pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: November 8, 2011
Date of Near Fatality Incident: October 25, 2013
Date of Oral Report: October 26, 2013

FAMILY KNOWN TO:

Armstrong County Children and Youth Services

REPORT FINALIZED ON:

July 3, 2014

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. On November 20, 2013, Armstrong County 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] 1990
[redacted]	Mother's Paramour	[redacted] 1981
[redacted]	Child	November 11, 2011
[redacted]	Half Sibling	[redacted] 2009
[redacted]	Half Sibling	[redacted] 2010

Notification of Child Near Fatality:

Armstrong County Children and Youth Services (ACCYS) received a phone call from the [redacted], reporting that a two year old little girl had been taken to Armstrong County Memorial Hospital with multiple contusions on October 26, 2013. The same day, ACCYS received a Child Protective Services (CPS) report regarding the near fatality of the child. The date of the actual incident was October 25, 2013. The initial report stated that the victim child was getting life flighted to Children's Hospital of Pittsburgh (CHP). The child presented to the emergency room because she was not "acting right". There were hand prints on the child's entire head, upper chest and arms. The emergency room physician at Armstrong County Memorial Hospital certified that the child was in critical condition as a result of suspected child abuse or neglect.

The child was with her mother and the mother's boyfriend on the evening of October 25, 2013. [redacted], along with the [redacted] Police Department, were already interviewing the alleged perpetrator. It was also reported that there were two other young children in the home at the time of the incident and the [redacted] were in the process of taking protective custody of them. [redacted], the criteria had been met for the case to be processed as a near fatality.

Summary of DPW Child Near Fatality Review Activities:

The Western Regional Office of Children, Youth, and Families (Department) reviewed all current and past records pertaining to the [redacted] family. In addition, the regional representative made numerous contacts with the ACCYS supervisor and caseworkers, (intake and ongoing) regarding the ongoing activities on the case. ACCYS held their Act 33 Team Meeting on November 20, 2013. The Department was represented at this meeting.

Children and Youth Involvement prior to Incident:

ACCYS had two prior involvements with this family. On December 30, 2011, ACCYS had received a General Protective Services (GPS) report that alleged that the child was eating poorly and had diaper rash. ACCYS conducted an investigation into the allegations and determined that the concerns had been remedied and closed the case on January 30, 2012.

On March 1, 2013, ACCYS received a second GPS referral indicating that the child's half-brother needed medical care for his [redacted], and that the child's half-sister needed medical treatment for her [redacted]. The agency closed the case on March 22, 2013 due to the situation being remedied.

Circumstances of Child Near Fatality and Related Case Activity:

On October 26, 2013, the child was taken to the [redacted] by her maternal grandmother, the maternal grandmother's paramour and the mother. The child had sustained a [redacted] 50% of her face had been bruised, and she had [redacted] neck bruising. In addition, her gum line had been bruised and was covered in dried blood. She also had bruising to her chest and back.

The physicians in the [redacted] at Armstrong County Memorial Hospital immediately notified the [redacted] and the [redacted] Police Department to the injuries the child had sustained.

The mother reported that the child had two separate incidents with her paramour within the last few days while she had been at work. The mother reported that, on one occasion, the mother's paramour had reported that the child had eaten approximately five cigarette butts and the he had to perform the Heimlich on the child causing bruising to her chest and back. During another incident, the mother's paramour had claimed that the child was in the bathtub with her half-brother, who allegedly was able to sit on the child's head underwater resulting in the mother's paramour having to perform CPR on the child; hence, causing additional bruises to the child.

The child was life-flighted to Children's Hospital in Pittsburgh due to the extent of her injuries. She received [redacted]

The maternal grandmother flew with the child to Children's Hospital of Pittsburgh due to the mother staying back to ensure the safety of her two children, whose father is the mother's paramour. The mother located her children at their paternal grandmother's home. The mother agreed that she would not allow any of her children to have access to the mother's paramour.

