pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: October 14, 2009
Date of Incident: March 29, 2013
Date of Oral Report: March 29, 2013

FAMILY NOT KNOWN TO:

Venango County Children and Youth Services

REPORT FINALIZED ON:

December 27, 2013

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. 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	10/14/09
[redacted]	Mother	[redacted]/85
* [redacted]	Father	[redacted]/82
[redacted]	Sibling	[redacted]/08
* [redacted]	Half-Sibling	[redacted]/05
[redacted]	Mother's paramour	[redacted]/84
[redacted]	Mother's paramour's son	[redacted]/10
[redacted]	Mother's paramour's son	[redacted]/07
[redacted]	Maternal Grandmother	

* [redacted] has had no contact with the child since May 2012 when he was indicated for the physical abuse of [redacted] was sent to live with his maternal grandmother at the time and has remained in her custody to date.

Notification of Child Near Fatality:

On March 29, 2013 Venango County Children and Youth Services received a report regarding a 3 year old male child who was transported to [redacted] by his maternal grandmother after it was noticed that the child was severely bruised, had been vomiting and appeared malnourished. The child was examined and found to have multiple stages of bruising, some of which appeared to be consistent with an implement. The physical exam showed that the child's eyes were sunken and he appeared to be approximately 5-10% dehydrated. There was bruising noted to the child's [redacted] There was also bruising to the [redacted] and abrasions on [redacted] and left leg. [redacted]

The treating physician noted the child's tongue to be blackish in color [redacted] symptoms were noted to be indicative of dehydration. The child was [redacted] and was determined to be in critical condition. The child was then transferred to Children's Hospital of Pittsburgh (CHP) for treatment.

After admission to [redacted], the child was examined and interviewed by the [redacted] and determined to have multiple stages of healing bruises, some of which were suspicious and appeared to be caused by an implement, such as a belt and/or a shoe. The child was interviewed and reported that his "mommy" hit him. He reported that he was hit with his daddy's belt.

The medical professional's findings indicated that the majority of bruising had indistinct appearance and did not suggest a specific object. Some bruising appeared fresher than others and indicated that the child was inflicted on more than one occasion. One area on the child's thigh was abraded and in a pattern of a loop. The child reported this came from a belt, which clearly matched the pattern. There was also a faint pattern on the abdomen which was suggestive of a shoe print; however the print was too faint to be certain. No major findings of internal injury were noted. [redacted]

When questioned, the grandmother reported that she was contacted on March 27, 2013 by the child's mother stating the child had developed a lot of bruising and the mother was not sure why. On March 29, 2013 the mother brought the child and his sister to the grandmother's home for an Easter visit. The children were scheduled to spend the weekend with the grandmother. The mother attributed the bruising on the child's face to a toy he had slept on. After the mother left, the grandmother noticed the child to be very thirsty and after drinking several juice boxes, began vomiting. The child was taken to the bathroom and the grandmother noticed the extensive bruising to the child's body. The grandmother and her paramour called the police and then transported the child to the local emergency room.

Summary of DPW Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family in both Venango and Blair Counties. The regional office also participated in the County Internal Fatality Review Team meeting hosted by Venango County on April 19, 2013, which involved input from both Bedford and Blair County as to the past involvement with the family.

The Department did become aware of a history with the mother's paramour's children in Blair County while reviewing the Venango County case files, however did not access the records on the paramour's family. A summary is detailed below regarding information recorded in the Venango County investigation.

Children and Youth Involvement prior to Incident:

BEDFORD & BLAIR COUNTY:

March 2012

Blair County received a report from Bedford County that [redacted] (children's grandmother) was making threats of self-harm and she had driven a car into a tree while her 6 year old grandson was in the car. Blair County was called as the report mentioned the child and his siblings were now living in Blair County with their mother. The child was seen and assessed by Blair County to be safe with the mother. Since the child was living with the mother in Blair County, Bedford County closed its case at intake.

BLAIR COUNTY [redacted]

May 2012

Blair County received a report regarding a 6 year old male child who presented with significant bruising to both sides of his face. The child was one of three siblings (ages 6, 4, 2) living with their mother in Blair County. The children were babysat by the two younger siblings' father, [redacted], while the mother worked. The child reported that his father (who is technically the child's stepfather) "hit him too hard last night". The child was not able to report why his father hit him only that his father said he was sorry and would never do it again. The victim child was sent to live with his maternal grandmother in Bedford County per a custody agreement between the mother and the grandmother. The county implemented a safety plan with the mother that the children would not have any contact with [redacted] (stepfather). The mother and the stepfather both signed the plan on May 4, 2012. The county [redacted] the report and the stepfather was criminally charged with simple assault in the incident. The case was [redacted] on June 20, 2012.

