



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

DATE OF BIRTH: June 18, 2013
DATE OF INCIDENT: May 5, 2014
DATE OF ORAL REPORT: May 5, 2014

FAMILY WAS NOT KNOWN TO:

Washington County Children and Youth Services

REPORT FINALIZED ON:
6/27/15

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. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine.

Washington County has convened a review team in accordance with Act 33 of 2008 related to this report on May 30, 2014.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	06/18/13
[REDACTED]	Mother	[REDACTED]/89
[REDACTED]	Father	[REDACTED]/87
[REDACTED]	Grandmother to [REDACTED]	10/28/65
* [REDACTED]	Half-Sibling to Child	01/27/10
* [REDACTED]	Half-Sibling to [REDACTED]	05/31/08
[REDACTED]	[REDACTED] Maternal Aunt	09/10/95
[REDACTED]	[REDACTED] Boyfriend	03/07/94
[REDACTED]	Paternal Aunt/	05/06/96
[REDACTED]	Paternal Grandmother	03/10/67
[REDACTED]	Paternal Grandfather	09/18/63

* [REDACTED] are siblings who share the same mother. [REDACTED] father is [REDACTED] does not know her father; however, her mother shares custody with [REDACTED] live a week on/a week off in the family home. At the time of the incident, they were both in the home.

Notification of Child Near Fatality:

On May 5, 2014, a referral was received by Washington County Children and Youth Services (CYS) alleging a ten month old infant was flown to Children's Hospital and diagnosed to be in serious condition after sustaining [REDACTED], one to the forehead and one over his left ear. Additionally, there was [REDACTED]. The injuries were diagnosed as suspected abuse.

It was reported that the child was found by his caregiver, the grandmother to a sibling, to be lying on the floor between a kitchen island and cabinets. The caregiver reported that when she approached the victim child, she noticed that he was not using his right arm. The caregiver took the victim child upstairs to his mother, who was sleeping. The mother called 911 to request an ambulance. The victim child was transported to Washington Hospital in Washington, Pennsylvania and then flown to Children's Hospital of Pittsburgh.

Summary of DHS Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. The regional office also participated in the County Internal Fatality Review Team meeting on May 30, 2014.

Children and Youth Involvement prior to Incident:

Washington County Children and Youth Services had no prior involvement with the family.

Circumstances of Child Near Fatality and Related Case Activity:

Upon the receipt of the referral on May 5, 2014, Washington County CYS initiated contact with the physician at Children's Hospital. The physician indicated that aside from the internal head injuries, the victim child had no other fractures. It was noted that there was significant swelling and a "goose egg" on the victim child's head. The preliminary time frame of the injury was estimated to be between the prior evening at bedtime and the time of admission on May 5, 2014.

On the date of report, May 05, 2014, the Washington County CYS completed a home visit to the family home to ensure the safety of two other children reported to be in the home. The Washington County CYS workers were met by the other household members, who allowed entry to the home. It was noted in the case record that the stairs and balcony did not have a railing. The other household members and the children who visit in the home were seen and interviewed. The interviews suggested that during the incident the mother was sleeping upstairs. The grandmother to a sibling was to be watching the children. The interviews reported that one of the children saw the victim child crawl up the steps after the caregiver had gone outside to take out the garbage. The victim child was seen falling from the steps by one of the other children.

The day following the incident, May 06, 2014, Washington County CYS made a visit to Children's Hospital to speak with the parents and see the victim child. Consistent statements were given indicating that the mother was not feeling well and was upstairs sleeping during the incident. The father was leaving to take his other child to school and the grandmother to a sibling was

asked to watch the children. The mother reported that the victim child was brought upstairs to her after he was found by the caregiver lying on the floor. The victim child was not crying but was having difficulty controlling his head and body. The caregiver was not able to give an account to the mother for what had happened. The mother then called emergency services and requested an ambulance.

The victim child [REDACTED] at Children's Hospital on May 7, 2014 and placed in a regular hospital room. The hospital staff reported that they did not see any behavior by the parents that would be considered concerning and indicated that the parents were being very attentive to the victim child. The victim child's condition improved quickly and he did not require [REDACTED]. The injury was expected to heal on its own. The only explanation that was plausible after the assessment was that the victim child had fallen from the second story and hit his head on the corner of a cabinet. The estimated time of the injury was consistent with the date the child was brought to the hospital.

