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REPORT ON THE NEAR FATALITY OF:



Date of Birth: July 12, 2010
Date of Near Fatality: October 25, 2010

**The family was not known to
Erie County Children and Youth Services.**

The family was known to other public/private social service agencies.

Date of Report: October 25, 2010

This report is confidential under the provisions of the
Child Protective Services Law and cannot be released
(23 Pa. C.S. Section 6340)

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

Reason for Review

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 by [REDACTED]. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	07/12/2010
[REDACTED]	Sister	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Father	[REDACTED] 1980
[REDACTED]	Mother's Paramour	[REDACTED] 1983
[REDACTED]	Maternal Grandmother	UNK
[REDACTED]	Maternal Grandfather	UNK

Notification of Child Near Fatality

A report of [REDACTED] related to the near death of [REDACTED] commonly known as [REDACTED] was referred to Erie County Office of Children and Youth by [REDACTED] on October 25, 2010. On October 25th, at approximately 2:00am, the victim child was taken to the local emergency room at [REDACTED] PA. The child was transported to the hospital by the father, mother and the father's sister in the sister's car. The parents did not call 911 but transported the child themselves. According to information obtained by hospital staff from the family, on October 24th the father had been caring for [REDACTED] while the mother was working. When the mother returned home shortly after 1:00am on October 25th, the father informed her he had tripped over a vacuum cleaner and fallen down 15 to 20 steps while holding [REDACTED] reportedly the baby's head had hit the steps with the father's shoulder landing on the baby. The mother reported she ran upstairs immediately and knew something was wrong with the child and that he was lying on his back in the crib. She said the baby did not "look like he was there", was not responsive in looking at her, that his eyes were rolled back in his head, and that he had very little tone overall. The mother states that she observed bruising on both sides of his face and both ears. The mother did not notice any abnormal breathing. Rather than contacting 911, the parents obtained assistance from the father's sister in transporting the baby to the emergency room. When examined at the ER, staff believed the child's injuries were life threatening and made arrangements for the child to be transferred to [REDACTED] via helicopter. It was reported by [REDACTED] from [REDACTED] that the child might have brain damage due to the severity of the injuries. The doctor also reported that the injuries were suspicious for non-accidental trauma.

Summary of DPW Child (Near) Fatality Review Activities

The Department of Public Welfare, Western Region Office of Children, Youth and Families, obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted by the assigned Regional Program Representative with Caseworker [REDACTED] Caseworker [REDACTED] and Supervisor [REDACTED], on October 28, 2010 and December 22, 2010. The regional office also participated in the County Internal Fatality Review Team meetings on May 2, 2011 and May 16, 2011. It is significant to note that May 2nd meeting was the initial Child Death Review meeting scheduled for this case.

Summary of Services to Family

- [REDACTED]
- Safe Net- Domestic Violence [REDACTED]
- Employment Assistance

Children and Youth Involvement prior to Incident

There was no previous history or involvement with the [REDACTED] family involving the victim child or with the siblings of the victim child. However, [REDACTED] had been open with child welfare services when he was a child. [REDACTED] parents had drug and alcohol issues, and at one time relocated to Arkansas with their children. While living there, [REDACTED] and his sister were removed from the care of the parents but later returned. This was recalled by a supervisor who remembered working with the family 20 years ago. [REDACTED] and his sibling are both currently adults.

Circumstances of Child (Near) Fatality and Related Case Activity

The case became known to Erie County Children and Youth Services on October 25, 2010 via a [REDACTED] report initiated by [REDACTED] which reported that the child was admitted with severe [REDACTED]. The child was then immediately flown to [REDACTED]. At the time the child sustained the injury, the mother, [REDACTED] was at work and [REDACTED] sibling, was with her maternal grandmother, [REDACTED]. The father, [REDACTED] reported to hospital staff that he was caring for the child and that he tripped over a vacuum cleaner and fell down the stairs with the full weight of his shoulder landing on the child's head.

The child was treated by [REDACTED]. Her examination revealed that the child suffered from [REDACTED] with multiple injuries. She stated that the father's explanation of how the injuries occurred was not plausible. Her medical opinion was that the child was severely beaten, with bruising on his ears and both sides of his face, had symptoms of being shaken, specifically [REDACTED], and a [REDACTED] with [REDACTED] stated that the child could be [REDACTED].

