



REPORT ON THE NEAR FATALITY OF:



Date of Birth: March 27, 2012

Date of Incident: May 5, 2012

Date of Oral Report: May 7, 2012

FAMILY NOT KNOWN TO:

Crawford County Children and Youth Services

REPORT FINALIZED ON: May 8, 2013

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. Crawford County has convened a review team in accordance with Act 33 of 2008 related to this report.

Summary of Review**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	03/27/12
[REDACTED]	Mother	[REDACTED] 88
[REDACTED]	Father	[REDACTED] 63

Notification of Child (Near) Fatality:

Crawford County Children and Youth Services received a report on May 7, 2012 regarding the child being admitted to [REDACTED] after his mother found him vomiting. The mother had reported to the medical professionals that on May 5, 2012 she and the child's father had been arguing when the father grabbed the child out of the mother's arms. The father then dropped the child. The child allegedly first landed on a nearby bed and then bounced off the bed onto the carpeted floor. When the mother noticed the child vomiting on the morning of the report, she brought the child to the [REDACTED]. The child was given a CAT scan and diagnosed with [REDACTED]. The child was certified to be in serious condition due to [REDACTED] and was transferred to [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. The regional office also

participated in the County Internal Fatality Review Team meetings on June 6, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

No prior involvement with the family

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

The County had received a general referral call [REDACTED], Saturday, May 5, 2012 reporting the domestic disturbance that had occurred on May 4, 2012. The report indicated that the mother and the father had been in a domestic dispute and the father had snatched the child from the mother and the child fell on the floor. The local police had responded and told the mother to stay at the neighbor's for the night. The child appeared fine according to the report and stayed in the home with the father. The next day the mother went back to the home and the father and the child were gone. The mother was requesting the child be seen at the hospital and the father would not take him, stating he felt the child was fine. The mother stated that the child and the father were at a relatives and she could not remember where the relative lived. The on call worker relayed the information to the supervisor who determined the report could be followed up on Monday since it was not known where the child's location was at this time.

On May 7, 2012 Crawford County Children and Youth Services received a CPS report regarding the child being admitted to [REDACTED] after his mother noticed him vomiting. The mother had reported to the medical professionals that on May 5, 2012 she and the child's father had been arguing when the father grabbed the child out of the mother's arms. The father then dropped the child. The child allegedly first landed on a nearby bed and then bounced off the bed onto the carpeted floor. When the mother noticed the child vomiting, she brought the child to the [REDACTED]. The child was given a CAT scan and diagnosed with a [REDACTED]. The child was certified to be in serious condition due to [REDACTED] and was being transferred to [REDACTED].

The child was given a follow up skeletal scan and found to have no further trauma. The medical examiners at [REDACTED] stated that although the initial scan at the [REDACTED] on the child's CAT scan that was indicative of [REDACTED], the other body scans showed no signs of a [REDACTED]. The hospital was still diagnosing the child with a [REDACTED] due to the previous scan. The child was showing no signs of trauma or concerns since being admitted and the exams showed no outward marks of trauma. On May 9, 2012 the child [REDACTED] to the mother's care.

On June 5, 2012 [REDACTED] were unfounded by the County. The medical records from the treating hospital could not indicate that the fall significantly injured the child. The case was accepted for services on June 15, 2012.

Current Case Status:

Crawford County continued to monitor the child in his mother's care on a weekly basis. The child was found to be safe and thriving in his home during these visits. The mother and the father were referred for [REDACTED] as well as [REDACTED] for the mother for [REDACTED].

Both parents were charged with "*Endangering the Welfare of a Child*" and a "*Parent Commits Offense-Drunkenness Prohibited*" on each other regarding the domestic dispute. The Preliminary hearing was held July 31, 2012 where all charges were waived to Court. Bail was set, removing all monetary value; conditions for bail in place included: parents attending [REDACTED] no drinking and working cooperatively with CYS. Both parents agreed to the conditions. Per the documentation, both parents had been very cooperative with the caseworker up to the court juncture; however neither had initiated any [REDACTED].

