pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: January 28, 2011
Date of Incident: January 25, 2013
Date of Oral Report: January 25, 2013

FAMILY KNOWN TO:

Venango County Children and Youth Services

REPORT FINALIZED ON:

September 27, 2013

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. Venango County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Child	01/28/11
* [redacted]	Mother	[redacted]86
* [redacted]	Father	[redacted]85
[redacted]	Grandmother/Caregiver	[redacted]65
[redacted]	Aunt/Caregiver	[redacted]83
[redacted]	Aunt's Boyfriend	[redacted]85
[redacted]	Brother	[redacted]03
[redacted]	Sister	[redacted]08
[redacted]	Cousin ([redacted] son)	[redacted]05
[redacted]	Cousin ([redacted] son)	[redacted]12

Notification of Child (Near) Fatality:

On January 25, 2013 Venango County Children and Youth Services received a report from [redacted] regarding a two year old child who was brought to the local emergency room after [redacted] was noted by her caregiver. The report indicated that the child was under a shared custody order of her paternal aunt and paternal grandmother. The child's mother was not living in the household with the child and had little to no contact at the time of the report. The child's father was incarcerated. The aunt called the grandmother on the date of incident and reported that she saw [redacted] on the child. The grandmother arrived at the home and noticed severe bruising that was not seen on the previous day when the grandmother dropped the child off to the aunt. The grandmother transported the child to the Emergency Room. On exam, the child was found to [redacted] A CAT scan showed [redacted] Based on information provided by the hospital [redacted] processed the report as a near fatality. At the time of the report the perpetrator/perpetrators could not be identified.

The child was transported by helicopter [redacted] where she was evaluated and found to be a victim of suspected child abuse. It was determined upon exam that [redacted] was likely a result of abuse. The child was released the next day to the care of her grandmother.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and prior records pertaining to the child's family. Follow up interviewing was conducted with the Venango County Quality Assurance supervisor, [redacted] and the on-going worker, [redacted] The regional office reviewed the County Internal Fatality Review Team report. The regional office was not invited to participate in the review due to the county's belief the report was being decertified.

Children and Youth Involvement prior to Incident:

REPORTS ASSOCIATED WITH CHILD'S MOTHER AND FATHER:

October 13, 2011

Referral was received by Venango County Children and Youth Services regarding concerns the children were being left home alone. At this time, the children were 7 years, 3 ½ years and 10 months. The county responded within two hours and found the allegations to be invalid. The oldest child was spoken to alone and denied the allegations to be true.

January 31, 2012

Referral was received by Venango County Children and Youth Services regarding concerns that the 4 year old was being discharged from her current medical provider due to numerous "no shows". The referral indicated that the child had a [redacted] diagnosis several months prior and the mother did not return after treatment for a follow up. The County responded on the day of the referral to determine that the mother had transferred medical providers. The children were all up to date on shots and appointments. The [redacted] had been treated and was no longer a concern. The County reviewed all medical records and made collateral contacts with both past and current medical providers at the time of the report. The case was closed at intake as invalid on February 7, 2012.

April 18, 2012

Referral was received by Venango County Children and Youth Services regarding a concern of supervision with the youngest children. The report indicated that the 4 year old was outside playing on the sidewalk without adult supervision. The County responded within 2 hours of the report to find that there was no evidence to support the allegations. The case was closed at intake as invalid on April 23, 2012.

May 31, 2012

Referral was received by Venango County Children and Youth Services regarding a concern of inadequate food in the family home. The County responded on the date of the referral. The contact made with the mother indicated that the father had left with the children several days prior to the report. The County located the father and the children within a reasonable time. The father and one of the children were staying at the father's sister's home. The other two children were in the care of their paternal grandmother, at the agreement of the father. The mother was no longer caring for the children. Both the grandmother and the aunt's home had sufficient food, were found to be free of hazards and were adequate to house the children and their father. The case was closed at intake as invalid on June 29, 2012.

October 12, 2012

The agency received a call [redacted] that the father had been arrested and was incarcerated. The children were staying with the paternal grandmother and [redacted] The call was screened out.

January 25, 2013

Referral was received by Venango County Children and Youth Services regarding the alleged abuse of the two year old by the aunt's boyfriend. The agency responded immediately to the report and assured safety of the child, her siblings and the aunt's children. Further detail is noted below regarding this referral.

REPORTS ASSOCIATED WITH THE CHILD'S PATERNAL AUNT/ CAREGIVER:

August 24, 2004

The county screened out a call on the aunt regarding concerns of her being in labor and having past arrest for drug charges. No current allegations of abuse were reported and no other children were in the home.

August 25, 2005

The county screened out a call on the aunt after a report was received that the aunt had been arrested and her child was being sent to stay with an aunt.

March 18, 2013

During the investigation of the near fatality, the children of the aunt (who had also been a caretaker for the subject child of this near fatality) made reports of physical discipline by her boyfriend. The case was open for GPS investigation. The allegations were confirmed; however, the case was closed at intake as the aunt and her boyfriend were arrested and the children were

voluntarily sent to stay with the grandmother. The children had no injuries that met abuse criteria at the time of the report; therefore the report was not indicated as a CPS.

