



REPORT ON THE NEAR FATALITY OF:



BORN: 03/15/2007

DATE OF NEAR FATALITY: 07/03/2010

FAMILY KNOWN TO:

**Erie County Office of Children and Youth
154 West Ninth Street
Erie, Pennsylvania 16501-1303**

REPORT FINALIZED ON 12/17/2010

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 by [REDACTED]. 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. Erie 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]	Victim Child	03/15/2007
[REDACTED]	Biological Mother	[REDACTED]/1988
[REDACTED]**	Biological Father	[REDACTED]/1983
[REDACTED]	Mother's Paramour [REDACTED]	[REDACTED]/1988

** - Not a household member

NOTIFICATION OF CHILD NEAR FATALITY:

The Erie County Office of Children and Youth (OCY) became aware of this near fatality on July 3, 2010 via a phone call from the [REDACTED], as the police were requesting a caseworker to meet them at the police station for "a three year old that has died." After receiving this information, a staff member of [REDACTED] called OCY to advise them that the child was currently at their facility and had not passed away as of the time of her call. According to [REDACTED] staff, the child was going to be flown via medical helicopter to Children's Hospital in Pittsburgh for further treatment. The caller advised OCY that the child was [REDACTED] and "has bruising to her entire body, swelling and bruising to both eyes, and has a [REDACTED] According to the [REDACTED] staff [REDACTED], the mother's paramour, brought the child to the Emergency Department (E.D.) as the mother, [REDACTED], was working. Subsequently the mother came to the Emergency Department to be with her child. [REDACTED] was asked about the injuries and he reported that the child was in the bathroom unsupervised at the time while he was washing dishes and he heard a "loud thump." [REDACTED] stated the child fell on her "lower back" and while he was dressing the child after her bath, she became unresponsive. The treating physicians at [REDACTED] did not believe the child's injuries were consistent with the paramour's story and contacted the authorities.

While there is no exact date of the injuries to this child, [REDACTED] reported observing bruising to the child on Thursday, July 1, 2010. When [REDACTED] questioned [REDACTED] about the bruises, he told her that the child sustained them "playing football with some neighborhood boys." [REDACTED]

█ did not seek medical treatment for her daughter at this time, as the child appeared to be fine.

█ was transferred to Children's Hospital of Pittsburgh. Staff from CHOP also contacted OCY with information about their concerns about the nature of the child's injuries. According to the physicians at Children's Hospital, the child may have an █, however, they were unable to verify by CT scan due to the child's current condition and her need for immediate █ to relieve the █. At the time of this call, Children's Hospital staff did not expect █ to survive.

Documents Reviewed and Individuals Interviewed:

As part of the review of this near fatality, the regional office reviewed the family's entire OCY file, including a recent prior █ investigation. In addition to the file review, interviews were conducted with the Caseworker █, the Casework Supervisor █, and █, Administrator of Intake Services on July 6, 2010. The regional office also participated in Erie County's Internal Fatality Review Team meetings that were held on August 26 and September 10, 2010. Although there were no medical records regarding the child's most recent injuries, medical records from the recent █ investigation were available and reviewed during the September 10th meeting.

CASE CHRONOLOGY

Previous CYS Involvement:

Erie County OCY had an open Intake assessment at the time of this near fatality. OCY received a █ report on June 1, 2010, with █ as the alleged victim and █ a.k.a. "█", as the █. The source for this report was listed as █. Documentation provided by the Erie Police shows they had knowledge of █ related to the child on May 31, 2010 but did not call OCY. The following information is in sequential order, starting with police involvement, which was prior to the █ report by █.

