pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/05/2016
Date of Incident: 07/31/2017
Date of Report to ChildLine: 08/03/2017
CWIS Referral ID: [redacted]

FAMILY UNKNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Mercer County Children and Youth Services

REPORT FINALIZED ON:
01/11/2018

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Mercer County Children and Youth Services (MCCYS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/31/2017 which was within 30 days of the date of the oral report of suspected child abuse which was 08/03/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	05/05/2016
[redacted]	Mother	[redacted] 1990
* [redacted]	Mother's Paramour	1990
* [redacted]	Half-Sibling	2011
* [redacted]	Half-Sibling	2009
	Father	1993
	Father of [redacted]	1981
	Father of	1989

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children Youth and Family Services (WRO) obtained and reviewed all current records and medical records pertaining to the family. Follow-up interviews were conducted with the Intake Caseworker and Family Service Caseworker to follow-up on criminal charges and ChildLine determination status. WRO participated in the County's Act 33 meeting that occurred on 08/31/2017.

Children and Youth Involvement prior to Incident:

The family was not known to Mercer County Children and Youth Services prior to the incident that occurred on 07/31/2017 and subsequently ChildLined on 08/03/2017.

Circumstances of Child Fatality and Related Case Activity:

On 08/03/2017, MCCYS received a CPS report of suspected child abuse on the victim child. The victim child was taken to the pediatrician's office at [redacted] by the mother, due to the child vomiting and her being unwilling to walk. This was the second time that the mother had sought medical care for the victim child. On 07/31/2017, the mother took the child to Urgent Care where she was [redacted] The victim child had a scabbed area on her lower lip [redacted] However, the victim child had bruising on her back and stomach which was not consistent with [redacted] The victim child also had pink areas on her buttocks and feet that appeared to be burns. The victim child was observed to have a bruise on her forehead which was "fresh." The pattern of injuries were suspicious for abuse. [redacted] physician [redacted] a skeletal scan at the local hospital and [redacted] The mother immediately took the victim child for the skeletal scan at a local hospital, [redacted]

The MCCYS caseworker completed a home visit on 08/03/2017 after the family returned home. The caseworker noted that the victim child's half-siblings appeared to be fearful; however, they did not make a disclosure. The caseworker had no concerns, but informed the mother that if there was another allegation she may be liable. The next day an MCCYS caseworker interviewed the victim child's half-siblings at the maternal grandmother's home. During this interview, the half-siblings disclosed the extreme discipline practices they were subjected to by the mother's paramour. They also said that the mother and her paramour had "compromised," after the mother had seen bruises. The mother allegedly told her paramour that he could not discipline them so harshly, but it continued. The paramour would tell the mother to leave the room and she would whenever he disciplined the children.

Later in the evening of 08/03/2017, the mother and her paramour took the victim child to Akron Children's Hospital in Akron, Ohio with concerns the victim child was not eating, but was vomiting. The mother reported to the medical staff that the victim child was seen at her family's physician's office, [redacted] in [redacted] Pennsylvania earlier that day and the office had concerns for physical abuse and sent the victim child to [redacted] Medical Center for a skeletal scan [redacted] was completed at the [redacted] Medical Center and the child [redacted]

At Akron Children's Hospital the victim child continued vomiting and began having seizures. During the evaluation, the victim child was found to have the following injuries: [redacted] a number of bruises which were identified on her forehead, shoulders and sacral area, red healing skin on buttocks, upper thigh and left foot. The victim child was admitted to the hospital [redacted]

Her condition stabilized [redacted] the victim child's injuries were not accidental and were signs of child abuse. The report was upgraded to a Near-Fatality report on 08/07/2017.

The mother and her paramour were unable to provide an explanation as to how the victim child obtained the injuries and could only say that she obtained the injury to her forehead from a fall off of the couch. The mother claimed that the other injuries were misdiagnosed by Akron Children's Hospital, based on the previous diagnosis that the mother had received from the Urgent Care medical staff and the pediatrician. The mother reported that her paramour watches the victim child and her half-siblings while she is at work and that he only disciplines because "he loves them."

