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REPORT ON THE NEAR FATALITY OF:



Date of Birth: [REDACTED] 2010

Date of Near Death Incident: 12/08/2011

FAMILY WAS NOT KNOWN TO FAYETTE COUNTY CHILDREN & 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 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.

Family Constellation

| <u>Name</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|-------------|----------------------------|----------------------|
| [REDACTED] | Victim Child | [REDACTED] 2010 |
| [REDACTED] | Mother | [REDACTED] 1993 |
| [REDACTED] | Father | Unknown |
| [REDACTED] | Maternal Grandmother | [REDACTED] 1958 |
| [REDACTED] | MGM Boyfriend | Unknown |
| [REDACTED] | Unrelated Household Member | Unknown |
| [REDACTED] | Unrelated Household Member | Unknown |
| [REDACTED] | Unrelated Household Member | Unknown |
| [REDACTED] | Unrelated Household Member | Unknown |

Notification of Child Near Fatality

On December 8, 2011, the mother contacted 911 emergency services. She noticed that the child was "not acting right" and "not breathing normally." The child was taken by ambulance to [REDACTED] Hospital Emergency Room in severe respiratory distress. The child was stabilized and immediately transported and admitted to the [REDACTED] Hospital of Pittsburgh. Tests revealed that the child had [REDACTED], and [REDACTED]. The physician certified that the child was in serious condition.

Summary of DPW Child Near Fatality Review Activities

The Western Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Interviews were conducted with the investigating County caseworker and supervisor, as well as the Agency director.

The Western Regional Office also reviewed the written summary and recommendations that were established as a result of the County Internal Fatality Review Team meeting that occurred on December 21, 2011.

Summary of Services to Family

At the time of the child near fatality incident, the family was not receiving any services from Fayette County Children and Youth Services, nor any other service providers within the County.

Children and Youth Involvement prior to Incident

Fayette County Children and Youth Services did not have any prior involvement with the child or family prior to the near fatality incident.

Circumstances of Child Near Fatality and Related Case Activity

The child was taken to the [REDACTED] Emergency Room via ambulance on December 8, 2011 after the mother recognized the child was "not acting right" and "not breathing normally."

The mother stated that on the date of the incident, she arrived back at the aunt's home around 8:00am, after returning from her boyfriend's house. She reports that the victim child woke up around 9:00am. The mother stated that the child seemed to be her normal self. Mother also reported that she heard the victim child crying, and she came into the room. The mother's family and household members reported that the child was running toward [REDACTED] (HMM) who was holding a glass. They reported that the victim child tripped and fell, hitting her forehead on the glass. The maternal grandmother picked the child up. The victim child calmed down, and maternal grandmother put the child on the couch, where she slept for the rest of the morning into the afternoon.

The mother and household members provided the explanation that the child may have tripped and fell on a glass, causing the child to fall asleep and not be wakened was inconsistent with the medical condition and injury. The mother and family also stated that the child had been healthy prior to the incident and had no knowledge that the child had consumed anything out of the ordinary; however [REDACTED] were found in the child's system.

The mother and family members were presented with information at the hospital that the child ingested [REDACTED], which was found in the victim child's system. The maternal grandmother offered information that possibly somebody had pills laying around the house that the victim child may have gotten into. The maternal grandmother said that her paramour has prescribed [REDACTED] in a pill form, and that the aunt's daughter's paramour who comes over to the house also has prescription drugs.

The CPS status determination, 12-15-2011 was indicated for physical neglect based on the mother's lack of supervision.

Current Case Status

Upon [REDACTED] on 12/10/2011, the subject child was [REDACTED] placed in kinship care with relatives, namely a maternal great-aunt and uncle. In June, 2012, the victim child was reunified with the mother, the mother's adult sister and her 3-year old son, and the maternal grandmother, who are the current household members.

No charges were filed against the perpetrator or any of the household members.

The County continues to be open with the family. Based on the initial assessment of the family, general protective service issues were identified. The County continues to work with the family to alleviate these concerns.

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

- **Strengths**
There were no strengths identified by the County.
- **Deficiencies:**
There were no deficiencies identified by the County.
- **Recommendations for Change at the Local Level:**
There were no recommendations for change at the local level identified by the County.
- **Recommendations for Change at the State Level:**
There were no recommendations for change at the State level identified by the County.

Department Review of County Internal Report

The Department reviewed the County's Internal Report. While it did not identify any strengths or deficiencies, there were several strengths noted by the Department in this case. This feedback was provided to the County verbally on December 22, 2011.

Department of Public Welfare Findings:

- **County Strengths:**
There were several strengths identified in the review of this child fatality. The County was diligent in their investigation, and worked collaboratively with law enforcement, and medical professionals. Safety and risk assessments were completed at the correct intervals, and the established safety plan for the child was adequate.
- **County Weaknesses:**
The Department did not identify any weaknesses in the review of this case.
- **Statutory and Regulatory Areas of Non-Compliance:**
The Department did not identify any statutory or regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

The Department does not have any recommendations related to this child near fatality.