May 31, 2010

According to the documentation for this █ investigation, █, █ went to the Erie City Police Department at 20:00 hrs (8:00 PM) and reported that █ had been hit on the left side of her face by █ new boyfriend, only known as █. The police report, which was faxed to OCY at 9:54 PM that same night, states █ believed █ was struck by █ causing her to sustain a █. Although the report states that the grandfather was babysitting the child and was not going to take the child back to the mother, the officer does not indicate whether he actually observed the child. *(However, the caseworker's contact summary from a contact with paternal grandfather later in OCY's investigation confirms the child was taken to the police department.)*

June 1, 2010

At 1:00 PM, █ contacted OCY and stated he wanted to "press charges against mother's boyfriend who hit his daughter in the face █ informed the OCY Call Screener █ that his father, █ contacted the police and they

advised him to contact OCY. Upon learning this information, the Caseworker located the fax from the Erie Police. [REDACTED] confirmed that the report indicated [REDACTED] had a "red mark on her cheek from [REDACTED] hitting her." Caseworker [REDACTED] was assigned the intake for further assessment.

At 4:40 PM, Caseworker [REDACTED] made an unannounced home visit to the mother's residence and spoke with [REDACTED]. He reported that [REDACTED] was working. [REDACTED] said that this was only the second time he had been babysitting [REDACTED] and denied hitting her. He reported that she has "temper tantrums" and she "jumped off the couch and fell onto one of her toys, cutting her lip and hurting her face." He said that after this happened; he contacted [REDACTED] who advised him to call the paternal grandmother to see if she could take [REDACTED]. He reported that he and [REDACTED] father have a "long history of disliking one another" that dates back to when they both lived in Iraq (both are Iraqi immigrants).

At 6:30 PM (as indicated in the contact summary), [REDACTED] contacted OCY and advised them that [REDACTED] father brought her to the E.D. as a result of her alleged assault by [REDACTED]. The reporting source told the Caseworker that according to the father, OCY told him to take [REDACTED] to the E.D. Caseworker [REDACTED] responded to the E.D. and saw the child and her father and also photographed the injuries. [REDACTED] attempted to interview the child about the injury; however, [REDACTED] would not speak to the worker. [REDACTED] father reported that he was going to keep her with him, as he did not feel she was safe with [REDACTED] and [REDACTED].

[REDACTED] also spoke with the nurse practitioner that treated the child. Her contact summary states that the nurse practitioner reported [REDACTED] had "facial contusions." Although the nurse was unable to say exactly how the contusions happened, the contact summary states the nurse felt they were "consistent with a slap." Since father had physical custody of the child and he reported he was not going to return her to her mother, the child was deemed "Safe."

[REDACTED] later reported suspected [REDACTED] to [REDACTED], who provided the investigation number to Caseworker [REDACTED] at 7:55 PM.

June 2, 2010

On this day the assigned caseworker, [REDACTED], contacted [REDACTED] mother, [REDACTED] via phone to discuss the allegations. [REDACTED] said that her daughter has "temper tantrums" and when the incident happened [REDACTED] called her and told her that [REDACTED] "had just thrown herself off the couch and landed on a toy and hurt her face." This was only the second time [REDACTED] had ever watched [REDACTED]. She did not believe that he would hit her child. [REDACTED] suggested he call the paternal grandmother to come get the child from him, which grandmother did. The mother reported that she had not seen the child or the extent of her injuries since the paternal grandmother picked her up.

June 3, 2010

Erie County OCY faxed a request to [REDACTED] for [REDACTED] medical records regarding her hospital visit on June 1st.

June 4, 2010

Supervisory review log states "child has a minor mark on her face. No disclosure, follow up necessary." Also states, "met [REDACTED] - child fell on toy." Box for risk box is checked "Low" but next to it is written "moderate for age."

June 7, 2010

[REDACTED] family contacted assigned caseworker [REDACTED] and reported that they did not want to keep [REDACTED] in their home any longer for fear "they might get into trouble if something bad were to happen while she was in their care" since they do not have custody of [REDACTED]

June 8, 2010

[REDACTED] attempted an unannounced home visit to the family residence, however they were not home. She did observe the family walking down the street and followed them for some distance to observe interactions / family dynamics. [REDACTED] described [REDACTED] as "playfully talking to her" as he pushed the stroller and [REDACTED] "was engaged with" him. The interactions between all were described as appropriate.

June 15, 2010

Supervisory review log says "follow-up" and also "young child age-mod." Safety continued to be assured, although no explanation as to how.

