



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

11 Stanwix Street
Room 260
Pittsburgh, Pennsylvania 15222

Elaine C. Bobick
Regional Director
Western Region

(412) 565-5728
Fax: (412) 565-7808

REPORT ON THE NEAR FATALITY OF:



BORN: October 27, 2010
NEAR FATALITY: October 24, 2011

FAMILY KNOWN TO:

Armstrong County Children, Youth and Family Services

REPORT FINALIZED ON: March 19, 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. Armstrong 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	October 27, 2010
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	Unknown
[REDACTED]	Mother's Paramour	[REDACTED] 1973

Notification of Child (Near) Fatality:

Armstrong County Children, Youth and Family Services received a general protective services referral on October 24, 2011 reporting that a one year old child was brought to [REDACTED] by ambulance at 4:20 pm. The child was unresponsive and [REDACTED]. The child was certified to be in critical condition, but was expected to survive. The mother reported that the child had a choking episode while drinking his bottle at approximately 7:00 a.m. that morning. The mother stated that the child was alert after the episode, however later in the day became unresponsive. After this change, the mother called 911. The child had been seen in the same hospital on September 22, 2011 for a similar respiratory episode along with burns to his forehead and ears. The report was being referred to the county because of the prior report in September and because the reporting source felt that the mother was not appropriately concerned about the child's condition.

On October 25, 2011 the county received a call from [REDACTED] that the general protective services referral received on the previous day was being reregistered as a numbered abuse investigation. There was no alleged perpetrator identified. The county was to report back to ChildLine if the child was certified to be in critical condition. On October 26, 2011 ChildLine received information from Armstrong County that the child had been flown to [REDACTED] and the attending physician had certified the child to be in critical condition. The hospital was suspicious of abuse or neglect based on the previous medical issues the child was treated for in September. ChildLine registered the report as a near fatality with the Department on this date.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region received regular communication and updates by the intake worker, [REDACTED]. The regional office also participated in the County MDT meeting on November 30, 2011. The Western Region Office of Children, Youth and Families obtained and reviewed the three CPS referrals and one GPS referral that the agency had received dated from September 23, 2011-October 25, 2011. The stated referrals were the only referrals the agency had received on the family and had no previous history prior to September 23, 2011.

In summary, and to be explained in more detail in later sections, the referrals included the following allegations:

- September 23, 2011 (CPS). The child was admitted to [REDACTED]. Upon admission, the child was also found to have burns to his forehead and ears.
- October 8, 2011 (CPS). The child was alleged to be wearing a neck brace due to his mother choking him. It was also alleged that the mother's paramour was caring for the child after he was told by Armstrong County that he could not be unsupervised around the child.
- October 24, 2011 (GPS). Child was brought to [REDACTED] unresponsive and in distress. Child was flown to [REDACTED]. It was reported child had a choking episode earlier in the day and became unresponsive. Reporting source felt mother's behavior was "odd" and inappropriate regarding her concern for the child.
- October 25, 2011 (CPS). ChildLine supervisor reviewed the October 24th GPS report and reregistered the report as a CPS on the 25th.
- October 26, 2012. The report was registered with DPW as a near fatality.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

• ***September 23, 2011***

The child was admitted to [REDACTED]. Upon admission, the child was also found to have burns to his forehead and ears. Armstrong County CYFS and Pennsylvania State Police investigated the allegations. It was discovered that the mother and the paramour work at the same health care center. She is a nurses' aid and her boyfriend is an LPN. They are scheduled to work opposite shifts. On September 22, 2011 the mother had left for work early in the morning and her boyfriend was home alone with the child. At approximately 10:30 a.m. the mother received a call from the boyfriend telling her that the child had just been burnt. The mother's boyfriend reported that he had made himself a bowl of ravioli and sat the bowl on the arm of the couch while he ran back to the kitchen to grab a drink. The child had been on the other side of the room and had crawled over to the couch and grabbed the bowl before the boyfriend could get back to the room. The bowl spilled over the child's head, burning him on his forehead and his ears. The boyfriend, being an LPN, treated the burn immediately with Silvadene ointment just as he would in his role at care center. When the mother called an hour later to check on the child, he was asleep. The child was taken to the boyfriend's mother's home around 1:00 p.m. so that the boyfriend could go to work. The mother arrived at the babysitter's home around 4:00 p.m. to pick the child up and noticed the child was having difficulty breathing. The mother reported that the child had been sick for the past couple days with a cold. They had been treating him with baby Motrin. The mother contacted the child's pediatrician who advised her to take the child to the emergency room. The child was transported immediately to the hospital where he was treated for the respiratory distress. The child was flown to [REDACTED] that evening. The attending physician in the [REDACTED] reported not seeing any burns or trauma to the child's airway; however it was noted that the child had [REDACTED] and the child's lungs were swollen. While being treated at [REDACTED], the child's condition was complicated [REDACTED].

