

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

Date of Report

February 9, 2010

Child Near Death Review

Child: [REDACTED]

DOB: 02/27/2009

NEAR FATALITY INCIDENT: 04/10/2009

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 fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected

Circumstances of the Child's Near Fatality:

At the time of the child's injury on April 10, 2009, [REDACTED] was less than two months old and was residing at [REDACTED], Arcadia, Indiana County, Pennsylvania, 15712. The family household was made up of the following persons:

Mother:	[REDACTED]	(DOB [REDACTED] 1985)
Victim Child:	[REDACTED]	(DOB: 02/27/2009)
Sister:	[REDACTED]	(age 3)
Sister:	[REDACTED]	(age 1)
Maternal Aunt:	[REDACTED]	(age unknown)
Maternal Grandmother:	[REDACTED]	(age unknown)
Maternal Grandfather:	[REDACTED]	(age unknown)

On April 10, 2009, the child presented to the Emergency Department at Punxsutawney Hospital with a skull fracture. As a result of his injuries, the child was transferred via medical helicopter to Children's Hospital of Pittsburgh for further care. Initially, the parent reported that one of the siblings hit the child in the head, but later claimed that the sister dropped him. The reporting source was concerned about the varying accounts and they appeared to be inconsistent with the injuries.

Once at Children's Hospital of Pittsburgh, the child received further assessment and treatment. A staff member from [REDACTED] was also involved in the assessment and investigation of the child's injuries.

[REDACTED]

Nature of Child Near Fatality Review:

Indiana County Children and Youth Services did not conduct a Near Fatality review as required, nor did they present the case to their Multidisciplinary Child Protection Team (MDT), as they use the MDT for sexual abuses only. [REDACTED]

[REDACTED]

Upon receiving the report on April 10, 2009, Indiana County CYC contacted Children's Hospital of Pittsburgh [REDACTED] and requested that mother be supervised while with her son, as she was en route with the child in the helicopter. Initially, Indiana County CYC was going to have Allegheny County Children Youth and Families make contact with the child and [REDACTED], however, Indiana's director requested that an Indiana Co. caseworker be dispatched to Children's Hospital of Pittsburgh to see the child and interview the mother. While on the way to Children's Hospital, the caseworker contacted the family home and made arrangements for the maternal aunt to ensure the safety of the children, with the help of the maternal grandparents. The caseworker spoke to the maternal grandmother who indicated that they were leaving the home to go to Children's Hospital. [REDACTED]

When the caseworker arrived at the hospital and met with the mother, her documentation states that the mother was holding the baby in her arms and the baby was doing well. Initially, the mother reported that she had left the home to run errands and while she was out, received a call from her sister stating the "baby was hurt" and the alleged victim's three year-old sister [REDACTED] had the baby in her arms. Mother returned home and took child to Punxsutawney Area Hospital. The mother claimed that when she left the home, the baby was in a "pack and play" and that her three year-old daughter is able to reach in the pack and play and remove the child. [REDACTED]

[REDACTED] reported [REDACTED] that the mother provided two different explanations as to how the injury occurred. The mother told them that her three year-old daughter dropped the baby, and then later stated the three year-old hit the baby. She was consistent in stating that her sister, the maternal aunt, found the baby with the injury. When [REDACTED] asked the mother about the injury, the mother reported that she had been home all day and the three year old came to the mother and said that she hit the baby's head off of the car seat handle. The child was reportedly in the "pack and play." Mother said she noticed the swelling and immediately went to Punxsutawney Hospital. The caseworker's dictation states that the mother is "completely contradictory," although it is unclear as to whether this is the caseworker's statement or [REDACTED].