June 16, 2010

[REDACTED] made an unannounced home visit to the mother's residence. [REDACTED], and [REDACTED] were all present. [REDACTED] reported that father returned [REDACTED] to her care the week prior, as he allegedly did not want to care for her any longer. After discussion about the family situation, [REDACTED] asked [REDACTED] and [REDACTED] to show her what toy [REDACTED] had fallen on to cause the injury to her cheek. The caregivers took [REDACTED] into [REDACTED] bedroom and showed her a large, plastic kitchen set that had been located in the living room prior to them moving it into the bedroom. This is what [REDACTED] allegedly hit when she fell. The Caseworker documented in her contact summary that "The injury is consistent with what the boyfriend said occurred." (*This is the last contact summary in the file until the near-fatality report was received on July 3, 2010.*)

June 21, 2010

Supervisory review log says safety assured, "monitor." Also on this date, [REDACTED] submitted the [REDACTED]" and the narrative stated "The explanation given by the [REDACTED] was consistent with the injury" as the basis for the determination. The [REDACTED] was signed by Supervisor [REDACTED].

It should be noted that the agency had obtained the medical records from [REDACTED] treatment at the E.D. related to this investigation. The hospital date stamped their documents on June 15, 2010, as this appears to be the date they sent the records to OCY. Supervisor [REDACTED] confirmed that these records were in their possession prior to submitting the [REDACTED], although the agency did not date stamp the records when they received them.

June 22, 2010

██████████ sent a letter to ██████████ telling her she made a referral for services to the Erie Family Center for the "1-2-3-Magic Program" to assist her with parenting.

June 23, 2010

The referral to the Family Life Center made on this day. Under the "Notes" section, it states "Family being closed."

June 30, 2010

Supervisory review log says safety assured; previously identified needed activities of the worker still outstanding was checked "yes," and "follow up" is written. Nothing else is written. (There was no other dictation until the near death report on July 3, 2010.)

CIRCUMSTANCES OF CHILD (NEAR) FATALITY AND RELATED CASE ACTIVITY

The agency received the report of this near fatality at 6:04 PM on July 3, 2010. According to the case note, the Police were requesting a Caseworker meet them at the station for a "3 year old that had died." There was no other information at that time, however, Hamot Medical Center contacted the county as well and reported that the child was in the E.D. and was still alive, but had to be transferred to Children's Hospital in Pittsburgh via medical helicopter as a result of her injuries. ██████████ paramour brought the child to the E.D. The medical staff reported that the child was ██████████ and had "bruising to her entire body, swelling and bruising to both eyes and has a ██████████." Apparently, the mother's boyfriend reported to the hospital staff that the child fell, but the treating physicians report that while the injuries aren't consistent with his story; they are consistent with ██████████.

The on-call Caseworker ██████████ responded to Hamot Medical Center at 6:30 PM. Both of ██████████ parents were present at the hospital, as were two Erie City Police Detectives. Prior to the child leaving Hamot Medical Center for Children's Hospital Pittsburgh, Caseworker ██████████ was able to photograph most of the child's injuries, but was unable to photograph her back, as they were not able to turn the child over for medical reasons ██████████, the ██████████ ██████████, was arrested at the hospital for prior, outstanding charges. ██████████ was briefly interviewed at the hospital and would be interviewed at more length at the police station at a later time. ██████████ informed the Police and Caseworker that ██████████ had bruising on Thursday (July 1, 2010) but ██████████ told her that she got the bruises from "playing football with some neighborhood boys." ██████████ did not take ██████████ for medical treatment at that time because she appeared to be "fine."

██████████ father left Hamot Medical Center with his parents so that he could be with his daughter at Children's Hospital in Pittsburgh.

The police interviewed both ██████████ and her paramour, ██████████, separately. The Caseworker ██████████ participated in the interviews. ██████████ reported that she was at work when the incidents occurred. ██████████ claimed that the child had to be brought to the E.D. this day due to being injured by falling in the bathtub. At this time in the investigation, ██████████ was the main suspect for ██████████ injuries and the police were considering charging ██████████ as well.

