



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 02/14/2015
Date of Incident: Unknown but prior to 03/17/2015
Date of Report to ChildLine: 03/17/2015
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Crawford County Children and Youth Services

REPORT FINALIZED ON:
8/26/15

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:

Senate Bill 1147, Printer’s Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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. Crawford County Children and Youth Services(CCCYS) convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on April 22, 2015.

Family Constellation:

	Victim Child	02/14/2015
	Mother	1992
	Legal Father	1992
	Sibling	2013
* 	Maternal Grandmother	1968
* 	Putative Father of VC	1992
* 	Putative Father of VC	1986

* 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 Near Fatality Review Activities:

The Western Regional Office of Children, Youth and Families (WRO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. WRO staff conducted interviews with the following Crawford County staff: Intake Caseworker, Family Services Caseworker, Supervisor and Administrator. These interviews occurred on 04/24/2015 before the Act 33 meeting that occurred that same day, in which medical professionals and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

On 05/12/2014 CCCYS received a referral with a concern that the mother could not care for the victim child’s sibling. The referral stated that the mother uses the child as a pawn, uses drugs and is [REDACTED]. The case was accepted for ongoing services on 07/03/2014. The reasons for accepting the case for service was due to the following concerns: The mother did not comply with home visits and was very uncooperative during the assessment. The mother had [REDACTED]

and substance abuse issues, was homeless and on probation. She was not employed and had no source of income. She was moving from home to home without a stable or permanent residence. Mother was linked with resources for [REDACTED] and did not follow through with the services. She had tested positive twice for Tetrahydrocannabinol (THC) and once for [REDACTED] and was [REDACTED]. The CCCYS caseworker expressed concerns for conduct of a parent that places a child at risk, parental substance abuse, [REDACTED] and lack of parental care which were all validated at the time of the intake. Once the case was opened, the mother complied with services. She completed parenting [REDACTED]. The General Protective Services (GPS) case was closed out on 02/09/2015 with the closing Family Service Plan being completed on 02/08/2015 and the model risk assessment being completed on 01/23/2015 with a risk of low. The closing in home safety assessment was also done on 01/23/2015 and there were no safety indicators that met the safety threshold. The agency did know that the mother was pregnant. The mother successfully completed the in-home parenting program which closed on 02/04/2015.

On 03/09/2015, a GPS referral was received alleging that mother had given birth to the victim child on 02/14/2015. The mother was missing well baby visits for the victim child. Mother missed a newborn appointment on 02/20/2015, but came to an appointment on 02/23/2015 and was told to come back in a week and she failed to do so. On 02/23/2015, the victim child was 8 oz below her birth weight which was of concern. Mother again no showed on 03/09/2015; the day of the report. The case was open for assessment on 03/09/2015 with a 24 hour response. The victim child was seen on 03/10/2015. The caseworker met the mother and the victim child at [REDACTED] where the victim child was seen medically. She had gained 7 oz. Case was still being assessed when the Child Protective Services (CPS) case and near fatality came in on 03/17/2015.

Circumstances of Child Near Fatality and Related Case Activity:

On 03/17/2015, CCCYS received a referral [REDACTED] that the victim child had been brought in by ambulance by emergency medical services for an alleged bump on the head. Upon further study, it was shown through [REDACTED], that the victim child had [REDACTED] and old bruises on her face. The local Police Department was called and interviewed the mother at the hospital. Mother initially admitted to dropping the victim child but then changed her story and said that she accidentally hit the victim child's head off of a tub. The treating physician advised that this explanation could explain [REDACTED]. The mother had no explanation for the bruises to the victim child's face. The treating physician did not believe that the injuries were consistent with the explanation and the physician was concerned for non-accidental trauma and certified that the victim child was in critical condition, displaying [REDACTED] findings that would place her in critical condition and that the victim child was being airlifted by medical helicopter to Children's Hospital of Pittsburgh (CHP). Mother

also admitted to the local police that she had shaken the victim child because she was crying.

