



**REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth:** 06/21/2016

**Date of Incident:** 01/03/2018

**Date of Report to ChildLine:** 01/05/2018

**CWIS Referral ID:** [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Beaver County Children and Youth Services

**REPORT FINALIZED ON:**

7/4/2018

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.

Beaver County Children and Youth Services (BCCYS) unfounded the report on 01/24/2018 which is within 30 days of the referral and therefore is not required to submit a report.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	06/21/2016
[REDACTED]	Mother	[REDACTED]/1991
[REDACTED]	Father	[REDACTED]/1990
[REDACTED]	Maternal Grandfather	[REDACTED]/1963
[REDACTED]	Maternal Grandmother	[REDACTED]/1964

**Summary of OCYF Child Near Fatality Review Activities:**

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed all current and past records pertaining to the family. The victim child’s medical records were obtained and reviewed. WRO was notified of the fatality on 01/05/2018.

**Children and Youth Involvement prior to Incident:**

There was one prior GPS report on the family on 08/16/17. The mother was hospitalized due to being [REDACTED]. The mother told the reporting source that she was an IV heroin user. Mother stated that there are times when she is under the influence of heroin and is caring for the victim child. Mother reported that she does not “shoot up” around the victim child. The investigation discovered that the mother had a [REDACTED]. The maternal grandparents stated that the doctor stated that the [REDACTED]. The maternal grandparents were interviewed and there were no concerns with them caring for the victim child. The mother was released from the hospital and was [REDACTED] for an expected time of 4-6 weeks due to [REDACTED]. The report was closed at intake due to being determined

invalid concerns on 9/22/17. The victim child remained in the care of the maternal grandparents.

**Circumstances of Child Near Fatality and Related Case Activity:**

On 01/05/2018 BCCYS received a report of suspected child abuse on the victim child. She had been admitted to [REDACTED] with a skull fracture of the frontal bone and intracranial hemorrhage. The injuries were without explanation.

The victim child reportedly fell and bumped her head on the corner of the computer stand on 01/03/2018. The family reported that the victim child never cried and did not act differently so the family did not think anything about it. On 01/04/2018, the maternal grandmother was pushing the child's hair back and felt a bump that was "squishy." The family immediately took the victim child to the local hospital after discovering the lump on the victim child's head. The local hospital performed a computed tomography (CT) scan on the victim child. She was diagnosed with a right parietotemporal bone fracture with underlying intracranial hemorrhage. The parents continued to deny any trauma but the victim child's mother stated that the victim child was coughing and had a temperature of around 100-101 degrees due to an upper respiratory infection. The doctor from the local hospital spoke with the doctor from [REDACTED] and it was agreed the victim child would be transferred to [REDACTED]. The victim child was transferred emergency via Emergency Medical Services (EMS) in no acute distress. The victim child was transferred to [REDACTED] at 10pm on 01/04/2018. The [REDACTED] Child Advocacy Center (CAC) was consulted after arriving hospital due to concern that the injury resulted from abuse/neglect. The doctor at the [REDACTED] emergency department certified the report to be a near fatality.

Initially [REDACTED] reported that the victim child's mother was unable to provide a clear description about the cause of the injury. The report from the local hospital indicated that when the victim child first presented to that hospital the parents had concerns for a lump on the right side of the victim child's head. The victim child's parents denied any falls or known trauma. The victim child's mother pulled the doctor aside at the local hospital shortly before the victim child was set to be transferred to [REDACTED]. The victim child's mother told the doctor that she thought she knew what happened to cause the victim child's injury. She stated that a few days ago the victim child was running through the living room towards her grandfather and tripped over a little bit and fell into the computer desk. The victim child hit the corner of the computer desk. The victim child's mother thought initially it was her foot that she hurt but she now thought it was her head that she had hit off of the corner of the computer desk.

The victim child had a skeletal survey at [REDACTED]. The CAC doctor reviewed the report and their impression and diagnosis was a fracture of the parietal bone of skull. The doctor noted that "It is unclear why there are discrepancies regarding the reported fall that caused the injuries (for example, coffee table versus computer desk, presence or absence of a corner protector). Regardless, this fracture by itself is considered nonspecific for physical abuse and can occur with accidental trauma.

Based on the available information, there is low concern for physical abuse." The child was discharged home to her parents on 01/05/2018. The victim child is doing well.

The caseworker and the police interviewed the victim child's mother, father and grandmother. All three interviewees described the same description of the set of events that led to the victim child's injuries and decision to take the victim child to the hospital which was the victim child tripped and fell hitting her head on the corner of the computer stand on 01/03/2018. BCCYS submitted the Child Protective Investigation Report on 01/24/2018 with a status of "Unfounded".

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

BCCYS was not required to submit a report since the case was unfounded within 30 days of receiving the report.

- Strengths in compliance with statutes, regulations and services to children and families;
  - None.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None.
- 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.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  - None.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse;
  - None.

**Department Review of County Internal Report:**

- BCCYS was not required to submit a report since the case was unfounded within 30 days of receiving the report.

**Department of Human Services Findings:**

- County Strengths:
  - BCCYS ensured the safety of the child.
  - BCCYS interviewed all parties.

- BCCYS worked well with law enforcement.
- BCCYS sent all records to WRO
- BCCYS completed the investigation within regulatory timeframes.
- BCCYS obtained the medical records for the victim child.
- County Weaknesses:
  - It is unclear from the reports as to the incident date. The initial notification of a near fatality from BCCYS indicates that the date of incident was 01/03/2018. According to the local hospital record dated 01/04/2018, the victim child's mother reported that the incident happened "a few days ago." BCCYS could have asked for clarification of the date of incident.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None.

**Department of Human Services Recommendations:**

Public Service Announcements as to the importance of having safety guards on furniture to prevent toddlers from injuring themselves.