Later in the evening at 8:09 PM, Children's Hospital of Pittsburgh (CHOP) contacted Caseworker ██████████ to update her on the child's status. The child had to have ██████████

██████████ and they reported that she may also have an ██████████ injury. They were unable to verify this ██████████ injury at the time of this call due to the severity of ██████████ injury.

At 11:30 PM, CHOP called once again to update the Caseworker on ██████████ condition. She was out of surgery and was in critical condition. According to CHOP, the child had to have ██████████ ██████████ to relieve the pressure and they did not believe she was going to survive. The treating physicians also confirmed the injuries to ██████████ were the result of ██████████.

On July 4, 2010 at 8:10 AM, the ██████████ from CHOP contacted the on-call worker (Caseworker ██████████ to inquire whether or not ██████████ was able to visit with her daughter. After speaking with a supervisor, Caseworker ██████████ gave CHOP the approval to permit mother to visit with ██████████.

A follow-up call from Dr. ██████████ from the Child Advocacy Center at CHOP was received by Caseworker ██████████ was providing further updates on ██████████ most importantly that she had to have ██████████. The physicians were unable to do much more for the child; however, they did lower her body temperature in an effort to reduce the swelling.

In phone conversations July 4, 2010 with ██████████ father, it was apparent to OCY staff that he did not understand the severity of ██████████ injuries and was very upset about the ██████████. He blamed ██████████ for causing the injuries and ██████████ for allowing it to happen.

Later in the afternoon of the 4th, the ██████████ from CHOP called again to advise OCY of ██████████ medical condition. Apparently ██████████. Both of ██████████ and if she were to survive her injuries, she is going to be blind, will not be able to function on her own, and will need 24-hour care.

On July 5, 2010, the hospital informed Erie Co. OCY that the child's pupils were fixed and dilated and as a result, they would more than likely begin the ██████████.

On July 6, 2010, OCYF Regional Office met with Erie Co. OCY staff, which included ██████████ (Intake Administrator), ██████████ (Intake Supervisor), and ██████████ (Intake Caseworker) to discuss the case, including the previous ██████████ investigation.

When reviewing the previous ██████████ investigation, the county provided the timelines of the interviews and the activities that led to their decision to ██████████ the report. Upon receiving this near fatality report, Erie OCY provided the Department with dictation from the first ██████████ investigation and included the case notes up to July 5th (the day prior to this meeting). There were two dictation entries that were discussed at length, specifically one dated June 1, 2010 in which the hospital reported the child had marks that were consistent with a slap and another from a home visit dated June 16, 2010. In the case note from the home visit, the worker documented that "The injury is consistent with what the boyfriend said occurred." ██████████ was asked about the discrepancy in her dictation (the medical evidence refuting the boyfriend's account) and why she didn't challenge the ██████████ on his statement. ██████████ provided no

explanation as to why this wasn't done. [REDACTED] stated she was still assessing the [REDACTED] concerns in the home at the time of the near fatality report.

In addition, the Caseworker was asked about the police's involvement in the investigation. [REDACTED] reported that she just received a call "last week" from Erie City P.D., who inquired what the agency did with the investigation. When they advised the police that they [REDACTED] the report, the worker said the officer responded by stating that as a result, they would not pursue charges. The agency staff was reminded that while a [REDACTED] investigation can be done jointly by the police and the agency, each can have the same or completely different outcomes. Apparently, the Erie City Police saw [REDACTED] on June 27, 2010 because the child wasn't returned to the mother on time and the child had bruises on her leg. The police advised the mother to take the child to the E.D. to have the child's leg examined if she had concerns. Hospital records obtained by the agency show that the mother did take the child to the E.D., however, left prior to [REDACTED] being seen.

As far as the child's current injuries, [REDACTED] said that on July 5, 2010, [REDACTED] admitted to the police that he beat [REDACTED] over a period of two days. Reportedly, [REDACTED] returned home from work on Thursday and observed bruises to [REDACTED], however, [REDACTED] provided her with the story about the child playing football. He has yet to specifically state what he did to [REDACTED] to cause the near fatal injuries; however, he claimed that he "really lost it."

