

**Department of Public Welfare
Office of Children Youth and Families
Western Region**

Report Finalized
February 2, 2010

Child Near Fatality Review



DOB: 11/23/2008
Date of Near Fatality: 02/26/09

Family was not known to Indiana County Children and Youth Services

This report is confidential under the provisions of the Child Protective Services Law and cannot be released further.
32 PA. C.S. Section 6340

Unauthorized release is prohibited under penalty of law .23 PA. C.S. Section 6349 (b)

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. 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.

Circumstances of the Child's Near Fatality:

Indiana County Children and Youth Services had no prior involvement with this family prior to the report received on February 26, 2009. The family moved to Indiana County from the state of Virginia in September of 2008 and no reports were made between September 2008 and the report on February 26, 2009.

At the time of the injury, [REDACTED] was three months old and residing at [REDACTED], Indiana County, Pennsylvania 15734. The household at the time of the injuries consisted of:

Mother:	[REDACTED]	1985)
Father:	[REDACTED]	1975)
Victim Child:	[REDACTED]	(DOB: 11/23/2008)
[REDACTED] Sister:	[REDACTED]	2008)
Brother:	[REDACTED]	
Half-brother:	[REDACTED]	1992)
Half-brother:	[REDACTED]	1993)

On February 26, 2009, [REDACTED] presented to Indiana County Regional Medical Center with [REDACTED]. As a result, the child was transferred to Children's Hospital of Pittsburgh for further evaluation and treatment.

According to the preliminary inpatient consultation prepared by [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Nature of Child Near Fatality Review:

In the early hours of February 26, 2009, Indiana County Children and Youth Services received a report [REDACTED] involving the subject child. An [REDACTED] was not known at the time of the report. As there were other children in the home (including teenage step-siblings), the investigation commenced with interviewing the teenage siblings at school.

Both of the step-siblings' initial accounts of the prior evening were similar, including playing football outside, returning home, eating dinner, and going to their rooms. Neither reported having any knowledge of the child being injured until they were told by their father that the child was being taken to the Emergency Department. One of the step-brothers reported that the family had just moved to Pennsylvania from Alexandria, Virginia and they had no social services involvement in the past. He also reported that both he and his brother "take care of the twins" and the twins "get up maybe twice in the night."

Due to the nature of the injuries and the other young children in the home, a safety plan was developed that resulted in these young children staying with the maternal grandparents during the investigation. The parents were permitted to visit with their children, however, they were not to be left unsupervised. [REDACTED]

[REDACTED] for assessment.

The caseworker contacted the Pennsylvania State Police (PSP) and both PSP and CYS investigators interviewed the grandparents at IRMC. [REDACTED]

" No further injuries were discovered, nor was any further treatment required for the sibling. A [REDACTED] investigation was initiated with the sibling child [REDACTED]

As per the Trooper's request, the CYS caseworker did not conduct interviews with any household members, as all were [REDACTED] to the victim child and the Trooper felt that the caseworker's presence "would only cause a distraction." The Trooper's investigation consisted of interviews and polygraphs of the parents and two step-brothers.

On March 4, 2009, the victim child was [REDACTED] from the hospital to the care of his maternal grandparents, with the safety plan already put in place to be continually followed. On March 5, 2009, the caseworker conducted a home visit to the grandparents' home to assess the safety of the children. The grandparents followed the recommendations made for the victim child at [REDACTED] and follow-up medical appointments. Indiana Co. CYS did not pursue custody of the victim and his young siblings, as they felt the grandparents were adequately assuring safety and "fully understood their role in providing supervision of the parents during their visits and interactions."

On March 10, 2009, the victim child was re-examined at Children's Hospital and other injuries were discovered. [REDACTED]

[REDACTED]

"This child has been [REDACTED] on more than one occasion. These injuries are not related to birth trauma and the child has no underlying medical problem which would explain them. [REDACTED]

[REDACTED] If this baby is returned to the same environment, he is at very high risk of being re-injured and/or killed."

The oldest step-brother was to take a polygraph test on March 20, 2009, however, when the Caseworker called to obtain the results, she was informed by the Trooper that he did not take the test, but rather admitted to causing the injuries to the child. The perpetrator provided a written statement about the injuries, but minimized his involvement by stating something to the effect that he gave the child "a little shake." Based on this confession, Indiana County CYS submitted [REDACTED] to the Department on April 16, 2009. The [REDACTED] was charged with aggravated assault on April 9, 2009 and placed through Indiana County Juvenile Probation. He was adjudicated delinquent on August 13, 2009.

The family was accepted for services, with the agency providing [REDACTED] [REDACTED] to the family. The victim, his [REDACTED] sister, and two year-old brother were returned to the parents' care on August 21, 2009. Indiana Co. CYS provided parent training and counseling for the parents and arranged for various home health services for the victim child until the family returned to the state of Virginia in November of 2009. Indiana County closed this family's case on November 16, 2009 and made a referral to Fairfax County, Virginia expressing concern about the child's welfare and received verification that the agency in Virginia was following up on the referral. *It should be noted that when the family moved back to Virginia, Indiana County Juvenile Probation released the perpetrator to his father's care and at the time of the release, was returning to the same home as the victim.*

III. Statutory and Regulatory Compliance:

Indiana County was required to complete a Child Near Fatality review or present the case to their MDT as per Act 33 of 2008, which was effective December 30, 2008. Neither of these took place. The Director has been made aware that as per Act 33 of 2008, this was to occur. A copy of the Act and subsequent Draft Bulletin will be provided to Indiana County Children and Youth Services to provide guidance and ensure future compliance. In addition to not completing the required review, the investigation was not completed within 30 days.

IV. Findings:

Based on the information provided by Indiana County Children and Youth Services, it appears as though the agency handled the investigation properly by making contact with the other children in the home quickly and ensuring the safety of the young children with the use of the maternal grandparents. The agency was thorough in ensuring the medical needs of all of the children were met, but paying particular attention to the victim child. Necessary services to ensure child safety and well being were put into place, i.e., the family was accepted for service and [REDACTED] services were initiated.

One concern noted is the lack of detail in the caseworker's case notes in relation to how the child sustained the injuries. It is understandable that the caseworker respected the wishes of the Trooper not to participate in the interviews, however, follow-up information should have been obtained whether via phone, written documentation, or both. If this information was obtained by the worker, it is vital to the investigation and case that it be included in the file.

V. Recommendations:

Specific recommendations related to this investigation are as follows:

1. When possible, complete a [REDACTED] investigation within 30 days. The investigation began on February 26, 2009. The caseworker had information from the Trooper on March 23, 2009 that the [REDACTED] admitted to causing the injuries. The [REDACTED] was not completed until April 15, 2009.
2. Case notes for all cases, regardless of the type, should contain as much information as possible to help justify decisions made during the life of the case/investigation. More details regarding the [REDACTED] actions should have been obtained and/or provided in the notes.