[REDACTED]

The case was transferred from Intake to Ongoing Services on November 4, 2010. Supervisor was [REDACTED] and now is [REDACTED]. Caseworker [REDACTED] was assigned to the case. [REDACTED]

On November 17, 2011, the father took a lie detector test and failed, and was arrested and arraigned immediately after the test. Detective [REDACTED] reported [REDACTED] failed the lie detector on two questions, specifically, "Did you shake your son?" and "Did you fall down the stairs?" Subsequently, [REDACTED] made a confession to shaking [REDACTED] and is awaiting sentencing.

A [REDACTED] investigation was initiated on October 25, 2010 by Erie County Children and Youth Services with the biological father, [REDACTED] being named as the [REDACTED]. On November 3, 2010, the case was [REDACTED] for [REDACTED]. The case was [REDACTED] based on the medical and the [REDACTED] investigation findings. The criminal case is still pending.

[REDACTED] was [REDACTED] from [REDACTED] on November 23, 2010, to his mother. He had a [REDACTED] which mother was instructed on how to use by [REDACTED]. Upon her return to Erie the mother was accompanied by a man she met in Pittsburgh who she was introduced to while at hospital. The man's name was [REDACTED] who lives in Pittsburgh. Mother stated that [REDACTED] had a job interview scheduled in Cleveland the next day. A clean check revealed that he had a past record of drugs, weapon-related charges, indecent exposure, and cruelty to animals. He was ordered to complete [REDACTED] and not to own any animals. A safety plan was implemented immediately which stipulated [REDACTED] was to not have contact with the child. It was arranged that [REDACTED] would reside at [REDACTED] aunt's house and that [REDACTED] would reside with her mother, [REDACTED].

On November 3, 2010 the case was [REDACTED] for [REDACTED]. The case was [REDACTED] based on the medical and the [REDACTED] investigation findings. The criminal case is still pending.

A second referral on [REDACTED] was received on February 23, 2011. The referral was called in by the [REDACTED] located at [REDACTED]. They provide day care for children with medical issues. The child was picked up at 0732 hours the morning of February 23, 2011, by [REDACTED] and bus driver [REDACTED]. [REDACTED] observed some minor red marks and scratches to [REDACTED] neck and face. When she asked the mother for an explanation of the injuries the mother stated that the child had scratched himself. The child was then transported to the day care. Upon arrival at day care, child's diaper was changed by staff member [REDACTED] (RN) and a staff member. [REDACTED] also noted minor red marks and scratches to victim child's neck and face. [REDACTED] stated that the child slept most of

the day which was very unusual. Day care personnel periodically checked the child for soiled diapers and repositioned child throughout the day. Early afternoon (1500 hours) victim child's diaper was changed and [REDACTED] observed bruising to the child's buttock. [REDACTED] and [REDACTED] decided to do a "head to toe" exam of victim child.

During the check the aforementioned personnel observed significant bruising to the child's buttock and anal area as well as a suspected anal tear. [REDACTED] said the observed injuries were photographed and a decision was made to immediately transport the child to [REDACTED] then notified the victim child's mother at her place of employment and Erie OCY personnel.

Once the mother arrived at the hospital she spoke with [REDACTED] and advised all present that [REDACTED] suspected injuries/marks are symptomatic of his medical condition. The mother was asked about her living arrangements and stated that she was the primary care giver for [REDACTED] and that she had changed all of [REDACTED] diapers yesterday and cared for him on Tuesday evening and put him to bed about 9:30pm. She further stated that [REDACTED] slept in her room with her, her boyfriend [REDACTED] and her 19-month old daughter, [REDACTED]. This arrangement was a clear violation of the safety plan she had agreed to with Erie OCY. [REDACTED] said that [REDACTED] was solely in her care until [REDACTED] picked him up for the day care the following morning.

Based on the nature of the child's injuries, a report of [REDACTED] was made and assigned to [REDACTED]. CYC for investigation. Erie CYC reported the case to law enforcement on February 23, 2011 and Officer [REDACTED] from the Erie County Police Department took the report. Subsequent attempts by the police to interview [REDACTED] have been unsuccessful. The Erie Police Department's investigation into the circumstances surrounding how the child sustained the injuries remains open. [REDACTED]. [REDACTED] is considered a person of interest.