For nearly two weeks following the assault, Children's Hospital of Pittsburgh was waiting to start the [REDACTED] on [REDACTED] due to the severity of her injuries. Eventually, [REDACTED] made enough progress that it was clear she was going to survive, but need constant care. The plan for this child was to be discharged to The Children's Institute, where she would receive further rehabilitation. The Children's Institute would also train any eventual foster parents/caregivers on how to care for [REDACTED]

The contact summaries from Erie Co. OCY show that as of August 19, 2010 [REDACTED] was still adamant that although her paramour was the only person with [REDACTED] prior to the assault, she has known him for "a very long time" and did not believe he caused the injuries because he is a "good person." As a result, the mother was denied visitation with [REDACTED] but was kept up to date on her medical condition. [REDACTED] father, was also restricted access due to his significant [REDACTED] and concerns for his emotional stability.

On August 26, 2010, Erie Co. OCY submitted a status determination of [REDACTED]" for the report dated July 3, 2010, naming [REDACTED] as [REDACTED] and the mother, [REDACTED], as a [REDACTED]

Current Case Status:

The agency continues to maintain custody of [REDACTED] based on a Court Order from September 2010. The child's current permanency goal is APPLA, however, neither biological parent was in agreement with the permanency plan and both refused to sign.

After having [REDACTED] gradually made enough progress to be released to an approved foster home on December 15, 2010 with foster parents that have been trained to care for her medical

needs. [REDACTED] paternal grandfather has been approved to be a kinship caregiver; however, OCY believes she is still too medically fragile for him to care for her at this time.

The [REDACTED] remains in jail. The county does not have any documentation explaining what exactly he did to her to cause the injuries.

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

The County conducted two team meetings, as is Erie's protocol. The first meeting held on August 26, 2010 was to discuss the child's involvement with the agency, both past and present. At the first meeting, team members signed a confidentiality agreement and were provided with a copy of the child's record for review before the next meeting. The final meeting took place on September 10, 2010. At this meeting, the actions of the county were reviewed in more detail and the areas below were discussed.

Strengths:

The strengths identified during the meeting were:

- All timelines were met with the initial intake in June
- [REDACTED] The caseworker made every effort to make contact with [REDACTED] to ensure [REDACTED] safety and well-being
- The caseworker followed the family while they walked and observed interaction (without the family's knowledge)
- The caseworker handled a difficult situation at father's home, as there were numerous people present that were upset and did not speak English
- The caseworker was aware and respectful of the cultural differences of the family
- The caseworker gathered the appropriate information for every member of the family

Deficiencies:

- The failure to review the hospital records in the initial report from June or disregard important information related to the child's injuries they provide.
- It is believed that when the case goes to trial, the media will place blame on OCY.

Recommendations for Change at the Local Level:

- Examine other counties' protocols regarding joint investigations of [REDACTED] (LEO/OCY) to improve communication between the two agencies
- The District Attorney needs to take a more proactive role in identifying each group's responsibilities and enlist the Mayor's help to obtain training for LEO in suspected [REDACTED] and communication with OCY. This should include education for both parties on each other's criteria for [REDACTED] and / or a criminal act.
- It may be helpful for written reports be provided to each agency from the other explaining rationale for their decision; also OCY may want to consider advising LEO whether they will remain involved with the family or close the case.
- More training on [REDACTED] for local hospital personnel; specifically:
 - Review protocols for local hospitals regarding examinations of children who may have been [REDACTED]
 - Hospitals must now report second-hand information; are they aware of this and doing their part?

- Offer one day trainings for medical personnel by utilizing a physician with an expertise in [REDACTED]
- Review the current CAC policy to see if a CY-104 is required for a forensic interview
- Review OCY's protocol on interviewing children for instances when an interview at home is not in the child's best interest or the best interest of the investigation

Recommendations for Change at the State Level:

There were no changes recommended at the state level.

Department Review of County Internal Report:

The document provided by Erie County OCY was a summary of the Team Meeting held on September 10, 2010. The Department received this document via e-mail on November 1, 2010. After reviewing the document, this writer responded to Erie OCY via e-mail advising them that the document provided did not contain a "Findings" section as required by the bulletin. The county revised their document and resubmitted the report on November 3, 2010.

