pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 7/13/12
Date of Incident: 7/14/13
Date of Oral Report: 7/15/13

FAMILY NOT KNOWN TO:

Union County

REPORT FINALIZED ON:
03/14/14

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. 6349 (b))

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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. Union 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]	Father	[redacted]/77
	Mother	[redacted]/82
	Victim child	07/31/12
	Brother	[redacted]/00
	Sister	[redacted]/08

Notification of Fatality/Near Fatality

On 7/14/2013, the victim child was lying in bed with his father. The father reports that the child leaned over to reach for his bottle and started to fall off of the bed. The father states that he tried to grab the child's leg but could not reach him before he fell onto his head. The child is reported to have fallen three feet onto his head. The child's parents called an ambulance after the child began vomiting, crying, going limp and sometimes becoming unresponsive. It was reported that the child may have experienced [redacted] after the fall. The child was taken to [redacted] and then life-flighted to [redacted]. He arrived there at approximately 8:00 pm. The [redacted] that evaluated the child, [redacted], did not believe that the explanation for the incident was consistent with the injury. He suspected that the injury was caused by non-accidental trauma. The [redacted] physicians were of the opinion that this could have occurred the way that it was described. Union County received the Child Protective Services report on 7/15/13 and was registered as a Near Fatality due to the child being in critical condition with a [redacted]

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records pertaining to the [redacted] Family. Follow up interviews were conducted with the county agency caseworkers: [redacted] on July 22, 2013. The Regional Office participated in the County Internal Fatality Review Team meeting on August 7, 2013.

Children and Youth Involvement prior to Incident:

The family had no prior involvement with the county children and youth agency.

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

On July 14, 2013, the victim child was alone with his father at the home. The father reported that the child fell backwards off the bed (approximately three feet) and hit his head on the hardwood floor. Emergency Services were called after the child began showing medical symptoms, such as losing consciousness. The EMT personnel responded and transported [redacted] where he was then transported via [redacted] to [redacted] medical staff performed a full evaluation that revealed a [redacted] No note of any evidence of [redacted] and there was no bruising. He was taken to the [redacted] He was [redacted] has since been able to [redacted], and was then transferred to [redacted] on August 5, 2013.

[redacted], the treating physician, was questioned about whether the child actually hit the side of his head where the [redacted] is or is it possible that he could have hit his head in another place. [redacted] explained that a [redacted] occurs when the [redacted] due to a trauma so this means that the actual impact did not necessarily occur on the [redacted] went on to explain that there were a large number of [redacted] and this is not typical for the type of fall that the father described. The child was described as being a big, "robust" child with a thick head of hair. There were several tests conducted to rule out any other [redacted] There was no evidence of a [redacted] and no [redacted]. They still needed to rule out [redacted] and there are [redacted] tests completed for [redacted] that can take up to 6 weeks to get the results for. The child's [redacted]. Although these were a direct result of the event, it cannot be determined whether the [redacted] appeared at the time of impact or were caused later due to [redacted] The [redacted] could have been caused by the [redacted] or from the [redacted]; so they could not be directly linked to the trauma itself. [redacted]

The [redacted] that performed the [redacted] was asked whether the father's explanation of the incident could have caused the extensive [redacted] injury to the child. The [redacted] stated that he suspected non-accidental trauma.

On 8/7/13, an MDT was conducted at the agency. After hearing from [redacted] and the information presented by C&Y staff assigned to the case, it was determined by the members of the review team that this should be an indicated case of physical abuse with the father named as the perpetrator.
On 9/12/13, a CY48 was sent to ChildLine with the status of indicated.

Current Case Status:
The family was opened for ongoing General Protective Services on 9/13/13. The victim child was [redacted] and returned to the [redacted] home 9/14/13. UCCYS caseworker, [redacted] met with the family on 9/16/13 and informed the mother that the current safety plan was still in effect and would require full supervision of the father with all of the children. The mother signed the safety plan that she will supervise all contact between the father and the children. The father is employed by a [redacted] and is away from the home for extended periods of time. The family is working with their attorney and as of this date, the family has refused to sign any release of information for the agency. The caseworker does visit monthly and has seen the [redacted] working with [redacted]. The caseworker has sent the family service plan to the attorney for his review and is awaiting its return for the family to review. At this time law enforcement has not filed charges against the AP.

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

Strengths: The county agency investigation complied with regulations and response times as required.

Deficiencies: The county agency's report did not reference any specific identified weakness.

Recommendations for Change at the Local Level: The county agency's report did not reference any specific changes for recommendation at the state or county level.

Recommendations for Change at the State Level: The county agency's report did not reference any specific changes for recommendation at the state or county level.

Department Review of County Internal Report:

The Department reviewed the submission of Union County Children and Youth Agency's report regarding this case. The county report was received on 9/23/13. Due to the circumstances of this particular case there are no areas to dispute or concur with identified in the report.

- County Strengths: Upon review of the documents associated with this particular case it would appear there is a positive working collaboration between law enforcement and the county agency.

County Weaknesses: The circumstances of this incident and review of the county's case did not identify any systemic weakness.

Statutory and Regulatory Areas of Non-Compliance: The review of the county case file notes and medical records did not find any areas of non-compliance.

Department of Public Welfare Recommendations:

The agency has a very good working relationship with both law enforcement and the medical staff at [redacted]. Their input was vital in the agency's investigation and final disposition in the finding of indicated.
There were no areas of deficiency found.