pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/27/1998
Date of Incident: 2/02/2015
Date of Report to ChildLine: 2/04/2015
[redacted]

FAMILY KNOWN TO COUNTY CHILD WELFARE:

Pike County Children and Youth Services

REPORT FINALIZED ON:
6/19/2015

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:

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, 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.

Act 33 of 2008 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. Pike County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on March 2, 2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Adoptive Mother	[redacted]1959
[redacted]	Adoptive Father	[redacted]1969
[redacted]	Adoptive Brother	[redacted]1996
[redacted]	Adoptive Brother	[redacted]2005
[redacted]	Victim Child	09/27/1998

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth, and Families (NERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. NERO spoke with hospital social workers regarding concerns for the victim child. NERO attended the Act 33 meeting held on March 2, 2015 in which mental health representatives, the D.A., Safe Haven representatives, law enforcement investigating the case, and CYS representatives involved in the case were present and provided information regarding the incident, as well as historical information. It should be noted that the hospital social workers were invited to the meeting and were expected to participate by phone due to distance. However, at the time of the meeting, the hospital staff could not be reached despite several phone attempts.

Children and Youth Involvement prior to Incident:

The agency did not have involvement with the family within 16 months of the near fatality report but there were general protective reports made to the agency in June 2013. These reports alleged concerns for [redacted] parents not calling in his blood

sugar levels and appropriate medical care. The mother did not get along with the [redacted]. She switched doctors and was following the recommendations from the new doctor. The agency was able to confirm that the parents were following through with medical care and an [redacted] for the VC. The case was closed at the intake level.

Circumstances of Child Near Fatality and Related Case Activity:
The victim child was diagnosed with [redacted] in June 2013. He was initially receiving care for this condition through [redacted] Medical Center in [redacted]. In 2013, the family chose to leave that practice and seek services through an [redacted] Health Care [redacted].

On February 4, 2015, [redacted] Medical Center in [redacted], called Childline to make a report of suspected child abuse for medical neglect.

It was reported that the victim child was admitted to [redacted] on February 2, 2015 with a blood sugar level over 800. The victim child had [redacted] The victim child also [redacted] It was reported that the father had found the victim child unresponsive at home and had initially taken him to [redacted] Memorial Hospital. The victim child is [redacted]. It was reported that the victim child was on a [redacted]. The victim child was reported to be in extreme critical condition with a guarded prognosis. It was unknown if the victim child would survive.

On February 4, 2015, on-call worker from Pike County Children and Youth reported this incident to the police and requested they respond to the home with her. Pennsylvania State Police accompanied the caseworker to the home to start the investigation. Mother would not allow the caseworker or the police into the home. She did allow the worker to briefly see the other minor child who was asleep when the worker arrived.

On February 5, 2015, the assigned caseworker went to [redacted] Medical Center to meet with the victim child and the father. Two state troopers accompanied the worker to the hospital to conduct interviews. The worker met with [redacted], who could not describe what [redacted] neglected to do for the child resulting in this condition. The hospital was still concerned that the [redacted] had not come to see the victim child at the hospital and they feared that she would not follow through with medical care or cooperate with services for the victim child. The victim child was still in bed [redacted]. An interview with the [redacted] was conducted. [redacted] at that time stated that the victim had been feeling sick with flu-like symptoms and was taking [redacted] prior to the incident. [redacted] also stated that the victim child sometimes over eats or eats things he is not supposed to eat knowing that this can be detrimental to his health.

On February 10, 2015, [redacted] Medical Center notified the agency that the victim child was [redacted] able to speak.

On February 13, 2015 the caseworker attempted a home visit to follow up with mother and the other minor child. No one answered the door.

On February 17, 2015, the worker attempted another home visit with mother and the victim child's sibling but no one answered the door.

On February 18, 2015, the worker met with the victim child and the father in the hospital. [redacted] stated that when the victim child is [redacted] the family will need to aggressively manage his blood sugar; count carbohydrates and the victim child will need to be in [redacted] did meet with the victim child and determined he may be [redacted]. The hospital was still concerned for the victim child's home environment being unsafe due to the mother's lack of cooperation and ongoing conflict in the home. The worker met with the victim child who was alert and able to discuss the concerns.

On February 18, 2015, the worker conducted a home visit with mother and the 2 other siblings (one over 18). The police accompanied the caseworker to this visit. [redacted] for the victim child's condition was observed to be in the home [redacted] also stated that the victim child would often not comply [redacted] by eating foods he was not supposed to eat and overdosing on his [redacted]. The adult sibling corroborated mother's explanation. There were no safety concerns for the other child in the home during this visit. The [redacted] agency and requested help in the way of services. She was agreeable [redacted].

On February 19, 2015, [redacted] Medical Center called to let the agency know they are inviting [redacted] to the hospital to take part in [redacted] and to discuss after care recommendations for the victim child [redacted]

On February 23, 2015, the agency made a referral to [redacted] to provide services to the family regarding in home conflict, the victim child's [redacted] The hospital also notified the agency this day letting them know that the victim child [redacted] and would be going home. They stated that things went well with the mother [redacted] over the weekend.

On March 2, 2015, the Act 33 Near Fatality meeting was held at the agency to discuss the case and the agency's plan to unfound the case due to lack of medical documentation to support any type of medical neglect. The police also reported they will not be filing any charges.

On March 3, 2015, the worker did a follow up home visit and met with the family. There were no noted concerns for this home visit. [redacted]

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

Strengths

- The agency responded immediately to ensure the safety of the child in the home.
- The agency immediately requested all medical documentation related to the alleged abuse/neglect.
- The agency coordinated services with the PA State Police and completed interviews using a team approach. Communication between the agency and law enforcement was seen as a strength.
- The agency utilized engagement skills to get cooperation from the mother.

Deficiencies

- No deficiencies were noted by the Child Fatality Review Team

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse

- none

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies

- none

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

- One recommended change would include more effective communication with out of state hospitals and medical providers. The agency did face some challenges when case planning for the victim child because the hospital felt that he should have been taken into emergency custody. The agency did explain the Child Protective Services Law in Pennsylvania and protocol regarding safety assessment, family engagement and gathering factual information to present to a Judge if custody does need to be obtained. Educating other providers about agency policy and law does need to be strengthened to prevent barriers in team work.
- Another recommended change would be that medical professionals provide medical documentation and findings to the agency as soon as possible to assist in the investigation. These records are imperative to safety assessment and case management.
- The third recommended change would be to continue to strengthen engagement skills and establishing positive relationships with families to best

service the children. This should be a continued effort by the agency workers and other providers/agencies involved in case investigation and planning.

Department Review of County Internal Report:

NERO received the Pike County Child Near Fatality Team Report on 04/02/2015. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 03/02/15. A letter confirming receipt of the Near Fatality Report was sent to the County on 04/09/15.

Department of Human Services Findings:

- County Strengths: NERO concurs with the strengths identified by the Act 33 team.
- County Weaknesses: NERO did not uncover any county deficiencies related to this case.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency There were no statutory or regulatory violations uncovered in relation to this near fatality review.

Department of Human Services Recommendations:

NERO again concurs with the recommendations outlined by the Act 33 participants.