



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 12/14/09

Date of near death incident: 12/08/11

**The Family was not known to
Blair County Children and Youth Services.**

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 No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, January 4, 2009. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.¹

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	12/14/09
[REDACTED]	Mother	[REDACTED]/80
[REDACTED]	Mother's Paramour	[REDACTED]/80
[REDACTED]	Sibling	[REDACTED]/07

Notification of Fatality:

According to the CY 47 report that was received by Blair County Children, Youth and Families Services, the victim child was admitted to the Children's Hospital of Pittsburgh [REDACTED] on 12/7/11, transferring from the Altoona Hospital. [REDACTED]

[REDACTED] Dr. [REDACTED] noted there was no clear history to explain the injury. Dr. [REDACTED] certified the child in critical condition. [REDACTED]

[REDACTED] The alleged perpetrator was listed as unknown [REDACTED] [REDACTED] had access to the child when the injuries could have occurred.

Documents Reviewed and Individuals Interviewed:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed the Blair County Children and Youth Services Child Protective Service investigation file. The file was inclusive of all medical reports, Police Criminal Complaint and agency dictation. The CROCYF interviewed Blair County Caseworker [REDACTED] and Supervisor, [REDACTED].

Previous CY involvement:

Blair County Children and Youth Services had no involvement with the family prior to receiving the Child Protective Services Report on 12/08/11.

Circumstances of Child's Near Fatality:

Beginning in September 2011, the victim child and his sibling, [REDACTED] every Tuesday and Friday. [REDACTED] had previously come to the family's home [REDACTED]

[REDACTED] the boys on 12/2/11 while the parents worked. On 12/3/11, the mother noticed the child's shoulder looked swollen. On 12/4/11, the mother took the child to Altoona Hospital. [REDACTED]

¹ 23 Pa. C.S. 6343 © (1)-(2).

[REDACTED] The injury was noted to be minor and was healing.

[REDACTED] she was told that the victim child's sibling had run and jumped on the victim child.

Through the evening of 12/6/11, the victim child continued to be lethargic and unable to keep anything down. The mother noted blood in his urine. She contacted [REDACTED] and spoke to Dr. [REDACTED]

The victim child was seen that morning and was immediately sent over to Altoona Hospital for evaluation. Altoona Hospital determined that the victim child should be transported to Children's Hospital of Pittsburgh. The victim child was admitted on 12/7/11 [REDACTED] certified the child in critical condition.

Throughout the interviews conducted by Blair County Children, Youth and Families and the PA State Police with the [REDACTED] no other information than what is noted above was obtained.

Current / most recent status of case:

Blair County Children, Youth and Families Services conducted this investigation in collaboration with the PA State Police. Neither agency could identify a perpetrator(s) in the case. The PA State Police stated they cannot move forward on any charges. Blair County Children, Youth and Families Services unfounded their investigation on 2/3/12; [REDACTED]

Upon the initiation of this investigation the victim's child brother was staying with relatives. When the victim child [REDACTED] from the hospital on 12/19/11 he also began staying with his sibling with the same relatives. [REDACTED]

There was no safety issues/threats observed during the agency visits or reported by the contracted service provider.

[Redacted]

[Redacted]

Blair County Children Youth and Families Services met with their attorney as well to discuss the case. The agency's attorney advised that [Redacted] were not appropriate. The two attorneys did come to an agreement

[Redacted]

Services to children and families:

Upon receiving this report a safety plan was initiated for the victim child's sibling. Family members were assessed and approved as caregivers. The safety plan was monitored by Blair County Children, Youth and Families Services.

[Redacted]

County Strengths and Deficiencies as identified by the County's Fatality Report:

The Child Fatality Review Meeting for this case was held on January 3, 2012. The agency conducted the investigation in collaboration with law enforcement. There were no deficiencies noted.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Fatality Report:

The Child Fatality Review Meeting for this case was held on January 3, 2012. There were no recommendations for changes at the Local (County or State) level.

Central Region Findings:

The investigation completed by Blair County Children and Youth Services was conducted timely and in collaboration with law enforcement services. Efforts to ensure the safety of the other child in the home [Redacted]

[Redacted] The agency sought input from their legal counsel as well and the agency was willing to initiate court involvement if necessary. Case documentation was thorough and the record was inclusive of all medical information. There were no regulatory compliance issues.