him from any feelings of pain or hunger. Subsequently, child's condition improved somewhat, and outside of periodic medical procedures to deal with airway and stomach issues, his health has been stable.

From the outset of the child and his sibling's placement in foster care, the mother engaged in weekly visitation with both of the children. The visits were supervised by the Bair Foundation through February 18, 2011. On that date, the victim child's sister was returned by the court to her mother's custody and 16 hours of unsupervised weekly visitation with the victim child was awarded to the mother. On April 19, 2011, the victim child was returned to the custody of the mother. The father of the victim child's sibling has had no contact with that child as he refused to cooperate with the agency.

Current Case Status

Mother has demonstrated ongoing cooperation with all agency services. She had conscientiously maintained appropriate weekly visitation with the victim child and his sibling. For the past three weeks, the mother has had both children in her home and has not encountered any major issues. She has participated in weekly [REDACTED] [REDACTED] focusing on [REDACTED]. Additionally, the mother also

continues to participate in three domestic violence groups per week through the Washington Women's Shelter. Washington CYS has no plans to discontinue services to the family at this time and the next review hearing will be held in August 2011. Child's father continues to be incarcerated and termination of his parental rights will be considered at the next hearing.

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 [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Washington County convened a review team in accordance with Act 33 of 2008 related to this report on October 15, 2010.

- Strengths: None identified
- Deficiencies: None identified
- Recommendations for Change at the Local Level: None identified
- Recommendations for Change at the State Level: None identified

Department Review of County Internal Report

The county report was initially submitted on January 14, 2011, and then resubmitted on April 27, 2011. It consisted of a one paragraph letter stating that compliance with statutes, regulations and services provided to the child and his family was achieved. It did not provide details of the issues reviewed by the county CFNF team.

Department of Public Welfare Findings

- County Strengths: The county response to the near fatality of the child was prompt and comprehensive. The child and his sibling were immediately placed in protective custody. A Family Service Plan and Child Permanency Plan for the subject child and sibling were developed promptly. Court intervention was initiated and the Review/Permanency Hearing process was comprehensive and detailed in terms of both services, as well as timelines. It is noted that a return to the maternal home was achieved in seven months from the date of the near fatality.
- County Weaknesses: The county report is unacceptable in its current form and does not adequately reflect the effort put forth by the agency in this case.
- Statutory and Regulatory Areas of Non-Compliance: None.

Department of Public Welfare Recommendations

The county will be required to enhance its internal report format as the content of the report it submitted is inadequate.