The child was [REDACTED] and [REDACTED] on September 28, 2011. The agency initiated a safety plan with the mother since the boyfriend was the sole caretaker at the time of the injuries. The mother agreed to utilize family supports to ensure that the boyfriend had no unsupervised contact with the child. After further communication with the child's physicians, the investigation determined that the child was burned accidentally when he pulled the bowl of hot ravioli onto himself. The respiratory episode was related to [REDACTED] and was independent from the burn. In review of the medical records, the child also had a positive history of [REDACTED] in February of 2011. The referral was unfounded on October 27, 2011.

• ***October 8, 2011***

The child was alleged to be wearing a neck brace due to his mother choking him. It was also alleged that the mother's paramour was caring for the child after he was told by Armstrong County that he could not be unsupervised around the child. This referral was received while the county had an active investigation on the family (see above). The child was seen on the date of the report and it was verified that the child was not prescribed a neck brace by the [REDACTED] on September 28, 2011. There were no marks suggestive of the alleged choking and no validation that the mother was violating the safety plan initiated by the county on September 23, 2011. The investigation was unfounded on *October 18, 2011*. The county remained active under the September 23, 2011 referral.

- **October 24, 2011**

The child was brought to [REDACTED] at 4:20pm. He was unresponsive and in distress. The child's mother had reported that the child had a choking episode earlier in the day while drinking from his bottle. The mother reported that shortly after the choking, the child became lethargic but was able to open his eyes. At some point in the day, the child was no longer able to open his eyes, prompting the mother to call 911. The reporting source felt the mother's behavior was "odd" and that she was not appropriately concerned for the child's condition. The child was [REDACTED]. On October 25, 2012, ChildLine supervisor reviewed the report and reregistered the report as a CPS, with no identified alleged perpetrator.

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

Armstrong County Children, Youth and Family Services received a general protective service referral on October 24, 2011 reporting that a one year-old child was transported to the [REDACTED] by ambulance at 4:20 pm. The child was unresponsive and [REDACTED]. The child was in critical condition, but was expected to survive. The mother reported that the child had a choking episode while drinking his bottle at approximately 7:00 a.m. that morning. The mother stated that the child was alert after the episode, however later in the day became unresponsive. After this change, the mother called 911. The child had been seen in the same hospital on September 22, 2011 for a similar respiratory episode along with burns to his forehead and ears. The report was being referred to the county because of the prior report in September and because the reporting source felt that the mother was not appropriately concerned about the child's condition.

On October 25, 2011 the county received a call from ChildLine reporting that the general protective services referral received on the previous day was being registered as a numbered abuse investigation. The county was to report back to ChildLine if the child was certified to be in critical condition. On October 26, 2011 ChildLine received information from Armstrong County that the child had been flown to [REDACTED] and the attending physician had certified the child to be in critical condition. The [REDACTED] was suspicious of abuse or neglect based on the previous medical issues the child was treated for in September. On October 26, 2012 ChildLine registered the report as a near fatality with the Department.

While in care at [REDACTED], the child underwent numerous consults and evaluations to determine the underlying cause of the medical concerns. The child's physician reported that there was no evidence at that time indicating [REDACTED], however testing was still being completed. The intake caseworker made a visit to see the child and interview the mother at [REDACTED] on October 25th. The mother reported that the child had a choking episode in the early morning. During the incident, the child was coughing and throwing up. The mother reported she picked the child up right away and he stopped choking and coughing. The child was cleaned up and laid down in bed, where he fell asleep. The child was checked on a few hours later and seemed to be sleeping normal with regular breathing. The mother took the child into the living room with her and laid him on the couch. The child became somewhat fussy and then fell back asleep. The mother noticed the child's breathing to be slightly "heavier" and that he had began snoring. The mother became concerned when the child began to occasionally gasp after snoring. The mother called the child's pediatrician, who advised her to call the ambulance. The mother met the emergency personnel on the front porch with the child in her arms. At approximately the same time the ambulance arrived, the child's lips turned blue. Emergency personnel immediately transported the child to the hospital. The

mother reported that the child been treated in September for a [REDACTED] and he never seemed to fully recover.

