



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 10/11/2015
Date of Incident: 11/17/2015
Date of Report to ChildLine: 11/24/2015
CWIS Referral ID: [REDACTED]

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

Washington County Children and Youth Services

REPORT FINALIZED ON:
04/14/2016

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.

Washington County Children and Youth Services (WCCYS) convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/18/2015 which was within the 30 day regulatory statute.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	10/11/2015
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Half Maternal Sibling	[REDACTED] 2009
[REDACTED]	Mother's Paramour	[REDACTED] 1978
[REDACTED]	Mother's Paramour's Daughter	[REDACTED] 2000
[REDACTED]	Mother's Paramour's Daughter	[REDACTED] 2002
* [REDACTED]	[REDACTED] of Victim Child	[REDACTED] 1981
* [REDACTED]	Maternal Grandmother	[REDACTED] 1969
* [REDACTED]	Half Maternal Sibling's Father	[REDACTED] 1988

* 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 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 attended the Review Team Meeting on 12/18/2015, which is within the 30 day regulatory statute. WRO was notified of the fatality on 11/24/2015. The team reviewed a summary of the case, a family genogram and a timeline of events leading up to the victim child's [REDACTED] subsequent placement in foster care. The team interviewed the caseworker, supervisor, and the treating physician involved with the victim child's medical care. The caseworker and supervisor provided information regarding the interviews conducted and information gathered in the course of their investigation.

Children and Youth Involvement prior to Incident:

WCCYS had no involvement with the victim child or his family prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child was referred to WCCYS on 11/24/2015. It was reported that this previously healthy one-month-old male was transported to Washington Hospital by his mother and maternal grandmother on 11/24/2015, due to the maternal grandmother noticing that the victim child was exhibiting some strange symptoms. The maternal grandmother was watching the victim child while the mother ran some errands. The maternal grandmother noticed that when the victim child became upset and was crying his temples were flaring and puffy. When the mother returned home the victim child was taken to Washington Hospital.

While at Washington Hospital, [REDACTED] Abuse was suspected due to the observed injuries. The victim child was certified to be in critical condition by the treating physician and transported by medical helicopter to Children's Hospital of Pittsburgh (CHP). The victim child presented at CHP [REDACTED]

[REDACTED] The victim child was admitted [REDACTED] at CHP for observation. It was also discovered the victim child had [REDACTED] which was reported to the assigned caseworker on 11/25/2015. The treating physician explained that [REDACTED] were most likely caused by being struck by an object. According to the treating physician, the injuries that he sustained would have caused significant pain and were strongly concerning for child abuse. The treating physician estimated that the date of the injury would have been in the three to seven days before he presented at the hospital, placing the date of the incident/injury between 11/17/2015 and 11/24/2015.

The victim child was living with his mother and her paramour. Also in the home was his six-year-old half sister and the paramour's two teenage daughters. On 11/24/2015, the WCCYS on-call caseworker and supervisor completed initial interviews with the mother, paramour, maternal grandmother and the paramour's two teenage daughters. The mother's paramour reported that the mother is the victim child's primary caretaker and she has been getting frustrated because the victim child has been so fussy. He stated "crying non-stop for about a week". The paramour's two teenage daughters reported that they have watched the victim child at times when the mother went to the store. Neither girl reported any concerns about the victim child's care. The mother stated that the victim child had been inconsolable for about 1-2 weeks. She suspected colic or a problem with his formula. The victim child spent the night with the maternal grandmother on 11/13/2015. The maternal grandmother also watched the victim child on 11/19/2015. The mother's paramour watched the victim child on 11/20/2015, to

give the mother a break. The victim child was fussy before and after 11/20/2015. The mother denied ever hurting the victim child or knowing that anyone else hurt the victim child.

[REDACTED] place both the victim child and his half-sister into foster care. The victim child's half-sister was placed that day; the victim child was placed [REDACTED] on 11/28/2015. [REDACTED]

A detective from the [REDACTED] Police Department was assigned to the case. The assigned detective and the WCCYS caseworker interviewed the mother on 12/02/2015, at the [REDACTED] Police Station. The mother did not give any indication of any knowledge of how these injuries would have occurred nor who may have inflicted them. The mother stated that her paramour noticed that the victim child was drooling blood about a week before he was taken to the hospital. The mother cleaned out his mouth and did not notice any cuts or injuries. The mother had not noticed the victim child fussing with feedings nor had she noticed any abnormality with his head. The maternal grandmother was the one who pointed out the bulge on the victim child's head when he would cry. The mother did, however, present herself as the primary caretaker of the victim child as she is currently on maternity leave and rarely leaves him with anyone else. She confirmed that the victim child was with her paramour and his thirteen-year-old daughter on "Light-Up Night" (11/20/2015). The mother and her paramour spoke several times that night and nothing abnormal occurred. She also left the children with a friend on 11/14/2015 so she could get her things from her apartment in Ohio. In addition, the mother left the victim child with the maternal grandmother mother on several occasions. The mother did not provide any explanation as to what could have caused the injuries the victim child suffered.