Due to the format of the final report, it is difficult to explain with which areas of the report the Department agrees / disagrees. The "Strengths" and "Weaknesses" were partially accurate, but did not include all of the deficiencies. There is no in depth discussion of the county's performance related to their involvement with this family.

The county was made aware that their format did not include all of the sections required by the bulletin; however, their response was that the required information is present under different headings.

Department of Public Welfare Findings:

County Strengths:

When Erie County received the reports of suspected [REDACTED] on June 1 and July 3, 2010 the agency responded promptly and appropriately by making contact with the child at the hospital Emergency Department, photographing her injuries, and then making subsequent contacts with both parents and the [REDACTED]. The caseworkers' documentation related to the case activity was detailed and well written. As the child received medical treatment for both [REDACTED] reports, the agency obtained medical records for each visit. In addition to the medical records, the caseworker obtained the demographic information for the parents and all caregivers and obtained detailed background information / clearances on them to help in the safety assessment process.

The caseworker managed the family very well considering the language barrier she had to overcome. Her initial home visit to the father's residence involved the paternal grandparents and extended family members, many of whom did not speak English or were communicating with each other in their language of origin. The family was also upset at the possibility of [REDACTED] being abused and [REDACTED] was able to maintain her composure and assist the family in understanding what was involved in the investigation.

After completing the first [REDACTED] investigation on June 21, 2010, the caseworker referred the family for in-home services while she continued to assess the [REDACTED] concerns in the home.

As far as the [REDACTED] report received on July 3, 2010, again the agency responded promptly and initiated the investigation immediately. The caseworkers involved worked cooperatively with the Detectives that were investigating the criminal acts. The agency maintained constant contact with the medical professionals at Children's Hospital of Pittsburgh in order to have [REDACTED] latest condition and prognosis. The contacts with all of the medical professionals were well documented in the file and the agency obtained custody of [REDACTED] in an effort to further ensure her safety. Erie Co. OCY was able to identify and use a foster family that is willing to provide the necessary care for [REDACTED] while she is with them. OCY also researched at least two separate kinship caregiver scenarios and, at this point in time, plans on using kinship care as soon as [REDACTED] medical condition becomes more stable and manageable.

Erie Co. OCY completed Safety Assessments and plans for [REDACTED] however, there are some concerns in the quality of these assessments that is addressed in the next section.

County Weaknesses:

As far as the weaknesses observed during the agency's involvement with this child and family, the most serious concerns exist with the agency's investigation of the first [REDACTED] report made on June 1, 2010. These will also be identified sequentially. The weaknesses identified are not solely attributed to Erie Co. OCY, as they extend to local law enforcement's knowledge of [REDACTED] and OCY's procedure / mandates.

On May 31, 2010 a police officer from the Erie City Police spoke with [REDACTED] grandfather and according to a contact summary from OCY, the grandfather took [REDACTED] to the police station due to the bruise on her face at the hands of [REDACTED]. The grandfather identified [REDACTED] as the person that caused the bruise. The police officer advised the grandfather to contact OCY and then faxed a report to OCY at 9:54 PM. Although this police officer was required to make an immediate verbal report of [REDACTED] to [REDACTED] as a mandated reporter a call to OCY would have sufficed, as it would have resulted in a report being made. The officer did neither. It is likely he is unaware of his responsibilities or reporting procedure as a mandated reporter under the CPSL.

At 1:00 PM on June 1, 2010 [REDACTED] father contacted OCY regarding the assault. At the time of the father's call, the call screener was unaware of the fax sent by Erie City PD. The call screener located the fax after speaking with the father. Although the response time was appropriate and within regulatory compliance, it is possible that this fax may not have been seen that day and delayed investigation further.

The child was taken for medical treatment at [REDACTED] on June 1, 2010. Hamot then contacted OCY to report the [REDACTED]. In Section IV "Present Concerns," the call-taker documented that the "injury is consistent with a slap."

Although the sense of urgency and the county's timelines for the first report were appropriate, the county disregarded the findings, that "injury was consistent with a slap," of the medical professionals that treated [REDACTED] on June 1.