During the interviews, the parents admitted to using cocaine the weekend prior to the incident. The parents were advised that due to the nature of the concerns, the case was going to be accepted for services. Each parent was going to be [REDACTED] and would likely be subjected to urine screens based on the admission of using cocaine. The parents were agreeable to the recommendations and were willing to work with the agency to ensure the safety of the victim child. The parents were told that a railing would need to be installed on the stairs and balcony. Washington County CYS also utilized the paternal grandmother and grandfather, who were not home at the time of the incident, to help ensure safety of the victim child through regular supervision upon [REDACTED] return home on May 10, 2015. The paternal grandparents were responsive and began working on the railing prior to the victim child's [REDACTED]. Clearances were run on all household members and potential caregivers. No safety concerns were noted based on the criminal histories.

Prior to the victim child [REDACTED] on May 11, 2014, Washington County CYS made a home visit to ensure the environment was safe for the victim child to return home. The family had installed a new railing on the stairs with baby gates, and attached blankets to the corners of the stone fireplace to ensure the children would not fall and be harmed on the corners. The victim child was [REDACTED] on May 11, 2014 to the care of his mother and father. The safety plan at the time [REDACTED] involved ongoing supervision of the child by the paternal grandparents until the parents were more formally assessed. The mother of the other two children was also contacted and was made aware of the safety plan. On May 29, 2014, the grandmother to a sibling (the caregiver), was indicated for a lack of supervision that resulted in a physical condition to the victim child.

Current Case Status:

Within two weeks of the child coming home, [REDACTED]

[REDACTED] The provider gave a positive assessment of the parents' ability to supervise and care for the child and expressed no concerns. The provider successfully discharged the family from services. The victim child had a medical follow up in September of 2014 and it was determined that the victim child was doing well but would need [REDACTED]

[REDACTED] The current status of the case is closed as of January 2015. Per the record, the family completed all the recommendations set forth by the agency and was compliant with all medical follow up for the child.

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Washington County has convened a review team in accordance with Act 33 of 2008 related to this report on May 30, 2014.

Strengths:

The Act 33 review identified several strengths with the case management and investigation of the report. The children and family members were seen and interviewed during the assessment. Collateral contacts were made with hospital personnel as well as the victim child's pediatrician. The services recommended and available were adequate and appropriate based on the assessment.

Deficiencies:

The Act 33 team review found no deficiencies with the investigation process at the time the review was held.

Recommendations for Change at the Local Level:

The Act 33 review recommended an increase in collaboration and communication among systems. Washington County CYS obtained information on "Baby Proofing Your Home" and distributed the information to all caseworkers and has posted the information in the agency waiting room. In addition, the agency purchased DVDs of "When Babies Cry" to be given to new mothers who give birth at the Washington Hospital in order to increase education about newborn care.

Recommendations for Change at the State Level:

The Act 33 review identified that this was a tragic accident that may not have occurred with proper supervision and child safety measures. It was suspected that the victim child fell from a second floor that was lacking a safety railing. The systems of care would not have knowledge of this internal safety issue without a referral to the family. A recommendation was made to increase awareness statewide regarding child development and the importance of baby/child proofing as children grow. Outreach efforts would be possible by local fire and police departments, who may be willing to conduct home safety checks and make recommendations for change.

Department Review of County Internal Report:

The Department received the County Internal Report via email on August 29, 2014. The Department would concur with all of the above recommendations given by the review team.

Department of Human Services Findings:

County Strengths:

The county agency responded immediately to ensure safety of the victim child while in the hospital as well as the two other children who were in the home at the time. Washington County CYS requested a courtesy visit from the neighboring county to see the subject child in the hospital on the day of the report. In addition, the assigned Washington County CYS caseworker made a visit to the hospital the following day. The other children, the parents and the majority of the household members were all interviewed within a day of the report. Washington County CYS completed very thorough interviews, which contributed substantial information to the assessment. Adequate services were initiated based on a very thorough assessment of the household.

County Weaknesses:

Although not entirely the fault of Washington County CYS, there appeared to be a heightened level of frustration that existed between the assessment worker and the parents. The dictation described some heated conversations that seemed to have the Washington County CYS caseworker defending decisions being made by Washington County CYS. The parents were increasingly agitated at the level of supervision being required by Washington County CYS regarding the parents and the children. This led to some accusatory statements by the parents. The Washington County CYS caseworker appeared to respond to these in a style that seemed personal.

Statutory and Regulatory Areas of Non-Compliance:

There were no statutory or regulatory areas on non-compliance.

Department of Human Services Recommendations:

In addition to the above mentioned recommendations made within the Internal County Report, the following recommendations are brought forth by The Department:

It would be recommended that Washington County CYS develop a practice to assist caseworkers when dealing with assertive and verbally assaultive parents. This would include understanding some of the root causes for these emotions and acceptable ways of response from workers. The sensitivity of the report and the emotions that all subjects were experiencing were likely factors in the responses from all parties. By building caseworker skills when dealing with these emotions may assist in strengthening engagement strategies.