The victim child was airlifted to Children's Hospital of Pittsburgh (CHP) where further testing was conducted. [REDACTED]

Findings from CHP concerning the victim child's injuries were as follows: [REDACTED]

[REDACTED] Bone scans were completed and found that the victim child had a healing fracture of her leg above her ankle that was approximately a week old. The victim child also had bruising on both sides of her face that are consisted with pinch marks. CHP's treating physician noted that [REDACTED]

[REDACTED]. These were approximately a week old and were caused by a shearing or twisting and are not seen by an impact. [REDACTED]

[REDACTED]. These findings were consistent with multiple incidents of abuse. The victim child [REDACTED] on 03/23/2015 and into the kinship care of the maternal grandmother.

The mother was named as the sole alleged perpetrator and was interviewed by a CCCYS caseworker on two occasions; one being on 03/17/2015 at the local hospital where she disclosed shaking the victim child and then reported that she put the victim child back to sleep. The second interview was on 05/13/2015 at the [REDACTED] Jail where she denied shaking the victim child and denied any knowledge of how the victim child sustained any of her other injuries. The mother reported that on 03/17/2015, she found the victim child vomiting in her crib. She took the victim child to the bath and while she was holding the victim child she fell out of her arms and hit her head on the side of the tub once. The mother advised that a few weeks before 03/17/2015, the victim child fell off a chair that both the mother and the victim child were sitting on, but the mother advised that she caught the victim child before she hit the ground. The mother admitted to being the sole caregiver of the victim child. The case was substantiated by the agency on 05/14/2015 for physical child abuse with the mother being the perpetrator of the abuse to the victim child.

The mother was arrested by the [REDACTED] Police on 05/05/15 and was charged with four felony counts of Aggravated Assault and one felony count of Endangering the Welfare of Children. The mother was incarcerated at the [REDACTED] Jail on 05/05/2015 and was released on a \$25,000 bond on 05/29/2015. She is currently waiting for her criminal trial.



The victim child's sibling is currently residing with his father, who is the victim child's legal father. CCCYS is monitoring this case as well to ensure continued safety of the sibling. [REDACTED]

CCCYS convened a Family Group Decision Making meeting with the family on April 28, 2015.

The victim child has been progressing appropriately and has regular follow up visits at CHP.

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

- Strengths in compliance with statutes, regulations and services to children and families:

Relevant information in regards to the status and well-being of the victim child was gathered diligently by the CCCYS Intake Department in order to make an informed decision about the safety and well-being of the victim child and family.

The Intake investigations began immediately and the agency met the identified response time frames on all reports in regards to the family and children. All statutes, regulations and services to children and families were in compliance.

- Deficiencies in compliance with statutes, regulations and services to children and families:

The review team did not identify any deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

The review team noted that caseworkers should have more training on being able to recognize health issues, weight issues and general issues to look for when involved with a case with a young baby. Provider agency staff also needs to be trained on what to look for when working with families in regards to bruising, lack of weight gain, skin color etc.

- 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.

During the course of the investigation, CCCYS found it very hard to obtain the necessary documentation from CHP that they needed for their investigation. It took weeks to obtain all of the necessary paperwork and, at the time of the Multi-disciplinary Team Meeting, CCCYS had still not obtained all of the medical records.

Department Review of County Internal Report:

WRO reviewed the County Internal Report on 04/20/2015 and the follow up MDT report on 07/15/2015. WRO finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings were representative of what was discussed during the meeting on 04/22/2015.

Department of Human Services Findings:

- County Strengths: WRO noted the same strengths as noted in the County's Internal Report. CCCYS did a thorough job during the investigation on this case and kept all parties up to date on findings and concerns.

County Weaknesses: The mother on this case had very little supports and the case was active with CCCYS when the abuse referral was made. The concerning piece is that a month before this near fatality, in February of 2015, with the mother days away from giving birth to the victim child, her case was closed. Given the fact that the mother had very little supports and was about to have another child, it may have been prudent to keep her case open and monitor her stability for some time after the birth of the victim child. Closing of the previous referral on 02/09/2015 may have been premature.

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

None

Department of Human Services Recommendations:

- CCCYS should consider establishing a protocol on cases that are looking to close due to no identified safety threats where the parent is pregnant and close to delivery. In this case in particular, the mother had a history of instability, [REDACTED] and lack of housing. She was nine months pregnant at case closure; despite completing services and no identified safety threats, given the knowledge of her past issues parenting a newborn, it may have been beneficial for CCCYS to keep the case open in order to provide supportive services to the mother to ensure safety of the newborn and then monitor the case and close after a determined amount of time.