The mother's paramour was interviewed by the detective on 12/08/2015 at the [REDACTED] Police Station. According to the detective, the paramour did not make an admission nor did he implicate any other persons that may have injured the victim child. The detective reported that the paramour was told by the mother that the victim child had been taken to the hospital and was being transported to CHP due to concerns for [REDACTED] while on his way home from work around 5:30 PM on 11/24/2015. This is concerning because at that time the mother had been notified by Washington Hospital that the victim child had [REDACTED] and she was aware that he did not have [REDACTED]. The paramour told the detective that he has never seen anyone handle the victim child roughly nor has he witnessed any accidental or intentional incidents that could explain the injuries. When interviewed by the caseworker supervisor, the paramour admitted to babysitting on Friday, 11/20/2015, but denies anything happening to the victim child or hurting the victim child during this time. About a week before the victim child was taken to the hospital, the paramour noticed that he had drooled on his white shirt and that the drool was tinged pink. The paramour mentioned it to the mother, and she said that the victim child must have scratched his gums. The

mother's paramour did not think that the victim child is unusually fussy, as described by the mother and had not seen the mother get frustrated with or be rough with the victim child.

The casework supervisor interviewed the victim child's [REDACTED] on 12/14/2015, and he has no knowledge of how the victim child's injuries were inflicted, nor has he had contact with the child during the identified time period. [REDACTED]

[REDACTED] he and his wife would like to provide full time care for his son.

A forensic interview was conducted with the victim child's half sister at A Child's Place at the Washington Hospital on 12/04/2015. The half sister did not make any disclosures of abuse and/or neglect pertaining to herself or the victim child.

Interviews were conducted with other relatives and friends who had contact with the victim child and his caregivers during the time when the incident was thought to have taken place. No one observed anything unusual or had concerns about victim child's care.

[REDACTED]

The maternal grandmother visits with the victim child once a week.

[REDACTED] the victim child's half sister went to live with her father, who was found to be an appropriate caregiver following an assessment by Erie County Office of Children and Youth (ECOCY). The half-sister visits with her mother and the victim child twice a month on Saturdays during their scheduled visitation and her grandmother attends one of these visits, as well.

On 01/22/2016, the agency submitted the Child Protective Services Investigation Report with a status determination as "indicated" as per the agency's investigation, although the perpetrator is unknown.

The victim child is doing well although he continues with follow-up [REDACTED] at CHP as a result of his injuries. [REDACTED]

[REDACTED] He will have at least one more follow-up appointment [REDACTED]

The victim child's pediatrician [REDACTED] The victim child has had two-month and four-month checkups [REDACTED]

[REDACTED] There were no concerns for his physical development. [REDACTED] The victim child will have his next checkup at 6 months. There are no concerns for his development at this time and he appears to be meeting developmental milestones for his age.

[REDACTED] The foster parents describe an even tempered baby; they do not find him to be a "fussy" child as has been reported by his mother.

Services to the family continue in an effort to reunify the victim child with his mother or father. [REDACTED]

[REDACTED] a request will be made to Ohio via the Interstate Compact process for an assessment and recommendations regarding placement of the victim child with his father. The father continues to visit weekly with the victim child. [REDACTED]

Criminal charges have not been filed.

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;
 - The child, family and home were seen throughout the agency's involvement in accordance with all applicable regulations.
 - Timely interviews were conducted with the victim child's parents and household members and other caretakers to determine what occurred.
 - Contacts were made with the hospital's medical personnel to determine the cause, extent, and results of the victim child's injuries.
 - Appropriate releases of information were obtained for collateral information regarding treatment and services rendered.
 - Ongoing communication occurred with law enforcement.
- 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; and
 - 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:

- WCCYS completed a thorough investigation with all family members at the home immediately after receiving the report.
- WCCYS worked cooperatively with the [REDACTED] Police and the District Attorney's office.
- WCCYS made appropriate recommendations to obtain growth chart to help identify if victim child was being fed properly.
- WCCYS requested records from Ohio protective services as the family previously lived in Ohio.
- The near fatality report submitted by the county was completed in a timely manner meeting all regulations.

Department of Human Services Findings:

- County Strengths:
 - WCCYS cooperated with [REDACTED] Police detectives and CHP doctors to conduct a thorough investigation.
 - WCCYS requested records from Ohio protective services.
 - WCCYS conducted a near fatality review team meeting within 30 days and submitted the County Review Team Report on time.
 - Risk Assessments, Safety Assessments, and Safety Plans were completed within regulatory time frames.
 - WCCYS notified the half-sister's father of their involvement. They worked with ECOCY who completed an assessment of the father which resulted in her placement with the father.
 - WCCYS is working with both the father and the mother on plans to return the victim child to either one of them.
- County Weaknesses:
 - None
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - None

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Department of Human Services Recommendations:

- o Community Services should be available to new parents who are overwhelmed by their parenting responsibilities in order to prevent these types of incidents from occurring.