Statutory and Regulatory Areas of Non-Compliance:

After reviewing Erie County OCY's involvement with and investigation of this family, it is apparent that the agency was in violation of three regulations / statutes.

* **3490.55 (c): Safety Assessment** *(Related to Safety Assessment and Management Process)*

Although Erie County OCY completed an initial safety assessment on June 1st and then a subsequent assessment on June 4th when a new worker received the assignment, the agency failed to complete an assessment upon learning information that may affect the safety of the child. The father informed OCY on June 7th that he was returning [REDACTED] back to the mother's home where the [REDACTED] would have contact with her. The caseworker attempted to make face-to-face contact with the child and family on June 8th, however, only observed the family walking down the street away from their home. Although the worker followed them to observe their interactions, she did not make contact with the family to discuss the current situation and thoroughly assess [REDACTED] safety.

At this point of the investigation, and based on the information obtained as of June 8th, a safety assessment should have shown the child to be, at a minimum, "Safe with a comprehensive safety plan." The reporting source and medical staff confirmed that the marks appeared to be consistent with a slap which should have been included as a concern on the safety assessment worksheet. The protective capacities of the mother and paramour [REDACTED] were diminished, as the mother worked and would be leaving the child in the [REDACTED] care and the [REDACTED] was not forthcoming about how the injury occurred. It is unknown how the mother would have reacted to the information that her paramour slapped the child, as the caseworker never informed her of that evidence.

In addition, safety assessments were completed for the [REDACTED] investigation / near fatality received on July 3, 2010.

- The safety assessment dated July 3, 2010 is incomplete, and does not include a safety decision (although the child was inpatient at Children's Hospital).
- The safety assessment dated July 11, 2010 identifies five potential safety threats yet the box for Section III ("Are safety threats present?") is checked "No." Although there were five possible threats identified, there were no protective capacities explained in Section III to mitigate any of the possible threats.

Section IV (Safety Analysis) indicates that there are no caregivers able to adequately manage safety without the assistance of CYS, but also states that an in-home plan is not appropriate. If there is no one able to control the threats in the home, the agency must identify the child as "unsafe" and seek emergency custody of the child. The agency did not seek custody [REDACTED] until early August.

The safety decision in Section VI for the July 11th assessment was "Safe with a comprehensive safety plan." This is an appropriate decision; however, the county claimed that no threats were present in Section II. In addition, although a safety plan was required for this decision, one was not completed.

* **3490.61 (a): Supervisory Reviews**

The supervisory reviews were held on a regular basis and are documented in the record on the county's standard form as taking place on June 4th, 15th, 21st, and 30th. This supervisor log uses standard questions with check boxes and space to write an explanation. Very little is written in the subsequent reviews after the initial one on June 4th. There is no documentation of a discussion regarding the progress towards reaching a determination. It is in these supervisions where evidence for investigation should be discussed, if any other parties are investigating or need to be notified (i.e., police), what is the status of the police's involvement, and what services, if any, the family may need.

From the initial report on June 1, 2010, the agency was aware that the hospital staff felt the child's injuries were as a result of a slap and also that the Erie Police were aware of the incident and had or may have had contact with the child. A discussion about the police's involvement should have been held, as well as questions as to why the medical staff's version of the injury differed from the [REDACTED] and how to address the discrepancy. There is no documentation anywhere in the file that this took place between the supervisor and the caseworker. There is no indication that the worker was advised to contact the Erie Police to inquire if they were investigating the incident further.

* **3490.55 (g): Investigation of reports of suspected child abuse** *(related to medical records)*

To the county's credit, the caseworker promptly asked for the child's medical records related to her treatment at [REDACTED] on June 1, 2010 by faxing a request to [REDACTED] on June 3, 2010. [REDACTED] date-stamped that they honored the request for records on June 15, 2010. According to [REDACTED], Casework Supervisor, this information was obtained prior to the caseworker making a status determination of "[REDACTED]" on June 21, 2010.

