



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



BORN: 7-28-12

DATE OF INCIDENT: 7-20-2013

Date of Oral Report: 7-20-13

**FAMILY WAS KNOWN TO:
POTTER AND MCKEAN COUNTY**

REPORT FINALIZED ON: 5/7/15

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

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	7-28-2012
[REDACTED]	Sibling, Sister	[REDACTED] 2011
[REDACTED]	Half-Brother	[REDACTED] 2007
[REDACTED]	Half-Brother	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1988
[REDACTED]	Father	[REDACTED] 1984

Notification of Child (Near) Fatality:

McKean County Children and Youth Services (MCCYS) received a call on July 20, 2013 [REDACTED] of a near fatality. The patient was at Charles Cole Memorial Hospital in [REDACTED] Pennsylvania. The patient was an 11 month old child who was brought to the Charles Cole Memorial Hospital Emergency Room because she was vomiting and lethargic.

The child was [REDACTED]

[REDACTED] The mother stated that she believed the injuries were due to child banging herself with toys and child's siblings playing too rough with the child. Dr. [REDACTED] from Charles Cole Memorial Hospital stated the injuries were inconsistent with the explanation given by the mother. The mother stated that she and her husband were the only caretakers for the child.

Dr. [REDACTED] Charles Cole Memorial Hospital, reported this was a case of serious abuse and neglect and determined that the child needed to be sent to Children's Hospital in Pittsburgh, Pennsylvania via medical helicopter.

MCCYS on-call caseworkers went to ██████████ Pennsylvania to meet with the ██████████ Detectives. The two MCCYS caseworkers and the two ██████████ Detectives went to the family's home. There were three other children that were not in the home, but were staying with their grandparents in ██████████ Pennsylvania. The County caseworkers saw the other three children and found no injuries on any of the children. As the MCCYS caseworkers drove the mother to Children's Hospital in Pittsburgh, the father drove himself to the ██████████ Detectives Office.

On July 21, 2013, all of the children were given skeletal exams and there were no concerns noted.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office obtained and reviewed the intake referral, contacts, and case records a week after the incident. Other information such as the criminal complaint, risk assessments, police interviews, ██████████ kinship home study requests, and medical records were also obtained in August 2013. Several phone calls were also made in order for the Department to be kept up to date with the case. Follow up interviews were also conducted with caseworkers, and supervisor. The County held the Multi-Disciplinary Team (MDT) Meeting on August 13, 2013.

Records were also obtained from Potter County Children and Youth Services (PCCYS) which contained a Family Service Plan (FSP), FSP review, supervisor log, closing safety risk assessment, closing caseworker summary, referral letter to McKean County Children and Youth Services and a closing letter to the family. Potter County Children and Youth Services had records dated from June 25, 2012 to February 8, 2013.

Children and Youth Involvement prior to Incident:

A referral was received on June 25, 2012 by Potter County Children and Youth Services (PCCYS) concerning the children's hygiene and a dirty house. ██████████ called in with concerns of ██████████ children living in dirty conditions. During this investigation, the PCCYS caseworker discovered that the mother's paramour had been convicted of shaking a baby and he had been incarcerated for this offense. The caseworker spoke with father about the events that caused his incarceration. He informed the caseworker that he was convicted of two counts of endangering the welfare of a child and simple assault. He claimed that he did not recall harming the child. He went on to report that he did not knowingly harm the child, but that he had, in a playful manner, thrown the child up in the air and would catch the child. The family was cooperative while they lived in Potter County and received caseworker services from PCCYS. The family moved to ██████████, McKean County and PCCYS sent McKean County Children and Youth Services a referral in February 2013.

MCCYS opened the family for services and had requested that the parents attend the ██████████ Also that

both parents would attend to their children's needs, especially their youngest daughter who was born premature and may require some special needs.

The family moved from Potter to McKean County in February 2013 and received services with [REDACTED]

[REDACTED]. They reported that was the last time they saw child which was at grandparent's home. They were in the house on July 18, 2013 to see the child's sister, but the family said the child was sick and she was in the bedroom.