Weekly contact was maintained through the end of September. The parents remained open and cooperative with the agency. There was no open sign of [REDACTED] during these visits. The child was being taken care of and appeared to be healthy and functioning normally. [REDACTED] were referred; however the child was assessed and found not to be in need of services. The child was found to be developing on target and required no further services. The child's follow up appointment with [REDACTED] determined he was doing well medically.

In October, the visits were changed to a biweekly schedule. The mother continued to comply with her [REDACTED]. On October 22, 2012 the mother pled guilty to the *Drunkenness Prohibited(S)* charge and a *Disorderly Conduct (M3)*. She was to appear later in court for the *Endangering the Welfare* charge. The father pled guilty to *Endangering the Welfare of a Child (M1)*.

On November 1, 2012 the agency assisted the family after the parents decided they could no longer be involved in a relationship with each other. The father moved out and the parents agreed to an arrangement for visitation and babysitting regarding the child. On November 12, 2012 the father was arrested for, and ultimately pled guilty to, *Simple Assault* and *Harassment* when he assaulted the mother and was placed in jail. The child was in the home at the time. A friend of the mother attempted to leave with the child, however the father took the child and left with him. The police apprehended the father and place him

in jail. The child was not injured. The mother followed through with obtaining a Protection From Abuse (PFA) order the next day.

On December 3, 2012 the mother contacted the worker seeking assistance as she [REDACTED] had been drinking at a party in Erie. She was asking for the worker to come to Erie and pick her up. The child was with the mother's new paramour, not in Erie with her. The mother also became aware of a bench warrant issued for her regarding a hearing that she never responded to the previous day. It was decided that the mother would turn herself in on the warrant. The mother made arrangements with family to care for the child during her incarceration. The mother was sentenced to a minimum of 2-12 months. Unfortunately, the family members were not able to commit to the arrangement and the child went into foster care on December 10, 2012 until the mother was able to be released from jail. The mother was released on February 1, 2013.

The mother began visits with the child at the foster parents' home and began [REDACTED]. The mother began working with the agency to [REDACTED]; she was no longer living with the child's father. The PFA remained in effect. The child was returned home to his mother's care on April 8, 2013 [REDACTED] for a 90 day trial home visit. The mother has located appropriate housing and was compliant in her [REDACTED]

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 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. Crawford County convened a review team in accordance with Act 33 of 2008 related to this report.

- **Strengths:**
 - Multiple home visits occurred and communication was open and consistent with the family.
 - Communication between the County, investigating law enforcement and hospitals was consistent and ongoing throughout the investigation.
 - The child was appropriately referred to [REDACTED] during the intake process.
 - Collateral contacts were made and documented with other community workers.
 - Background and clearances were completed during the intake process.

- Deficiencies:
 - The county received a call on 5/5/12 stating that the child fell; however no follow up was completed due to a lack of knowledge regarding the child's whereabouts. A follow up should have been made with the mother on 5/6/12 to determine if the child had been located and to gather information about the need of the child to be seen by medical professionals.
- Recommendations for Change at the Local Level:
No recommendations given by the local team.
- Recommendations for Change at the State Level:
No recommendations given by the local team.

Department Review of County Internal Report:

The county finalized the internal report on July 2, 2012 and the Department received the report on July 2, 2012.

Department of Public Welfare Findings:

- County Strengths:
The Department recognizes 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. Weekly home visits were being made for the first four months of the case, which included well documented quality visits.
- County Weaknesses:
The Department concurs with the above findings of county weaknesses, which were made known in the county's internal report.
- Statutory and Regulatory Areas of Non-Compliance:
No findings of statutory and regulatory non-compliance.

Department of Public Welfare Recommendations:

Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to DPW and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the following:

- Deficiencies and strengths in compliance with statutes, regulations and services to children and families;

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse and neglect.

The final report submitted to the Department contained details that fell under headings titled "Policies, Procedures and Regulations" and "Findings", however it would be recommended that these sections be all-inclusive to better identify the "Deficiencies and Strengths" as a whole in compliance with the statutes, regulations and services to the families. Additionally, the report failed to include recommendations, if any, for changes on the state and local levels on reducing the likelihood of future child fatalities/near fatalities related to child abuse, the monitoring of county agencies and on collaboration of community agencies/service providers to prevent child abuse. It would be the Department's recommendation that this information be added to the final reports.