pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/29/13
Date of Incident: 06/01/13-06/02/13
Date of Oral Report: 06/02/13

FAMILY NOT KNOWN TO:

Washington County Children and Youth Services

REPORT FINALIZED ON:
11/14/2014

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))

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. Washington County Children and Youth Services has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]94
	Father	[redacted]93
	Paternal grandmother	[redacted]64
	Paternal grandfather	[redacted]64
	Paternal uncle	[redacted]03
	Victim child	01/29/13

Notification of Child Near Fatality:

On 06/02/13, Washington County Children and Youth Services (CYS) received the report that the victim child came to the [redacted] emergency room (ER) for a head injury. The mother stated that on 06/01/13 she was out of the home and the father was in the shower. The father placed the child in a bouncy exerciser outside of the shower. The father heard crying, got out of the shower and consoled the child. The child settled down. Approximately two hours later the parents and child were with other family members who noticed that there was swelling to the right side of the child's scalp. The parents said that they observed the child for the rest of the day and the child seemed stable. On 06/02/13, an aunt, who is also a nurse, saw the injury and told the parents to take the child to the Emergency Room (ER). The child was diagnosed with a [redacted] and was to be transported to [redacted] for further treatment. [redacted] was the physician who certified the incident as a near fatality.

Summary of DPW Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current records pertaining to the [redacted] family. Follow up interviews were conducted with the

caseworker, [redacted] on 01/24/14 and 01/27/14. The regional office also participated in the County Internal Fatality Review Team meetings on 06/25/13 where medical records were reviewed and medical opinions related to the nature of child's injury was discussed.

Children and Youth Involvement prior to Incident:

Washington County CYS had no prior involvement with this family before the near fatality report of 06/02/13, nor was there any information to indicate that the family had involvement with other counties within the preceding 16-months.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/02/13, the victim child was transported by his parents to [redacted] ER due to noticing a tennis ball sized lump to the right temporal area of his head. The lump was mushy to the touch and bruising was starting to develop. While in the ER, the parents fed the child a bottle, which he immediately vomited. Based on his condition, [redacted] from [redacted] had the child life-flighted to [redacted] for further examination and testing. [redacted] also certified that the child was in serious condition due to possible abuse and neglect. [redacted] from [redacted] reported that the child had sustained a [redacted]

The mother reported that she had left the family residence around 9:00 am on 06/02/13 to go to work. When she had left, the child was alert and playful. The father reported that he was the only caretaker for the child on 06/02/13. He initially reported that he had placed the child into an exercise saucer while he took a shower. While in the shower he heard the child cry and the father jumped out the shower to comfort the child. He had theorized that the child must have hit his head off one of the toys attached to the exercise saucer. When the father was confronted by hospital staff and told that the injury sustained was due to a forceful event, he changed his account of events. He then explained that he had placed the child in the middle of his bed with pillows propped around him while he was in the shower. The father; however, still denied that the child had rolled off the bed. [redacted] from [redacted] reported that the child's injury was accidental in nature. However, [redacted] from [redacted] was the physician who certified the incident as a near fatality. The child was expected to make a full recovery. On 06/05/23, the child was discharged from [redacted] to the home of his parents and paternal grandparents with a comprehensive safety plan in place. The paternal grandmother was the primary person responsible for supervising the child. The family had extraordinary support from multiple family members who met with the Washington County CYS worker at the home on 06/05/13. The family members indicated their willingness to assist with supervision and transportation of the parents and the child as needed.

A referral was made to [redacted] on 06/06/13 for the child's parents to receive in-home parenting education. Both parents work and the mother attends school. The family had been very cooperative and willing to participate in services. On 08/31/13, the safety plan was lifted. There was no Juvenile Court involvement and the child was not removed from his parent's care.

Washington County unfounded their child abuse investigation on 07/31/13 as medical evidence could not definitively prove that the injury was inflicted or indicative of child abuse.