The victim child's half-siblings had forensic interviews in which they disclosed physical abuse. Child Protective Service (CPS) reports were made as a result of the disclosures on 08/04/2017. The reports on the victim child's half-siblings were indicated for interfering with breathing, naming the mother's paramour as the perpetrator. The victim child's half-siblings stated that the mother knew that the paramour was harming them; hence, the mother was indicated as well. Both the mother's paramour and the mother were indicated for interfering with the breathing of a child on the two half-siblings along with the victim child.

The victim child and her half-siblings were removed from the mother's care. The victim child is now in the care of her biological father. The victim child's biological father obtained a Protection from Abuse order against the mother. [redacted] The victim child's oldest half-sibling [redacted] was placed in the care of her maternal grandmother. The maternal grandmother has filed for custody. The other half-sibling is with her biological father.

While they were conducting the investigation agency caseworkers had conversations with extended family members who said that they had seen bruises on the children. They provided pictures to the police of the injuries. They said that they did not report their concerns for the children because they were afraid that the mother would not allow them to see the children if they made a report.

On 08/08/2017, the mother and her paramour [redacted] attempting to commit suicide together. [redacted] The mother claimed that she ended her relationship with the paramour.

[redacted] later that month, the mother shared that she knew that her paramour was slapping the kids but it was because he loved them. She did not understand why the physician did not just treat the victim child for vomiting.

On 09/01/2017, MCCYS submitted the Child Protective Services Investigation report with a status of "Indicated." The criminal investigation is ongoing as of today's date no charges have been filed. MCCYS closed the case on 12/04/2017.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

- Strengths in compliance with statutes, regulations and services to children and families; None Identified
- Deficiencies in compliance with statutes, regulations and services to children and families; None Identified
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None identified
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: None Identified
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. None Identified

Department Review of County Internal Report:

WRO received an internal report from Mercer County on 12/20/2017. The report included the minutes from the Near Fatality meeting and a summary of the agencies work with the family after the incident.

Department of Human Services Findings:

County Strengths:

- There was immediate and excellent interaction and cooperation with the [redacted] physician, social worker and medical staff. Children and Youth responded immediately following the near-fatality to ensure the safety of the victim child and her half-siblings. There was collaboration between the county and the police department to interview all parties involved.
- The agency immediately met with the mother and the mother's paramour to discuss the allegations and to secure timelines of the events.
- The agency met with the victim child's father, the victim child's half-sibling's father and maternal grandmother at their homes to assure that they were capable of assuring the safety of the children and demonstrated protective capacities.
- The agency and family members signed and agreed upon a safety plan by utilizing family members and service providers.
- The agency's caseworker maintained on going supervision to discuss the case plan and to determine how they would assure the safety of the children.
- The agency completed several announced and unannounced home visits to assure that the family was following the safety plan.
- The agency notified the local police barracks about the incident and allegations. The agency worked cooperatively with law enforcement
- There was teaming among the agency, agency supervisor and the family.
- The agency complied with all report and investigations timelines.
- The agency worked cooperatively with law enforcement.

County Weaknesses:

- The near fatality report submitted by the county did not include deficiencies and strengths in compliance with statutes, regulations, and services to children and families including cooperation between law enforcement and county agencies during investigations of suspected child abuse; recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; recommendations for changes at the state and local levels on monitoring and inspection of county agencies and recommendation for changes at the state and local levels on collaboration of community agencies and services to prevent child abuse.
- The County Internal Report was not submitted to the Department within 90 days after the convening.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.

- CPSL:6365(d)(4)(v)- Within 90 days of convening the review team a final written report on the child near fatality is to be submitted to the Department. MCCYS submitted a final written report to the Department on 12/20/17. Report should have been submitted by 11/30/2017.

- 3130.21(b) as per Bulletin 3490-15-01- The near fatality report submitted by the county did not include deficiencies and strengths in compliance with statutes, regulations, and services to children and families including cooperation between law enforcement and county agencies during investigations of suspected child abuse; recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; recommendations for changes at the state and local levels on monitoring and inspection of county agencies and recommendation for changes at the state and local levels on collaboration of community agencies and services to prevent child abuse.

A licensing action has been sent to the County for a plan of correction regarding these areas of non-compliance.

Department of Human Services Recommendations:

Training needs to be provided to physicians at Urgent Care Centers to be able to identify the signs of abuse in children.

The County needs to ensure compliance with all state laws and regulations when conducting a near fatality meeting to ensure future cases of similar nature do not occur.