The [REDACTED] report was assigned to Erie CYC Intake Caseworker [REDACTED] under the supervision of [REDACTED]. Injuries included unexplained bruising on his jaw, neck and anal area, including an [REDACTED]. [REDACTED] did an emergency [REDACTED] examination of [REDACTED]. [REDACTED] believed it was indicative of [REDACTED]. A second opinion was sought and both doctors agreed the injuries were indicative of [REDACTED]. A full body scan could not be done on [REDACTED] because of the severity of his medical condition. A full body scan of [REDACTED] was done and it came back negative.

[REDACTED] has significant delays. He cannot sit up unassisted and it is unclear how much he can see. He had an appointment in June with [REDACTED] to determine how much he can see; however, those results were not made available. The last CAT scan on his brain [REDACTED]. He had [REDACTED] in December 2010 to [REDACTED]. If returned home, he will qualify for [REDACTED] services. [REDACTED] has shown substantial improvements in his health. However, he is developmentally delayed due to the [REDACTED] to which he was subjected. He remains in a [REDACTED] and continues to improve. At times

- Strengths: The county internal team met on May 2 & May 16, 2011, and believed that the agency did comply with all statutory and regulatory requirements related to the provision of services to the family. The county took the appropriate measures to ensure the safety of the other child in the home while the case was being investigated for possible [REDACTED]

The county conducted a record check on mother's new paramour prior to allowing him accesses to children during visits. The agency conducted periodic home visits and made collateral contacts throughout the length of the case.

- Deficiencies: The county agency did not comply with Act 33 of 2008 that requires that the agency convene a review when a report of [REDACTED] involving a child fatality is [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to Childline.
- Recommendations for Change at the Local Level: The County Review Team made the following recommendations for change at the local level:
 - A case management component should be added to the process, especially for cases like this one with a young mother. [REDACTED] was quite overwhelmed and stressed at the time of [REDACTED] injuries and could have used a case manager to help her set up appointments and services. The hospital social worker and agency case aides could be enlisted as well to assist the family.
 - The maternal grandparents, [REDACTED] need to be considered for visitation. This may help to build and improve the family relationship between [REDACTED] and [REDACTED]. The relationship between mother and daughter are very strained.
 - Work on better connecting systems and services somehow to help families.
 - Research what other counties are doing to achieve the best results.
 - Assemble an emergency team of "first responders" to meet as soon as possible after a child death to map out a plan specifically for that family.
- Recommendations for Change at the State Level: There were no recommendations for change at the state level.

Department Review of County Internal Report

The county assisted to help mother get services which were appropriate for the families needs. The services that have been provided are in place and the family is responding well. The county agency's ongoing caseworker has worked diligently to help the family to stabilize. [REDACTED] current foster home has been a wonderful support to his family while meeting his serious physical medical needs.

Department of Public Welfare Findings

- County Strengths: Service providers and community providers have responded well for this family [REDACTED] has been assisted by CYS to obtain employment. She has also been able to get support through [REDACTED] which has helped her with the domestic violence which has occurred within her family.

Ongoing caseworker assigned, [REDACTED] has done an exceptional job to help meet the needs of the family and children.

[REDACTED] is in a supportive foster home which has helped to meet all of his critical medical needs. He is slowly progressing but will have difficulties throughout his life due to the head injuries he has suffered.

Although the mother continued to have contact with her paramour, the county continually monitored the provisions of the safety plan by completing unannounced visits to the home and frequently checking with family members to ensure the safety plan was being followed.

- County Weaknesses: The county failed to hold a review within the 30 days of the incident as per Act 33 of 2008 which requires that county children and youth agencies convene a review when a report of [REDACTED] involving a child fatality or near fatality is [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to Childline.
- Statutory and Regulatory Areas of Non-Compliance: The county will be issued an LIS due to not complying with Act 33 of 2008 that requires that county children and youth agencies convene a review when a report [REDACTED] involving a child fatality or near fatality is [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to [REDACTED].

Department of Public Welfare Recommendations

The Department notes that the county must immediately set up a date and convene Child Fatality/Near Fatality Review Team meetings within 30 days on any child death or near death that yields an [REDACTED] status determination or when the investigation continues beyond 30 days of the initial report being received by [REDACTED]. This will allow for enhanced planning to assist families in obtaining the services which will help. The county must ensure the safety of all children, as in the case of this child, [REDACTED] ([REDACTED])

The county should ensure a representative from law enforcement or the District Attorney's Office participates in the review process.