Current Case Status:

The family was opened for on-going general protective services on 07/31/13 due to continued concerns related to safe parenting practices.

The family was referred to [redacted] to work on improving the parent's parenting skills. They received the [redacted] service from [redacted] from 06/06/13 to 08/31/13, at which time their service was successfully completed. The parents of the victim child completed [redacted] at [redacted]. at which time they were recommended to participate in [redacted] through [redacted] The [redacted] were completed on 08/27/13 with no further services recommended at that time. Both parents submitted to a drug screen on 06/28/13 and both tested negative. Both parents completed [redacted] at [redacted] through [redacted] The father completed his assessment on 07/29/13 and he tested negative for drugs that date and no further services were recommended at that time. The mother completed her [redacted] on 07/08/13 and 07/11/13; she tested negative for drugs on 07/11/13 and no further services were recommended at that time. In search of answers for the child's injuries, Washington County CYS attempted to look at all possibilities including possible drug/alcohol issues. However, with the drug tests [redacted] the Agency was not able to identify any concerns related to drug/alcohol issues for the parents. A Family Service Plan was developed with the family on 08/15/13. The child had been seen at [redacted] and his pediatrician's office [redacted] He was seen for consultation at [redacted]. At his appointment on 06/19/13, it was identified that his lab work showed an [redacted] level that remained elevated and [redacted] recommended that he be seen by an [redacted] to make sure that there was not [redacted] It was reported to the Agency that the [redacted] and the recommendation was that he follow-up with [redacted] at the end of October 2013. An [redacted] test measures the amount of [redacted] The child was seen by an [redacted] He was also seen as a follow-up with [redacted] as well on 07/13/13. He was seen at his pediatrician's office on 08/23/13 for a well-child check, prior to Washington County CYS closing the case, with no concerns identified at that time. The family completed all identified goals. The mother, father and the child had extraordinary family support as well. The case was closed with Washington County CYS on 09/20/13.

The criminal investigation is still ongoing and the assigned investigator is [redacted] of the Pennsylvania State Police, Washington Barracks. The Trooper is attempting to re-interview the parents. At the time of the polygraph examination during the 2013 summer, the father did not pass a question related to knowledge of what occurred.

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

Washington County CYS submitted a County Near Fatality Report on January 27, 2014 when they were requested to do so by the Department's Representative. Until the Department's request the county agency was of the erroneous opinion, based on the physician [redacted] statement that the near fatality may have been the result of an accident, that the report had been decertified. The county agency has been informed that unless there is a definitive response from the Department that a report has been decertified county agencies are required to adhere to the requirements of Act 33 in fatality and near fatality cases; including submission a formal Near Fatality report.

Strengths:
None identified

Deficiencies:
None identified

Recommendations for Change at the Local Level:
None identified

Recommendations for Change at the State Level:
None identified

Department Review of County Internal Report:

Washington County CYS' internal report was essentially a summary of agency activity pertaining to the receipt of the near fatality report, the subsequent CPS investigation, and subsequent service provision to the family. It did not adhere to the requirements for internal reports outlined in Act 33. Agency staff have been advised of the need to adhere to those requirements and have indicated a willingness to do so for future reports.

Department of Public Welfare Findings:

County Strengths:

Washington County CYS responded appropriately to the near fatality report and implemented the essential safety plan and services to the child and family. The family was opened with Washington County CYS for supportive services and monitoring, and referrals to community social service agencies were made for the family.

County Weaknesses:

Washington County failed to submit the County's Near Fatality Report in a timely manner and the report did not adhere to guidelines provided in Act 33.

Statutory and Regulatory Areas of Non-Compliance:

As noted above the county's near fatality report was not submitted in a timely manner and did not adhere to an acceptable format.

Department of Public Welfare Recommendations:

The Department recommends that Washington County CYS follow through with the timely completion and submission of the County's Internal Fatality Reports for all Fatality/Near Fatalities received by the County to the Department of Public Welfare, Office of Children, Youth and Families.