[REDACTED] reported that she was cleaning her room and the mother was in the bathroom, while the child was asleep in the "pack and play," which was located in mother's bedroom. [REDACTED] stated she heard the baby "holler," so mother came out of the bathroom and [REDACTED] observed the three year-old with the child. [REDACTED] did not see how the child was injured, but thought that the three year-old may have tried to get the child out of the "pack and play." She said that at approximately 1:00 PM, she noticed bruising on the child's head and informed the mother. [REDACTED] also said that the mother never left the

home prior to taking the child to the hospital. [REDACTED] that she had also never observed the mother "be rough" with the child.

When the caseworker spoke with the mother regarding the injury, she maintained that she had gone to the store and her sister was watching the children and provided the same scenario, i.e., three year-old picked the up the baby from the "pack and play" and dropped him. [REDACTED]

[REDACTED] The safety plan was modified to have the maternal grandparents and other family members and friends ensure the safety of all three children.

A corporal from Pennsylvania State Police (PSP) contacted the caseworker via 911 and reported that he heard a child was flown to Children's Hospital with a skull fracture and [REDACTED] just contacted their office to advise them of the investigation. PSP also conducted an investigation into the injury.

The child's condition continued to improve while at the hospital. On April 11, 2009, [REDACTED] contacted the caseworker and informed them that the child was "eating well" and they were going to observe the child that day and then planned a [REDACTED] on April 12, 2009. [REDACTED] informed the caseworker that "the incident was low force and not necessarily child abuse but it was an unwitnessed event." The mother reported that the three year-old bumped the baby's head. [REDACTED] stated that the injury may have happened as described. There were no other bruises or fractures on the child. [REDACTED] felt the mother's family was appropriate.

The child was [REDACTED] from Children's Hospital on April 12, 2009, with a safety plan of maternal grandparents and other family members and friends helping to supervise and care for the children in the home. The potential caregivers provided by the family were all cleared through ChildLine and the Pennsylvania State Police. The family attended the follow-up visits to the child's doctor and obtained a home-health nurse for the days following the child's discharge.

The caseworker continued her investigation after the child's discharge and re-interviewed the mother and her sister on May 6, 2009 at the agency. The sisters were consistent in their accounts of where each other was at the time of the child's injury, as well as seeing the three year-old holding the child at the time the child was heard crying. The caseworker also obtained releases for the children's pediatrician and made collateral contacts to ensure the children's medical needs were being met.

A final home visit was completed on May 13, 2009, where the home was found to be an appropriate size for the family and a safe environment. Precautions to keep the siblings out of the child's room have been taken by the mother and explored, observed, and documented by the caseworker. [REDACTED]

[REDACTED] Additionally, the family was not being accepted for services, as referrals for [REDACTED] were made for the other children in the home and the mother would continue to receive assistance with childcare when necessary.

Statutory and Regulatory Compliance:

Since the investigation was not completed within 30 days 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.

Findings:

[REDACTED]

Their response time was prompt and the safety plan enacted appears to have been adequate. Additionally, the caseworker follow-up with the family to ensure they were taking precautions to ensure that the likelihood of a similar incident such as this is minimized.

[REDACTED]

[REDACTED], the agency learned that this was a less than two month-old child with a skull fracture and inconsistent histories as to how it occurred. Serious consideration should be given as to when to involve Law Enforcement in an investigation. Due to the age/vulnerability of the child and the nature of the injury, Law Enforcement should have been made aware of the allegations and provided an opportunity to initiate a joint investigation with CYS. The caseworker's dictation states the PSP Corporal heard about the child's injuries from [REDACTED] and contacted the caseworker at 9:11 PM. The caseworker notes in her dictation that she contacted PSP earlier in the evening (approximately 7 PM) to run criminal history checks on potential caregivers. No mention of the caseworker informing PSP of the investigation is made during that contact.

Recommendations:

After reviewing the case notes from the investigation, it appears as though the following recommendations would be appropriate:

The agency should notify Law Enforcement as quickly as possible, should they feel the injuries rise to the level of police involvement. In this instance, the initial report was that the child was in critical condition, which was appropriate for the PSP to begin an investigation.

Caseworker dictation should be professionally written and include facts, findings, and observations. [REDACTED]