Late on June 23, 2012 police responded to the children's father's residence after receiving a report of a disturbance. Police arrived to find that the father was having a party, which included underage people drinking. It was also discovered that both of his children (aged 4 and 2) were in his care after the mother left the children there to go to work. Police arrested the father for endangering the welfare of children and furnishing alcohol to minors. [redacted]
These two children were the subject child and his sibling. The older sibling was still in the care of his grandmother.

Unfortunately, the foster care provider did not make the county worker aware that the foster parents went out of town every week for several days and only wished to keep the children for the weekend. The children were sent to a respite home on June 27 to allow for the family to leave town. The original foster home requested the children remain in the respite home instead of returning to their care. Blair County reviewed the home study of the respite home and decided the home "was not a good fit". It is unknown what concerns the agency supervisor had regarding

the home study but the supervisor asked that the children be returned to the original home. The foster home continued to request removal of the children. On July 27 a home was found to move the children to, however on July 30 the family requested removal as well as they realized they did not have enough room in their vehicle for all the car seats that were required to transport the children. The foster father also felt "uncomfortable" regarding hygiene of the young girl. The children were moved to yet another foster home on July 30, 2012. The children remained there until October 12, 2012 when the maternal grandmother was given custody of the children. [redacted] Prior to this, the children had begun visits with the grandmother, who was also participating in reunification services with the mother.

The mother was [redacted] in September 2012. This involved parenting instruction, supervision of visits and work on identifying "safe people" to have as supports. The mother was educated on the signs of domestic violence and was recommended several times to attend [redacted] to empower herself in this area. She never completed the [redacted] due to provider conflicts and work schedules.

During the course of agency involvement, the mother's boyfriend, [redacted] became more involved in the reunification services. There were never any concerns identified regarding the paramour and in fact it was recorded that he showed positive influence and attachment to the mother and the children. As mentioned above, the children were sent to live with their maternal grandmother in October 2012. On November 8, 2012 the grandmother reported to service providers that she was feeling overwhelmed with the children, specifically with the subject child's behavior. Then, on November 24, 2012 the grandmother dropped the children off for an overnight visit and told the mother she could keep them for the entire weekend. This was not previously approved by the county and the mother reported it to her service provider. The children were sent back to the grandmother November 26. During a conversation with grandmother, it was reported she was using physical discipline with the 3 year old as he was displaying difficult behaviors. The service provider offered some support to the grandmother and suggested she seek out guidance from [redacted] in managing the stress. On December 1, 2012, the children were again taken to their mother's home by the grandmother and left there after the grandmother reported she had to respond to an ill relative. The mother again called the service provider to report the issue. The county decided to allow the children to remain with the mother on an "extended home visit" because [redacted] was in a few weeks. During this time, only one documented visit is recorded with the mother, which occurs on December 2 by the service provider. On December 12, 2012 [redacted]. The county's only documented visit to the mother's home during the "extended home visit" and "unexpected return home" was on December 20. Between December 20 and February 19, only one visit was documented by the county. This occurred on February 19, 2013. The service provider completed one visit in January. The provider reported things were going relatively well for the children in the mother's care. [redacted] and the mother reported the children were doing well. She stated that the 3 year old is now potty trained and she will be moving with her boyfriend and the children to Oil City, Venango County. The mother gave the address of the family's new residence. [redacted]. Blair County made a referral on March 28, 2013. Venango County considered it a low risk referral

and placed a five day response on the report. The near fatality report was subsequently received on March 29, 2013.

BLAIR COU NTY [redacted]

August 2012:

There is documented history of [redacted] mother's paramour, being involved with the Blair County system in regards to his children. According to notes obtained during the Venango County investigation, Blair County had [redacted] after one of the children were found wandering around without supervision. The mother and another adult in the home had been passed out and the home was found to be deplorable. The children were placed in the care of their paternal grandparents at that time. It is believed this involved a transfer of custody to the grandparents and Blair did not maintain supervision of the case. Allegations in the case file were that the father, [redacted] used bath salts. The Blair County caseworker who provided the information to Venango County was not aware of why the children were returned to the father. This information was never documented in the Blair County case file pertaining to the subject child of this report.