During the mother's paramour's interview with the [redacted] and [redacted] Police Department, he reported that the child had bitten the mother and the mother threw an entire box of toys over the child. This information led ACCYS to modify their safety plan so that the mother was no longer allowed unsupervised contact with her children. The MGM agreed to care for the two half siblings to the child while the investigation continued.

The mother's paramour reported to the [redacted] and [redacted] Police Department that he had to perform the Heimlich and CPR on the child in two separate incidents within the last week which resulted in bruising to the child.

Due to the mother being aware of injuries to her child and not seeking medical care for her, on October 28, 2013, ACCYS had the mother added to the CPS report as an alleged perpetrator by omission.

While the child was at [redacted] receiving medical care, the mother attempted to have her two other children placed back into her care. [redacted] The children remained in the MGM's home.

On November 4, 2013, the child was released from [redacted]. She was released and placed into the MGM's home with her two siblings. It was recommended that the child continue to receive follow-up medical care at [redacted] and that she be referred for [redacted] which did occur.

On November 12, 2013, after the mother's paramour had met with the [redacted] and the [redacted] Police Department for an additional interview, he was arrested and taken to the [redacted] County Jail pending a Preliminary Hearing. He did not report any abusive action. He was charged with Aggravated Assault, Endangering the Welfare of a Child, Simple Assault and Recklessly Endangering Another. The mother was also charged with Endangering the Welfare of a Child. As of the writing of this report, both are still waiting for their hearings.

During a transport to a visit with the mother, the child's half-sister reported that the mother's paramour had stepped on the child's stomach and choked her because she had vomited on his bed. She also disclosed that the child had been misbehaving and the mother's paramour stuffed cigarette butts down the child's throat. In another situation, the child was told to stand in the corner but kept falling down because she was hurt which

angered the mother's paramour. Both children reported that the mother's paramour, who is their biological father, would lock them in a room when he disciplined the child.

Current Case Status:

All three children [redacted]. They are all placed into the same foster home. The MGM was no longer able to meet the needs of all three young children due to her and her paramour working full time jobs.

Through the use of Family Finding, ACCYS was able to locate the child's biological father. He has expressed interest in caring for his child long term. The child's biological father has been referred for a [redacted] with his child. The mother is also being considered as a placement option for the child as well as her other two children. She is currently receiving parenting services and receives her supervised visits with all three of her children [redacted]. The mother was also referred for a [redacted]

Both the mother and her paramour were indicated for physical abuse – paramour by commission and mother by omission. [redacted]

The mother and the mother's paramour's criminal hearings are still pending. The mother's paramour still remains in the [redacted] County Jail.

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

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. On November 20, 2013, Armstrong County convened a review team in accordance with Act 33 of 2008 related to this report.

- Strengths:

  The county identified that the Act 33 team members praised the cooperation between local and state law enforcement, combined with ACCYS intervention, which enabled a positive resolution of the case.

- Deficiencies:

  The Act 33 team did not identify any deficiencies in complying with statutes, regulations, and services to children and families in regards to the processing of the present and past referrals for this case.

- Recommendations for Change at the Local Level:

  No recommendations for change at the local level were identified by the Act 33 team.

- Recommendations for Change at the State Level:

  No recommendations for change at the local level were identified by the Act 33 team.

Department Review of County Internal Report:

The county submitted its internal report to the region on January 16, 2014. The region is in agreement with the county's overall findings and communicated that to both the intake supervisor and county director who finalized the report. The county report was detailed and comprehensive in its overall review of the near fatality and any prior involvement with the family. They also identified the timeline of events that occurred when they became aware of the incident. They provided a thorough description of caseworker and supervisory activity from the beginning to when the report was submitted to the region.

Department of Public Welfare Findings:

- County Strengths:

  Details of what had occurred from when they became aware of the incident to when the report was submitted to the region.

- County Weaknesses:

  None noted

- Statutory and Regulatory Areas of Non-Compliance:

  There were no areas of non-compliance identified as a result of this review.

Department of Public Welfare Recommendations:

The Department has no recommendations at this time.