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

On January 25, 2013 Venango County Children and Youth Services received a report regarding a two year old child who was brought to the local emergency room after [redacted] was noted by her caregiver. The report indicated that the child was under a shared custody order of her paternal aunt and paternal grandmother. The child's mother was not living in the household with the child and had little to no contact at the time of the report. The child's father was incarcerated. The aunt called the grandmother on the date of incident and reported that she saw [redacted] on the child. The grandmother arrived at the home and noticed [redacted] that was not seen on the previous day when the grandmother dropped the child off to the aunt. The grandmother transported the child to the Emergency Room. The child was transported by helicopter [redacted] where she was evaluated and found to be a victim of alleged child abuse. It was determined upon exam that her [redacted] was likely a result of abuse. The child was released the next day to the care of her grandmother.

The child, her siblings and cousins were all placed under an approved safety plan with the grandmother. Based on information obtained during the investigation of the allegations of suspected abuse, the aunt and her boyfriend were identified as the alleged perpetrators of abuse related to the near fatality. The aunt was arrested on the evening of January 25, 2013. The aunt was immediately placed in Venango County Jail on charges of Endangering the Welfare of a Child and Recklessly Endangering another person. The boyfriend was not immediately located, however turned himself in on January 28, 2013. He was charged with Simple Assault, Recklessly Endangering another Person and Endangering the Welfare of a Child. Both remain incarcerated and awaiting trial or plea negotiations.

The agency maintained weekly contact with the children and the grandmother, who was living with her cousin during the episode. Forensic interviews were arranged and completed for the two oldest children to determine if more details surrounding the abuse could be identified. The interviews supported the use of extreme physical discipline at the hands of the boyfriend. The aunt was registered for failing to report the abuse and failing to seek medical attention in a timely manner. The boyfriend was registered for physical abuse. Both the aunt and her boyfriend were identified as perpetrators of physical abuse related to the near fatality report.

Current Case Status:

The case was accepted for services on February 28, 2013. The child, her siblings and the aunt's children remained in the care of the grandmother. A Family Group Decision-Making conference was held to bring the family supports together and get everyone involved on the same page. The child's father has been released from jail and is currently living with the children at the grandmother's home. He has been a very positive support to the grandmother and the children.

The father has plans to attend the local Fatherhood Initiative Program. The child continues to do well as do the other children. The grandmother has the support of the child's great aunt and now the father to assist in caring for the five children. Structure is being implemented with routine and consistency. The mother has been in contact the agency and has asked to begin having involvement again with the children.

The mother was recently incarcerated with a hearing scheduled for August 15th. It is believed that the arrest was related to a probation violation. The child's aunt and boyfriend continue to remain incarcerated for the abuse.

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

A local review team was convened on February 12, 2013. The regional office was not invited to participate in the review due to the county's belief the report was being decertified.

- Strengths: There were no strengths identified in the report.
- Deficiencies: There were none identified in the report.
- Recommendations for Change at the Local Level: There were no recommendations identified in the report.
- Recommendations for Change at the State Level: There were no recommendations identified in the report.

Department Review of County Internal Report:

The county review team met February 12, 2013. The Department was not included as a participant in the meeting. The teams report was submitted to the Department February 14, 2013. The report gave a summary of the facts associated with the investigation and the decision whether to request a de-certification of the near-fatality based on the information given by the medical professional. The meeting agenda appeared to only address these two items. The report gave no finding of strengths, deficiencies or recommendations.

Department of Public Welfare Findings:

County Strengths:

- The investigation was managed collaboratively among the county Children and Youth agency, law enforcement and the examining physicians.
- The visits completed with the grandmother and the children were quality visits and were completed on a weekly basis.
- The caseworker made several visits to the prison to speak to the child's father and to the aunt.

- There were meetings held with the family to arrange supports for the children and the grandmother while the children were in her care.

- In regards to the past investigations, the department found that the investigations were appropriately conducted and the findings seemed justified.

County Weaknesses:

The Department did not identify any county weaknesses regarding the services provided to the family, nor with the previous investigations.

Statutory and Regulatory Areas of Non-Compliance:

The county did not arrange for the participation of a representative of the Department in the Near Fatality Team meeting held on February 12, 2013. No other findings of statutory and regulatory non-compliance have been identified.

Department of Public Welfare Recommendations:

Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to DPW and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the following:

- Deficiencies and strengths in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse and neglect.

It is recommended that the county ensure the participation of a Department representative in all future Fatality/Near Fatality Team meetings for purposes of facilitating the provision of technical assistance and alleviating the potential of duplicating efforts required of agency and departmental staff in completing assessments. It is also recommended that reports submitted by the county be all-inclusive to better identify the "deficiencies and strengths" as a whole in compliance with the statues, regulations and services to the families.

Additionally, the county report failed to include recommendations, if any, for changes on the state and local levels on reducing the likelihood of future child fatalities/near fatalities related to child abuse, the monitoring of county agencies and on collaboration of community agencies/service providers to prevent child abuse. It is the Department's recommendation that this information be added to the final reports. This has already been addressed with the County

and the Department has been assured that future reports will be strengthened to contain the above information.