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REPORT ON THE NEAR FATALITY OF:



Date of Birth: November 11, 2008
Date of Near Fatality Incident: April 2, 2011

The family was known to
Crawford County Children & Youth Services

Date of Report: August 2, 2012

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.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	11/11/2008
[REDACTED]	Half Sibling	[REDACTED] 2005
[REDACTED]	Half Sibling	[REDACTED] /2010
[REDACTED]	Half Sibling	[REDACTED] 2010
	(Date of death – 01/27/2011)	
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	[REDACTED] Father*	[REDACTED] 1982
[REDACTED]	[REDACTED] Father*	[REDACTED] 1982
[REDACTED]	Mother's Boyfriend	[REDACTED] 1989
	(Father of [REDACTED])	

*Not a member of household

Notification of Child Near Fatality

The determination to certify [REDACTED] injuries as a near fatality was made on May 25, 2011 as a result of information obtained during the course of a CPS investigation of a report of suspected abuse which was originally made [REDACTED] on April 2, 2011. After reviewing medical records and consulting with [REDACTED] treating physician, Crawford County CYD determined that her injuries met the criteria of a near fatality and notified Childline of those findings. ChildLine then [REDACTED] the report as a near fatality on May 25, 2011

The April 2, 2011 report of suspected abuse was made by [REDACTED]

[REDACTED] The child's mother, [REDACTED], stated she was just learning to walk. The reporter went on to state that, according to the mother, the child had climbed up on a chair and fell off the side landing on her head. The child suffered a [REDACTED] which needed to be [REDACTED]. The treating physician believed that it was possible that this injury may have been the result of a non-accidental injury as he was

not comfortable with the story that the parents provided as to how the child sustained the injury. The Western Region Office of Children, Youth, and Families received the preliminary notification of the near death [REDACTED] on the same date. The notification confirmed that the child had suffered a [REDACTED] that may have possibly been the result of a non-accidental injury.

Summary of DPW Child Near Fatality Review Activities

The assigned Western Regional Office Program Representative reviewed the case file and had frequent contact with Crawford County CYC caseworkers and supervisors assigned to this case related to the child near fatality as well as subsequent activity with the family. The regional program representative also attended two Crawford County Multi-Disciplinary Team (MDT) meetings pertaining to the case on June 30, 2011 and September 5, 2011.

Summary of Services to Family

Circumstances of Child Near Fatality and Related Case Activity

On April 2, 2011, at approximately 8:44 a.m., Crawford County CYC received a [REDACTED] report regarding the victim child, [REDACTED], initiated by [REDACTED]. The child's mother reported that the child climbed onto a chair and fell off and landed on her head. Child had a [REDACTED] that needed to be [REDACTED]. The treating physician reported that this was a non-accidental injury. The physician also reported not being comfortable with the explanation of how the injury occurred. The report was numbered as a physical abuse due to a medical professional's concern that the injury may have been non-accidental. It was also reported [REDACTED] that the child, who was diagnosed with [REDACTED] and was just learning to walk. At the time of the report the household consisted of the mother, her boyfriend, the victim child and her two half siblings, [REDACTED].

After receiving the abuse report related to [REDACTED], the agency could not ensure the safety of her two siblings in the family home. Consequently the children were placed in a kinship home of the maternal grandmother on April 2, 2011. [REDACTED]

On May 25, 2011 a Near Fatality Report was generated on [REDACTED] as a result of the CPS investigation in conjunction with the findings of medical professionals from [REDACTED]. On May 26, 2011 a CY 48 was submitted identifying [REDACTED] as perpetrators of physical abuse. On June 7, 2011, the mother was charged by the Meadville City Police with simple assault, aggravated assault and endangering the welfare of a child. The mother's boyfriend was never

charged but was [REDACTED] [REDACTED] sustained her injury and could not be ruled out as a perpetrator. The [REDACTED] perpetrator status was changed from indicated to founded following [REDACTED] adjudication on criminal charges.

Children and Youth Involvement Prior to Incident

Overall there were three prior GPS referrals made to the county regarding the parent's abilities to care for their children's medical issues. The initial GPS referral to Crawford County CYC came in on August 7, 2009 when the family returned to Crawford County from Louisiana where they resided the preceding year. The family was eventually accepted for ongoing services on December 22, 2011 when allegations of parents not being able to care for all of their children were made. The referral emphasized concerns related to one child who was in the hospital but would require total care upon discharge from hospital. See below case chronology for specific details of the GPS referrals.

Case Chronology

On August 7, 2009 the family was referred to Crawford CYC by [REDACTED] reporting that [REDACTED] met the criteria for [REDACTED]. The child had [REDACTED] which would require [REDACTED] throughout her life. The reporting source believed the mother was doing better in caring for her children but had concerns about her ability to keep necessary follow up [REDACTED] appointments. Information obtained during the assessment revealed the family had relocated to Crawford County from Louisiana where they resided the past year. The report was eventually screened out because when the caseworker went to the address where the family had been residing, the child's grandmother reported the family relocated to Cleveland, Ohio with an aunt. A phone number for the aunt with whom the family was staying was obtained and contact confirming the family's move was made. Subsequently Crawford CYC made a referral to Cuyahoga County, Ohio CYC.

