REPORT ON THE NEAR FATALITY OF:

Date of Birth: 11/24/2017
Date of Incident: 06/06/2018
Date of Report to ChildLine: 06/06/2018
CWIS Referral ID: [REDACTED]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Erie County Office of Children and Youth

REPORT FINALIZED ON:
Completed by State Reviewer

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))
**Reason for Review:**

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Erie County has not convened a review team in accordance with the Child Protective Services Law related to this report. Erie County completed their investigation within thirty days and unfounded the report.

**Family Constellation:**

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victim Child</td>
<td>11/24/2017</td>
</tr>
<tr>
<td></td>
<td>Mother</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>Father</td>
<td>1987</td>
</tr>
</tbody>
</table>

**Summary of OCYF Child Near Fatality Review Activities:**

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all records pertaining to the family.

**Children and Youth Involvement prior to Incident:**

There is no prior involvement with this family.

**Circumstances of Child Near Fatality and Related Case Activity:**

Erie County Office of Children and Youth (ECOCY) received a near fatality report on 06/06/2018. The report stated that the victim child was being held by the sister-in-law of the mother and supposedly rolled out of her arms and hit the floor, approximately three feet off of the floor. The victim child was unresponsive with respiratory arrest upon arrival at the local hospital. The child was intubated and transferred to [redacted]. It was reported that the victim child also had a subdural hematoma where the child’s head hit the floor. Upon admission to the local hospital, the treating physician certified the victim child to be in critical condition due to neglect of the mother. The victim child was also having serious respiratory problems at that time, but the child was expected to survive. However, concerns were noted to the potential disruption to the child’s quality of life.
On 06/06/2018, ECOCY contacted Allegheny County Children, Youth and Families and requested that they conduct a courtesy visit with the victim child. Allegheny County confirmed they would go to the hospital and see the victim child and family and take a picture of the child. The ECOCY caseworker called and spoke with the Children’s Advocacy Center (CAC) physician assigned to the case. The victim child was admitted into the Pediatric Intensive Care Unit (PICU) and was sedated and placed on a ventilator. The treating physician stated that she had low level concerns for abuse. She stated the child had been sick and had gone back and forth between the local emergency room and the child’s Primary Care Physician over the last week. It was also stated that the victim child was septic and the physicians were unsure what was causing the victim child to be sick. It was noted that the physician felt it possible that the victim child could have had a seizure or fallen off of the bed, but she did not believe that the child was abused nor neglected.

Over the course of the next few days, the caseworker made multiple phone calls to the hospital and Allegheny County for updates on the victim child as well as to try and locate the father. It was reported by that the mother and the father are with the victim child and planned to remain with the child until discharge. It was also determined that the family was from Nepali and spoke English as a second language. The caseworker was able to schedule a time to speak with the mother on the phone with an interpreter to discuss the allegations and ask what happened on the date of incident. The mother stated that she, the aunt and victim child were upstairs lying on the bed. She stated she went downstairs to get the child a bottle and the aunt got up to close the window. It was at this time the victim child fell off of the bed. The mother stated she ran back upstairs and the child was crying and then stopped and went limp. The aunt began Cardiopulmonary Resuscitation (CPR) and the family called for emergency services. The victim child was transported to the local hospital via ambulance. The caseworker did reach out to the detective on the case and it was reported that they had interviewed the aunt and her story of the incident was the same as the mother’s. The detective reported that law enforcement was closing the case. The father was interviewed and reported he was not home at the time of the incident. ECOCY made the determination to unfound the case based on the statements from the medical doctors, the interview with the mother and the aunt as well as follow up discussions with law enforcement. The report was submitted as unfounded on 06/19/2018.

On 06/29/2018, it was reported that the victim child had been going back and forth from the PICU to a regular room due to high fevers, a high heart rate and a rash, but overall was doing better. The caseworker called on 07/05/2018 and was informed that the child was doing well and that she would be discharged the following day. It was reported that the victim child was diagnosed with . The caseworker spoke with the family and made arrangements to meet at their home within a few days.

The family made plans to move in with the paternal grandparents due to the long recovery of the child. ECOCY made referrals for .
On 07/09/2018, after the victim child and family returned home, the caseworker met the interpreter at the maternal grandparent’s home, this was the initial visit with the family as the family had been with the victim child at [Redacted] for a month. The caseworker also met the aunt and spoke with her concerning the incident and she reported the same as the mother. The father reported that the child had [Redacted], [Redacted], and [Redacted]. The family reported that they have a case manager from Multicultural Community Resource Center (MCRC), to assist them with community services.

The victim child had her first appointment at [Redacted] the week of her discharge, and was having follow-up appointments with [Redacted] as necessary. ECOCY offered to assist the family with transportation, if needed to those appointments. The family was willing to have any assistance from the county that ECOCY could provide. A General Protective Services (GPS) referral was generated on 07/12/2018 for initiation of these services, and the family was opened for services.

The parents and the victim child transitioned into the home of a friend until their move to their own apartment on 08/12/2018. ECOCY continues to provide services to the family. ECOCY has completed a Family Team Meeting and developed a plan with the family. The child is doing better and has made all of the necessary follow-up appointments. The family has inquired about when their case will be closing due to all of the services in the home. The case remained open at the time of this report.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County’s Child Near Fatality Report:**

ECOCY did not hold a local convening as the status determination was submitted as unfounded within 30 days of the date of the report. There was no county report.

- **Strengths in compliance with statutes, regulations and services to children and families;** N/A
- **Deficiencies in compliance with statutes, regulations and services to children and families;** N/A
- **Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;** N/A
- **Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;** N/A
- **Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.** N/A
**Department Review of County Internal Report:**

ECOCY did not hold a local convening as the status determination was submitted as unfounded within 30 days of the date of the report. There was no county report.

**Department of Human Services Findings:**

- **County Strengths:** The County responded immediately to the report, working with law enforcement and Allegheny County. Providing appropriate services to the family and assisting them as needed.

- **County Weaknesses:** No weaknesses were noted.

- **Statutory and Regulatory Areas of Non-Compliance by the County Agency**
  There were not areas of non-compliance noted.

**Department of Human Services Recommendations:**

The Department would recommend the availability and utilization of interpreters for families who speak English as a second language, when treatment is sought at medical facilities. The Department recognized several inaccurate details reported by the reporting source resulting in this report being registered as both a Child Abuse and a Near Fatality. It does not appear the family was afforded the use of an interpreter at the time of the initial medical assessment at the local hospital. When questioned about the inconsistencies given by the reporting source, the record indicates that the family was difficult to understand and it was possible they were misunderstood by the local hospital personnel.