Circumstances of Child Near Fatality and Related Case Activity:

On March 29, 2013 Venango County received the reported near fatality regarding the subject 3 year old child. Venango County immediately contacted Bedford County and Blair County to assess the involvement of each county with the family. History of past case involvement was documented and a safety plan was developed for both the mother's children and the mother's paramour's children who were reportedly living in the home at the time of the incident. The subject child's sibling went to the maternal grandmother's home, where she was planned to be for an extended visit prior to the incident. The sibling was examined and found to have no injuries. The paramour's two sons were sent to their paternal grandmother's home in [redacted] County. To the knowledge of this writer, the children remain in her care.

The subject child [redacted] from Children's Hospital on April 1, 2013 to the care of his maternal grandmother. The child, his sibling and the paramour's children were all interviewed in a forensic interview setting. The subject child was not cooperative in the interview. The other children all reported seeing the child hit with a belt. Both the mother and the paramour were said to have disciplined the child. The children could not give exact timelines of when they saw the paramour hit the child. The mother admitted to hitting the child during an interview and the paramour reported seeing the mother hit the child and reported that the discipline that day "went too far" by the mother. The mother was arrested and placed into [redacted] prison. She was charged with Endangering the Welfare of a Child, a Felony of the 3rd degree and Simple Assault, a Misdemeanor of the 1st degree. She posted bail on April 5, 2013. Conditions of her bail were that she was to have no contact with the victim or go within 1000 feet of the victim's residence. The mother pled guilty in August and was sentenced to confinement and probation. The [redacted] on the mother for physical abuse based on the injuries to the child, the child's statements and the mother's admission. The report regarding [redacted] was unfounded. The dehydration could not be associated with any intentional [redacted] and

was likely a result of the flu the child reportedly suffered from days prior. The report [redacted] on the paramour for allegations of physical abuse was unfounded based on the county's inability to attribute the current injuries to an exact time that the paramour may have hit the child.

Current Case Status:

Venango County had identified concerns with the maternal grandmother's emotional capacity to care for the children based on previous involvement with the family in Blair County, as well as the initial referral made to Bedford County. [redacted] The agency sent a referral to Bedford County to request an assessment of need for case monitoring; however after the intake assessment the case was closed in Bedford. The grandmother had begun custody proceedings regarding the children in that county. To this writer's knowledge, the case is not currently open with any of the county agencies. The mother was [redacted] with Venango County based on the plan to reunify the children, [redacted] The paramour's children were still in the care of the paternal grandmother in [redacted] County.

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

- Strengths: The local team did not identify any strengths.

- Deficiencies: The local team did not identify any deficiencies that were not covered in the recommendations below.

- Recommendations for Change at the Local Level: The following list are recommendations based on the activity provided prior to the near fatality:
    - Additional home visits should be made when children are returned home, especially when returned home unexpectedly. These home visits should be completed by Children and Youth Caseworkers. When age appropriate, the caseworker should speak to children alone during home visits.
    - Children should only be returned home when the caregiver and the children are ready. It appears these children were returned home because their maternal grandmother was overwhelmed and not because the mother was ready to care for them.
    - Blair County CYS pursue a parenting assessment tool. The original referral to Venango County CYS indicated that the mother had "good parenting skills", in hindsight, this was clearly not accurate.
    - Blair County appeared to place a significant amount of "safety assurance" on service providers. It is recommended that caseworkers make decisions based upon their observations and assessments and use service providers reports to

guide a thorough and structured home visit. Recommendations of the service providers should supplement the caseworker's decisions.

- Background checks, to include local county CYS involvement, on all paramours and household members over the age of 14.
- Blair County establish an internal policy regarding the termination of dependency and when a family relocates to another county. It is recommended that a referral be made within three days.

- Recommendations for Change at the State Level: No recommendations at the state level were included in the county report.

Department Review of County Internal Report:

The Department received the County Internal Report via email on August 9, 2013. The Department would concur with all of the above recommendations given by the review team.