The child was [REDACTED] on November 2, 2011. Upon [REDACTED] medical personnel described the child as a "medical mystery". While trying to [REDACTED] the child, it was determined that the child had an upper airway problem. Oxygen levels in the child's blood stream were very low and doctors suspected that this [REDACTED]. Two major theories were being considered as the cause of the child's medical issues, [REDACTED]. The doctors were not indicating [REDACTED] of the child, however had concerns regarding supervision which resulted in the burn the month prior and the delay in obtaining medical intervention for the choking/coughing episode on October 24th.

The agency discussed many medical possibilities with the consulting physicians and not one of the physicians reported a theory of child abuse. Although some of the physicians were concerned in the delay of response from the mother, it was noted that the situation was not a case of medical neglect. The investigation was unfounded on December 5, 2011.

Current Case Status:

The child was [REDACTED] to the care of his mother on November 2, 2011. The county continued involvement to ensure that the parents followed up on recommended medical treatment. The child appeared to be doing well and had no noticeable signs of balance or coordination problems, as originally this was a concern of medical personnel. While in the hospital, the child did develop [REDACTED]. Since being [REDACTED] many additional consultations have been scheduled. The child was referred to [REDACTED]. Except for the [REDACTED] [REDACTED] the child was [REDACTED] absent any outstanding [REDACTED] instructions. At this time, the agency has no concerns regarding the care of the child being given by the parents.

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

- **Strengths:** The County review team did not submit a report to the Region identifying any county strengths.
- **Deficiencies:** The County review team did not submit a report to the Region identifying any county deficiencies.
- **Recommendations for Change at the Local Level:** The County review team did not submit a report to the Region identifying any recommendations for change at the local level.
- **Recommendations for Change at the State Level:** The County review team did not submit a report to the Region identifying any recommendations for change at the state level.

Department Review of County Internal Report:

The Armstrong County MDT functions as the child fatality/near fatality review team. Minutes are kept of these meetings and the minutes pertaining to this report were provided to the Department; however, these minutes do not meet the requirement for the county's internal reports as outlined in Act 33. The county's internal reports needs to be a stand alone document, specific to the victim child of the fatality or near fatality. The county internal report is subject to disclosure on the state website, following redaction of identifying information. The elements required for the county internal report are stated within the Department of Public Welfare Recommendations that appear on the last page of this document.

Department of Public Welfare Findings:

- **County Strengths:**

The Department felt that the agency conducted a thorough assessment and displayed positive collaboration with hospital and law enforcement staff. Significant interviews and correspondence took place during the investigation process, which openly supported the final determination of the unfounded status. The County responded within state regulated time frames regarding all reports. Safety assessments were completed at regulatory intervals and with detailed documentation.

- **County Weaknesses:**

The County does not have a child fatality/near fatality review protocol that includes a final report submission to the Department. The County MDT meeting makes recommendations for case management, which are documented on a signature page; however the team has not developed a format for the county internal report that meets the requirements of Act 33.

- **Statutory and Regulatory Areas of Non-Compliance:**

The Department found no regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to DPW and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the following:

- Deficiencies and strengths in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse and neglect.

The final report submitted to the Department only contained suggestions for case management and a listing of attendees. The report failed to include any of the above mentioned information. The Department sees a need for further technical assistance to the county on the implementation of Act 33, especially in regard to the responsibilities of the county child fatality/near fatality review team to develop an internal county report.

Although the local review report gave no recommendations for change at the state level, the Department sees a need to further review the state requirement of the local team meeting within 30 days of the start of a child death investigation, unless the case is unfounded. The 30 day time frame does not always give enough time for a county to have sufficient information to report back to the team. This often times will lead to information being vague and sparse in the first review meeting, requiring a follow up meeting to be held at a later date.