On July 29, 2010 an unidentified reporter made allegations that [REDACTED] had not had any medical care in over a year. According to the reporter the child was diagnosed with [REDACTED]. The case was assigned for an intake assessment. When contacted the mother admitted to being back living in Meadville for over a year. She reported the child had [REDACTED] in Cleveland, Ohio for [REDACTED]. The home conditions were observed to be poor, however, confirmation was obtained that two of mother's children were opened with [REDACTED]. This case was not accepted for services at this time as the caseworker, who conducted several home visits during the assessment process, believed the mother was very attentive and concerned for her children. Caseworker also reported that the child was seeing a [REDACTED] in addition to documenting that the family was working with [REDACTED]. The caseworker also documented that the mother was seeing [REDACTED] the child, which reported she was on the right path to obtaining the appropriate [REDACTED] care for her children. The service providers and reporting source had no further concerns regarding the child's care; therefore, the case was closed at the conclusion of the intake assessment.

On October 22, 2010 [REDACTED] contacted Crawford County CYS to refer [REDACTED] five-month old half sibling. According to the reporter the child has many [REDACTED] issues including a [REDACTED] requiring 24-hour supervision. When observed in the hospital, it appeared that the mother needed assistance with all of the children. Following an assessment by the agency the case was accepted for service on December 22, 2010. Subsequent to the case being accepted, there were three additional reports by [REDACTED] made to the county regarding the mother's ability to meet their children's needs, particularly the 5-month old. On January 27, 2011 while hospitalized, the five-month old passed away. According to the physician at [REDACTED], the child died as a result of his medical condition; his heart was losing functioning and he would not have gotten any better with time. The hospital did not attribute his death to neglect of his medical condition by his mother.

Current Case Status

The family was accepted for on-going services on December 22, 2010. The mother's other two surviving children, [REDACTED], were placed in kinship care with their maternal grandmother on April 2, 2011. Upon [REDACTED] on April 5, 2011, [REDACTED] was placed in the same home. Subsequently [REDACTED] have been placed together in a foster home while potential adoptive kinship placements are being studied. [REDACTED] has been placed with his paternal grandmother who is in the process of adopting him. The removal of the children from the home of the maternal grandmother occurred because she could not be certified as a kinship care resource. Visits between the siblings are occurring on a regularly scheduled basis. Crawford County is in the process [REDACTED].

At the present time, the children's mother is receiving [REDACTED] and adult probation services.

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

On July 1, 2011 and September 5, 2011 Crawford County Human Services conducted internal and external child fatality/near fatality reviews pursuant to DPW Bulletin Number 3490-00-01 relating to child death review and report protocols. Those present believed, based on case documentation and information provided by agencies extending services to the family, that the near death incident was surprising to those who worked with the family. The consensus opinion of the MDT members was that the only way to have prevented this incident would have been to place this child in substitute care prior to the injury. This, according to the county, was not an option based on the determination of the safety assessment with consideration to the risk assessment and service provider contacts. The county identified the following areas of strength related to services extended to the family:

- Family surrounded by several service providers from different systems to include [REDACTED], and children and youth ongoing services to family to include in home parenting .
- County completed a thorough documentation of case chronology and the numerous contacts by the service providers involved with the family.

The MDT also concluded that there were several indicators dating back to August 2009 which could have been identified as critical concerns, including:

- [REDACTED] previous documented history of [REDACTED]
- History of past and present lack of medical care.
- Limited parenting skills and a family being overwhelmed with stressors related to children's medical problems.
- No back up medical documentation that would have precluded the removal of the child from the home prior to the incident.
- Delay in opening the case for service, when on several occasions, the parents had not obtained follow up medical care for their children.

Department Review of County Internal Report

The Department concurs with the findings of the Crawford County MDT report in terms of their stated strengths and deficiencies. The department believes that Crawford County was honest in their assessment of this case in that this family could have been opened for ongoing services at an early time in the history of the case as evidenced by the number of GPS referrals on the family.

Department of Public Welfare Finding

The Department has concerns as to when the case was eventually opened for ongoing services. The county was aware of the medical condition of both [REDACTED] and her younger half-sibling [REDACTED] before the case was actually opened. They had become aware of the family in July of 2009. The case was initially screened out in August 2009 as the family moved to Cuyahoga County in Ohio. They received a new GPS referral on July 29, 2010 regarding the care of [REDACTED] but the case was closed out on September 27, 2010 as it was reported that the mother was attentive and concerned about her children and [REDACTED] were involved with the family. The Department believes the case should have been open for ongoing services at this time as they were aware of the medical conditions of both [REDACTED] and [REDACTED]. When the case was subsequently opened approximately two months later, there was documentation that [REDACTED] was not receiving appropriate medical care by her parents and a petition for dependency could have been filed at that time.

Crawford County CYS has been extremely cooperative with the Department in the investigation into the near fatality of the identified child, [REDACTED]. The county has held two MDT meetings to address the issues involved in the case and steps taken to assure the safety and well-being of the children subsequent to the incident. Although the county states their "surprise" amongst the individuals who worked with the family that the incident occurred, the fact that the incident did occur and the seriousness of the

injury to the child did necessitate the placement of the identified child and her two other siblings into substitute care.

Department of Public Welfare Recommendations

The primary concern of the Department was the amount of time elapsed before the case was accepted for ongoing case management services. It is also a concern that the county did not file a dependency petition prior to the serious injury to the victim child. Based on the medical issues of the two children (the victim child, [REDACTED] and her sibling, [REDACTED] there is reason to believe that more expedient intervention by Crawford County CYS may have had a beneficial impact on the children's' well-being

It is the recommendation of the Department that Crawford County address situations involving families with marginal parenting skills and medically-needy children by formally reviewing them with the agency MDT before finalizing case disposition.