REPORT ON THE NEAR FATALITY OF:

BORN: 7-3-09
Near Fatality: 5-12-12

FAMILY KNOWN TO:
The Family was not known to Lawrence County prior to Near Fatality

REPORT FINALIZED ON: 6-3-13
DATE OF ORAL REPORT: 5-12-12

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, 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.

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. Lawrence County had not convened a review team in accordance with Act 33 of 2008 related to this report. The agency did not convene a review since the report was unfounded.

Family Constellation:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[REDACTED]</td>
<td>Victim Child</td>
<td>7-3-09</td>
</tr>
<tr>
<td>[REDACTED]</td>
<td>Mother</td>
<td>1978</td>
</tr>
<tr>
<td>[REDACTED]</td>
<td>MGM</td>
<td>1956</td>
</tr>
<tr>
<td>[REDACTED]</td>
<td>Brother</td>
<td>2008</td>
</tr>
<tr>
<td>[REDACTED]</td>
<td>Father</td>
<td>1984</td>
</tr>
<tr>
<td>[REDACTED]</td>
<td>Maternal Aunt</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

(*not a household member at time of incident)

Notification of Child (Near) Fatality:

Date of incident was 5-12-12. On 5-12-12, Lawrence County Children and Youth Services (LCCYS) was alerted by [REDACTED] Pennsylvania that a 2 year old child fell out of a 1st floor window about 4-5 feet from the ground. The child was immediately transferred to [REDACTED] Pennsylvania via Medivac (Life Flight). The child was suspected to have sustained head trauma due to the fall and was listed in critical condition at the time of the transfer. Child was expected to survive. It was reported that the child [REDACTED] and unresponsive due to trauma. The report also stated that the mother was a [REDACTED]. Child had been at the emergency room in the past for stomach issues; however, the exact date of this visit to the hospital is unknown. It was also reported that the father was more concerned about calling CYS than requesting information regarding the overall condition of his child. The report also stated that the mother’s interaction with the child was appropriate and that the child was well taken care of and clean. The mother and the maternal aunt were at the hospital with the child after the incident.
Summary of DPW Child (Near) Fatality Review Activities:

On July 18, 2012, the Western Region Office of Children, Youth and Families obtained and reviewed all current records pertaining to the [REDACTED] family. All current dictation was reviewed, the intake screening report, the hospital report, notification letters, Allegheny County contact reports, the safety assessment worksheet and the CY-48 report. It should be noted that Lawrence County had no other history on the family prior to this near fatality.

Summary of Services to Family:

The family is receiving services from [REDACTED] due to the child being diagnosed with [REDACTED]. The child is receiving services for her[REDACTED].

Children and Youth Involvement prior to Incident:

There was no prior history with the family and LCCYS until this near fatality report was received on 5-12-12.

Circumstances of Child (Near) Fatality and Related Case Activity:

On May 14, 2012, the Western Regional Office of Children, Youth and Families contacted Lawrence County CYS to inquire about the current status of the case. It was reported that LCCYS had requested that Allegheny County CYF conduct a courtesy interview since the child was placed [REDACTED]. Allegheny ACCYF interviewed the mother and provided the following information to the Lawrence County caseworker. The mother stated that the child fell out of the kitchen window. She believed that her four year old son opened the window. The mother was standing between the kitchen and the living room when the incident occurred. The grandmother saw the child fall out of the window, but was unable to reach the child prior to her falling. The mother reported that the child is autistic and receives [REDACTED].

[REDACTED] did a CAT scan on the child and it showed no serious injuries to the child. There were no significant injuries identified. It was presumed that the child suffered from a concussion. A review of the [REDACTED] report was negative for injuries, fractures, or lacerations. The head CT scan was negative for [REDACTED].

On May 14, 2012, the Department contacted LCCYS to inquire of any updates on the case. It was reported that an unannounced home visit was conducted; however, no one was home, so the caseworker left their card and left a message for the family to contact the agency. The mother was still [REDACTED] with the child and the grandmother was not at the residence.
On May 15, 2012, a home visit was conducted with the mother, grandmother, the victim child and her sibling. There was plenty of food in the home and both children had their own beds. The CW viewed the window where the child fell out and saw that the drop was approximately 4-5 feet from the ground and how the screen was missing. Apparently, the child had gotten onto a toy car and fell off of the car and out of the window. The mother stated that she was in-between the living room and the kitchen. She said it happened so fast that she couldn't reach the child in time. The grandmother reported that she was making brownies and was next to the stove and couldn't get to child quick enough to prevent the child from falling out of the window. They both reported that a neighbor saw the child fall out of the window, but could not tell if the child hit her head or not. A safety plan was developed for both of the children which stated that the children must be supervised at all times and that they should not have access to windows. The mother and grandmother both signed off on the safety plan and said they would ensure that the plan is followed at all times.

On May 15, 2012, the Department contacted the Agency to see what the status of the case was and was informed that the County and [REDACTED] both concurred that the incident was the result of an accident. The social worker [REDACTED] reported that they did not have any concerns and that the mother and child interacted properly. They were appropriate throughout their stay at the hospital and felt that mother’s interaction with child was appropriate.

On May 18, 2012, the CY-48 was filed with a status determination of unfounded. The basis for the unfounded case was that the child did not suffer a severe injury. In addition the hospital believes that it was an accident and that both alleged perpetrators tried to get the child prior to the child falling out of the window.

**Current Case Status:**

The case was closed on May 18, 2012, since it was believed that the incident was the result of an accident. This was concurred by the Agency and [REDACTED] The case was not open because it was apparent to the County that the mother has a good support system in place with extended family. The children are also receiving services through [REDACTED] The County decided not to open a case based on these circumstances.

There was no police involvement with the case.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County’s Child (Near) Fatality Report:**

There was no review conducted due to the incident being ruled accidental by the County and [REDACTED]. The Department reviewed all pertinent information and determined that the County did follow up with family and was able to collaborate with the hospital and Allegheny County CYF to ensure the safety of the child.
**Department Review of County Internal Report:**

A County internal report was not written due to the near fatality being ruled accidental by the County and the hospital; hence, the ChildLine report was unfounded within 30 days of incident. It was determined by the hospital that the child did not sustain any serious injuries due to the fall from the window. The Department was able to review all reports and dictation of the case. There were no deficiencies noted.

**Department of Public Welfare Findings:**

- **County Strengths:**

There were several strengths identified in the review of this child near fatality. The County was diligent in their investigation, and worked collaboratively with medical professionals and with Allegheny County CYF. The case documentation completed by the County caseworker was detailed and well organized. Safety and risk assessments were completed at the correct intervals, and the established safety plan for the identified child was completed timely to suit the safety and well-being of both children.

**County Weaknesses:**

The Department did not identify any weaknesses in the review of this case.

- **Statutory and Regulatory Areas of Non-Compliance:**

There were no statutory and regulatory areas of non-compliance with this near fatality. There was no prior history with the agency and family.

**Department of Public Welfare Recommendations:**

There were no systemic issues or concerns noted in this near fatality report. The County followed proper protocol in the handling of their investigation. There were no weaknesses or deficiencies present and there are no recommendations.