The child had received services [REDACTED] prior to incident. She is developmentally delayed and had [REDACTED]. She was able to sit up and reach. She can grasp and transfer. She was not able to stand. She did not crawl, but was able to move by acting like an inchworm. She does not walk. [REDACTED]

The Family Service Plan (FSP) was very specific and stated that the parents would not physically abuse their children, including shaking, of infant, young children, and no throwing the children in the air or spanking. It also stated that the father was never to be a solo caregiver of any of the children; this was the mother's responsibility to ensure. Other services to the family were case management, case aide/parenting skills and the father was on Pennsylvania State Parole until September 2012. Both parents signed off on the initial FSP on August 24, 2012.

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

On July 20, 2013, MCCYS received a referral [REDACTED]. An 11 month old child was brought to the emergency room stating the child was vomiting and lethargic. On further examination from Dr. [REDACTED] Charles Cole Memorial Hospital, the child had bruising to her face, [REDACTED]. Dr. [REDACTED] concluded that this was a case of serious abuse and neglect and then had the child transferred by life flight to Children's Hospital of Pittsburgh.

On July 20, 2013, a [REDACTED] Trooper in [REDACTED] Pennsylvania was called to the Charles Cole Memorial Hospital to investigate an infant with multiple injuries. The Trooper spoke to the parents at the hospital. The father told the Trooper that the child had started vomiting on Wednesday. On Thursday she was okay and then on Friday she was vomiting again. On Saturday morning they took her to the hospital. The

father said he did not know the reason for the child's illness. The father did say that someone had stepped on the child in the first couple of weeks in March. The MCCYS caseworker stated she was told it happened in January. The father's sister's boyfriend had stepped on the baby while the baby was under a blanket. He said they had blankets piled up for the baby to sleep on and one to cover her and that is how she got stepped on. The father also stated that the child had fallen backwards and smacked her head and would hit herself on the arms and legs with her toys, so they took all the hard toys away from her. The mother said that the baby hit herself in the head with the toys and did not know about all the injuries.

One of the [REDACTED] Detectives met with the [REDACTED] Trooper to give him the official photos. The [REDACTED] Trooper said the stories the parents were saying did not match the injuries. The MCCYS caseworker said that the mother had a "flat affect" and that the mother did not cry. The father was very fidgety as the questions became more intense.

[REDACTED] Detective interrogated the father for 2 ½ hours before he arrested him on July 20, 2013 and he interviewed the mother for 1 ½ hours. The father was arraigned in front of a [REDACTED] Judge and was taken to the [REDACTED] Jail on \$75,000 bond.

On July 22, 2013, two [REDACTED] Detectives spoke with the father. The father admitted to spinning the baby around on the kitchen floor. He was using the kitchen floor as a slip'n slide and had put water on the floor to make it slippery. When he spun her around she hit her head on the floor. He said this happened two weeks prior to the emergency room visit. When questioned on the bruising on the arms and legs, the father admitted to squeezing the child's arms and legs in an effort to make her stop crying. The father's criminal record showed that he was convicted in 2005 for shaking another child and served 3 ½ years in prison.

The father went into more detail later admitting that he had dropped the baby on July 19, 2013 on top of her head as he stood up by the bed and said she fell out of his hands about 4 feet. He then admitted throwing the baby into her crib about 3 feet and bounced her head off of the side of the crib. He admitted that this all happened the week before the child's emergency room visit. He said he was frustrated due to the child crying.

On July 21, 2013, the biological father of the two boys received emergency custody of his sons via an Emergency Custody Court Order through Potter County. Potter County Children and Youth Services did the home safety check and ran the criminal record checks to make ensure the boy's father's home was safe. [REDACTED]

[REDACTED] The child's sister was placed in a foster home in [REDACTED] Pennsylvania, while the child remained at CHP. The three children were all given medical exams on July 21, 2013 at Charles Cole Memorial Hospital. The child's siblings had skeletal surveys with no concerns noted. The child's [REDACTED] [REDACTED] was born 24-25 weeks premature, but that did not have anything to do with any of the injuries.

