pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/18/2017
Date of Incident: 08/12/2017
Date of Report to ChildLine: 08/13/2017
CWIS Referral ID: [redacted]

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

Somerset County Children and Youth Services

REPORT FINALIZED ON:
01/31/2018

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

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

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.

Somerset County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 09/01/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1987
	Father	[redacted]1990
	Victim Child	04/18/2017
	Sibling	[redacted]2010
	Sibling	[redacted]2008

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYF, obtained and reviewed the Somerset County Children and Youth Services, (SCCYS), child protective service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. Interviews were conducted with the agency caseworker, supervisor and director in August and September 2017 and January 2018.

Children and Youth Involvement prior to Incident:

SCCYS was previously involved with the family prior to receiving the Child Protective Services Report on 08/13/2017.

03/03/2017 to 03/03/2017: SCCYS received a referral that the father had left the mother at a store in [redacted] and the mother had to walk home. There were no allegations of child abuse and/or neglect reported. The agency screened out the case.

03/27/2017 to 03/27/2017: SCCYS received a referral that the father had kicked the mother in the stomach while she was pregnant. Additional information was provided that the parents are separated and the children are in the care of the mother. There were no allegations of child abuse and/or neglect reported. The agency screened out the case.

05/09/2017 to 06/23/2017: SCCYS received a referral that the father was using inappropriate discipline on the child's sibling and there was reported to be domestic violence in the home. The agency conducted an assessment, conducted announced and unannounced home visits and obtained service provider records. The family was receiving [redacted] services from [redacted] Medical records were also obtained and verified the children's medical needs were met. The family denied the domestic violence issues and a records search revealed no PFAs or criminal records. All of the allegations were invalidated by the agency at the conclusion of the assessment on 06/23/17. There were no safety threats identified and there was no need for ongoing protective services. The case was closed on 06/23/2017.

Circumstances of Child Fatality and Related Case Activity:

SCCYS received this Child Protective Services report [redacted] on 08/13/2017. On 08/12/2017, the mother had gone to [redacted] Hospital [redacted] While the mother was at the hospital the father was caring for the children. The father reported that while he was caring for the children, the child had a seizure. The father reports he called 911 and the child was taken by ambulance to Somerset Hospital. [redacted] indicated that this was highly concerning for abuse. The parents stated that there had been no trauma to the child and they stated that the child was never left around his siblings unsupervised.

[redacted] doctor determined that the child needed a higher level of [redacted] and the child was then transferred by ambulance to Children's Hospital of Pittsburgh, (CHP). At CHP the parents reported that the child had been displaying seizure like behaviors for a couple weeks so they had taken the child to their pediatrician on two occasions. [redacted]

Based on [redacted] information received, a safety plan was developed on 08/14/2017. On 08/15/2017, the child [redacted] and he and his siblings were placed by the parents in the care of their paternal grandparents in Crawford County. Crawford County Children and Youth Services (CCCYS) assisted with the safety planning and conducted courtesy safety home visits and assessments. The mother moved with the children to the paternal grandparents'

home to assist with the children's care under the supervision of the paternal grandparents. The father remained in Somerset County due to his employment and he has supervised visitation on the weekends with the children. CCCYS has continued to conduct monthly safety visits with the family. SCCYS and CCCYS worked collaboratively on this case and CCCYS agreed to accept the case for services at the conclusion of the child protective services investigation. This occurred on 10/12/2017.

[redacted] the child's parents have obtained an attorney and are refusing any further interviews regarding the child protective services investigation. They remain cooperative with safety planning, service planning and communication with SCCYS and CCCYS.

Medical testing continues to be conducted to verify the determination/cause of the child's injury. At this time, law enforcement has not pursued any charges against the parents, who were both named as alleged perpetrators, due to the unconfirmed [redacted] and cause of the child's injury. SCCYS determined this case to be "pending criminal court" on 10/12/2017 due to law enforcement's investigation continuing and they submitted the CY-48 on the same date. A recent case review was conducted on 01/11/2018 and the agency indicated they plan to conduct a final case review with medical professionals and law enforcement by 01/26/2018 to make a case determination.

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;
  The County Review Team felt that SCCYS and the State Police showed cooperation and collaboration between the agencies during the investigation. SCCYS immediately notified the State Police upon receipt of the report and the agencies responded in coordination with each other and conducted initial information gathering interviews together. All the children were seen within regulatory time frames following the receipt of the ChildLine report and a preliminary safety assessment was conducted within regulatory time frames.

  SCCYS coordinated safety efforts with CCCYS to assure a home visit occurred, the children were seen and a safety plan was initiated. Previous reports regarding this family with SCCYS were conducted in compliance with regulations.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  A new information safety assessment should have been conducted following the initiation of a safety plan with the family.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; There were no recommendations made.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  There were no recommendations made.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  There were no recommendations made.

Department Review of County Internal Report:

The Act 33 Child Fatality Review Team Meeting Report was received by CROCYF on 09/20/2017. The CROCYF did not attend the Act 33 Child Near-Fatality Review Team meeting on 09/01/2017 due to an oversight by SCCYS. However, upon realizing the oversight SCCYS immediately contacted the CROCYF and provided a review of the discussion, recommendations and outcome. Based on the review provided by SCCYS and the review of the Act 33 meeting notes, CROCYF finds the county's report content and findings are representative of what was discussed during the meeting on 09/01/2017.

Department of Human Services Findings:

- County Strengths:
  SCCYS conducted the investigation in cooperation with law enforcement and medical services/providers. The record was comprehensive; including medical reports, interviews, risk and safety assessments, and case dictation.

- County Weaknesses:
  There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  There were no areas of non-compliance noted.

Department of Human Services Recommendations:

All counties should to continue to adhere the Pennsylvania Child Protective Services Law statutes and conduct a thorough and timely investigation in collaboration with law enforcement, the court, other County Children and Youth agencies and medical and service providers.