Department of Public Welfare Findings:

- County Strengths: The Department identified strength in the collaboration between counties, law enforcement and medical facilities during the investigation regarding the near fatality. Venango County made collaborative contact with Bedford and Blair Counties to determine a more detailed history of the case prior to Venango County's involvement. Additionally, Venango County requested assistance from Allegheny County to ensure safety and see the child as a courtesy; Allegheny County did not hesitate to assist. The Venango County case record reflected that the county worked closely with both Bedford and Children's Hospital in obtaining updates and records which correlated with the investigation. Local law enforcement and Venango County worked closely to update each entity with evolving details surrounding interviews, disclosures and new evidence.

- County Weaknesses: The Department identified several areas of weakness regarding the previous case involvement involving Blair County.
  - Once the case was accepted for services on June 20, 2012, the assigned caseworker made only the following documented visits with the mother until the children were reunited: June 23, [redacted], August 17 [redacted] following a supervised visit and November 26 when the grandmother refused to pick the children up after an overnight visit. The assigned caseworker never supervised a visit and only had one documented placement visit with the children. The supervised visits were supervised by at least three separate people, none of who was the assigned worker. The children's safety in their placement setting was solely reliant upon the provider agency.
  - The children [redacted] on June 24 (early morning hours) and placed in an emergency foster home. After only 2 days the foster parents were asking to respite the children since the foster parents leave the state weekly to visit family. The foster home where the children were placed requested that the children

simply remain in the respite home and to not return to the original foster home for this reason. This information was never provided [redacted] and could have prevented a significant number of moves if the question was asked of the foster parents regarding their ability to keep the children longer term. It does not seem that enough information was provided to or requested from the foster parents to determine appropriateness of placement. Ultimately the children were moved five times during the June 24-October 15 placement period.

- The maternal grandmother inquired to be a resource in early July; only about two weeks after the children were removed from their parents. The agency made the first visit to the grandmother's home on August 17. The home evaluation of the grandmother did not include a formal home study and the children were simply placed [redacted] in October. [redacted] after the children had some visits at the grandmother's home.
- On December 1 the grandmother transported the children to the mother's home without prior approval from the County and left the children in the care of the mother. Although no concerns were noted by the *service provider* who made a visit to the mother's home, this was an unexpected change in the safety plan for the children. [redacted] The County showed no documented visit to the mother's home to see the mother and assess the children's safety until December 20.
- After the unexpected return home and the visit on December 20, the County's next documented visit was not until February 19. The service provider made one visit in the month of January. This amount of visitation and monitoring does not appear to meet satisfactory levels when dealing with an unexpected return home.
- Of all the visits that were completed with the children during the placement episode, the children were only seen one time in a placement setting by the caseworker.
- [redacted] the case be referred to Venango County on March 13, 2013 however it took until March 28 for a referral to be made.

- Statutory and Regulatory Areas of Non-Compliance:
  At this point no LIS has been issued; the findings of this report will be shared with the OCYF Central Region office for that offices consideration.

Department of Public Welfare Recommendations:

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

- A formal home study of the grandmother's home may have given the agency better insight into the grandmother's emotional capabilities to handle the placement of the children and might have identified areas of need to assist the grandmother, possibly preventing the unexpected return to the mother.

- The mother began services with a reunification provider in September. Once this service began, most face to face contact with the mother was made solely through the service provider or by other persons supervising the visitation between the mother and the children. The assigned caseworker had very little face to face interaction with the mother. To better assess and identify progress and concerns, it would be recommended that the agency establish policies to ensure that at least monthly face to face contact is accomplished between the caseworker and the parent/caregiver.
- Additionally, at least monthly contact with the children should be established to better gather information regarding their safety, history and needs. Continued assessment of cases must continue even within the ongoing departments. Interviews with children should be occurring regularly as a part of these assessments.
- Improved communication between county and provider personnel at the time of placement would allow for a better exchange of information. Adequate questioning and information sharing could lead to better placement matching and less placement moves.
- Following reunification with a parent after an extended placement episode, regular visits should be made by the county caseworker to monitor and assess transition back into the home. This is especially necessary when the return is unexpected.
- [redacted] due to a family relocating to another county, the Department recommends referrals be made to the new county within appropriate time frames. [redacted] on March 13, the county did not make a referral to Venango until March 28. That time lapse was not acceptable.
- Blair County had an extensive history with the mother's paramour's children. This information was never documented nor did appear to be known by the active caseworker or the service providers involved with the mother's case. Although criminal clearances were run, no history within the county agency was ever documented. It should be common practice to search out all members of a household when a family is active in a county agency. This includes an internal search related to previous or current county agency involvement.