The mother was charged the following Monday on July 29, 2013 with Endangering the Welfare of a Child. [REDACTED] The mother was pregnant at the time and was set to be released with bail conditions that she does not have any contact with any of the children. The MCCYS Supervisor asked the mother if she ever witnessed any violence by the father. She admitted that she was a couple of feet away when the child slipped out of the father's arms by the bed, but denied seeing it. The mother said she witnessed he father putting food in the child's mouth, putting her head back and rubbing her throat.

[REDACTED] Detective was given the cell phone used by the father and the mother. The cell phone was owned by the father's parents. There were pictures on the phone which showed the child prior to the incident. The father had text messaged his mother saying "we think [REDACTED] has a concussion from cracking her head on the floor." Pictures from July 15, 2013 on the cell phone showed the child had no injuries.

On July 23, 2013, MCCYS supervisor and caseworker went to Children's Hospital in Pittsburgh (CHP). The MCCYS caseworker took pictures of the child [REDACTED] [REDACTED] Dr. [REDACTED], from CHP, also submitted a summary of the medical report.

The agency did seek to find a foster home which could care for the child and her sister since the home in which child's sister was in would not be able to provide the needed medical attention that the child would need once discharged from the hospital. The paternal grandparents wanted to provide care for both children, however, there were concerns as that is where the child got stepped on under the blanket and there were many people in the home.

[REDACTED] There is a possibility that she may never walk, feed herself or talk. The child [REDACTED] [REDACTED] and was placed in a foster home which can accommodate a medically fragile child. They were trained on how to care for the child's medical needs and have extensive experience with these types of children.

The CY-48 was completed on September 9, 2013 and both parents were indicated. The mother was indicated by omission for failing to provide adequate medical care for the child. The father was indicated for physical abuse due to medical evidence showing the child is a victim of shaken baby and has multiple injuries as a result of physical abuse determined through the Child Protective Services (CPS) investigation.

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

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- County Strengths:
- MCCYS conducted a timely MDT on 8/13/13. Several people were able to attend the meeting and provide their input about the case. Dr. [REDACTED] from Children's Hospital of Pittsburgh was able to participate by phone and provided her conclusions on why she felt this was a case of shaking baby syndrome. [REDACTED] The County immediately responded to the safety of the other children in the home and medically assessed each child the day after the incident was reported. The County was able to reach the father of the boys [REDACTED]
- The County developed an FSP plan that addressed the family and the medical needs of the child. Attempts were made to provide kinship placements for the children.

- Deficiencies:

There were no deficiencies noted in this report.

- Recommendations for Change at the Local Level:

There was no recommendation for change at the local level.

- Recommendations for Change at the State Level:

There was no recommendation for change at the local level.

Department Review of County Internal Report:

The review team did not have any recommendations for change for reducing the likelihood of future child fatalities and near fatalities directly related to this case. The family was known to PCCYS and MCCYS and information was properly exchanged. The family was properly assessed when they moved from Potter County to McKean County and the family was at the time properly caring for their children with services in their home.

The review team did recognize that collaboration of community agencies and service providers is essential when working as a team and addressing the needs of families. The Department agrees and also recognizes the importance that agencies and providers working together and communicating with each other as we continue to work with families.

Department of Public Welfare Findings:

- County Strengths:

MCCYS responded to the needs of the other children in the home [REDACTED] and were able to place them in an appropriate and safe home. The two boys were placed with their father in Potter County and the other sibling was placed in foster care in [REDACTED] Pennsylvania. The new born was placed in a kinship placement. PCCYS did the home safety check and ran the criminal record checks to make sure the boy's father's house was safe. The three children were sent for medical exams on 7/21/13 at Charles Cole Memorial Hospital. The child's siblings had a skeletal survey-no concerns were noted.

- County Weaknesses:

There were no weaknesses noted in the internal report.

- Statutory and Regulatory Areas of Non-Compliance:

There were no statutory or regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

- Overall, the agency routinely has good communication with medical professionals, service providers and law enforcement in investigations and cases such as this. This is one practice that should continue.
- In addition, matching a foster child's need with the strengths of a specific resource home should also continue, as it is in the best interest of the children that the agency serves.
- Family Finding should be continued as early possible in a case so that potential family members can be utilized as potential placement resources.