Although this determination may have been appropriate for the [REDACTED] report dated June 1st (because the child's injury did not meet the CPSL definition of [REDACTED] the caseworker did not challenge the mother's paramour [REDACTED] regarding his version of how the injury occurred. The agency had verbal information provided to the call screener on June 1st and then written documentation in the child's medical record that the child had been slapped, yet did not confront [REDACTED] or bring this to his or [REDACTED] attention.

Medical documentation / consultation is important for determining whether a physical injury meets the criteria for [REDACTED]. In addition, it can also be critical in understanding how an injury occurred as well. A closer examination of the medical opinions / records from the initial [REDACTED] investigation should have had a significant impact on the safety assessment and safety decision for [REDACTED]. No explanation was provided as to why the worker did not confront the [REDACTED] and mother with the information refuting accidental injury.

Department of Public Welfare Recommendations:

There appears to be a fairly good system in place that ensures that reports of [REDACTED] [REDACTED] receive a prompt response to have a face-to-face contact with the alleged victim. In addition, collateral interviews were completed, background checks were completed on all involved parties, and medical / psychological records were also obtained. These practices should continue and will help further ensure the safety of children in Erie County.

After reviewing the county's format for documenting an internal review of the case, it is recommended that Erie Co. OCY revise their format so that it contains all required headings and necessary information as outlined in the Child Fatality/Near Fatality Bulletin.

The agency's process for conducting 10-day supervisory reviews should be reviewed, more specifically, what is discussed during the meeting and how it is documented. The current format does not lend to an understanding of what has transpired in a case to date. Should there be a need for a different supervisor / administrator to make a decision on case or investigation, this person should be able to understand not only what the current status of the case is, but why it is at that status. Critical questions regarding investigations need to be asked and answered during these times. More training for staff may be required to help them further understand the importance of these meetings.

There is a need for additional training and accountability related to the safety assessment process, as a critical assessment was not done, one was incomplete, and another was inconsistent in supporting the determination made. This is a critical process that has been heavily trained, heavily emphasized, and has many layers of support (both internally and externally). The errors were made by caseworkers and approved by supervisors.

Another area of concern is how the agency utilizes supportive documentation it receives related to an investigation, assessment, or case that has been accepted for service. In this instance, a caseworker disregarded the opinion of at least two medical professionals as to how the child's face was bruised. The information that is obtained by caseworkers must be shared with supervisors so that appropriate case decisions can be made.

Finally, there seems to be a need for more education in the community related to [REDACTED]. The most critical area at this time is related to law enforcement's understanding of their role in the child protective service system and how to improve the working relationship between OCY and law enforcement. As a mandated reporter, the initial officer was required to make a verbal report of [REDACTED], but rather faxed a report instead. It also appears as though OCY did not follow-up on the Erie Police's involvement with the child, as the grandfather reported to them initially on the night of May 31, 2010. Although both can have an independent outcome from each other, an investigation into the assault could have been done jointly. The child's injury could have met the criteria for simple assault and had a joint investigation been done, a more thorough look into the [REDACTED] care and potential threat to [REDACTED] may have taken place. However, neither the police nor OCY spoke with each other until the police called to inquire the status determination. Once he learned that OCY had [REDACTED] the report, the officer determined not to pursue the case criminally.

It would also be beneficial for the local hospitals to seek out medical experts in the field of [REDACTED] to help educate their staff on the possible signs of [REDACTED] and what to do if it is recognized. On at least two occasions, [REDACTED] was seen in local emergency departments for injuries such as [REDACTED] in May of 2009 and another in July of 2009 where she had an unexplained [REDACTED]. Although these injuries were not reported to OCY, they are both concerning, as one is an unexplained injury to the head of a then two year-old child and the other is an injury that can result when children are pulled up by their arm. While either of these

injuries alone may not be cause for concern, it may have been "best practice" for the hospital to report these injuries to OCY, as she had been seen twice in a three month period. Educating the hospital on when and how to report may help close some loopholes in reporting.

The previous two recommendations would also be beneficial for all counties in the state and the issues are not exclusive to Erie County. There have been prior attempts to facilitate these sessions by using "EPIC SCAN" presentations; but a more concerted effort to fulfill this need should be explored.