



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

BORN: September 4, 2013
DATE OF INCIDENT: June 22, 2014
DATE OF ORAL REPORT: June 22, 2014

FAMILY WAS KNOWN TO:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:

3/16/15

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, DHS 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. Westmoreland 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	09/04/13
[REDACTED]	Mother	[REDACTED]/85
[REDACTED]	Father	[REDACTED]/82
[REDACTED]	Sibling	[REDACTED]/07
[REDACTED]	Sibling	[REDACTED]/09
[REDACTED]	Sibling	[REDACTED]/11

Notification of Child (Near) Fatality:

On June 22, 2014 the Agency received a referral that the victim child had been taken to Children's Hospital of Pittsburgh for a suspected near drowning. Child was found by paramedics at the home to be flaccid and blue upon their arrival. Victim child required [REDACTED] and CPR. She responded to the CPR and was transported to Children's Hospital of Pittsburgh (CHP) [REDACTED]. Upon arrival at the hospital she was upgraded to a [REDACTED] because of her [REDACTED] and possible seizure. The admitting diagnosis was [REDACTED], near drowning and possible non-accidental trauma. The child was [REDACTED] and transferred to the [REDACTED], where [REDACTED] and she was able to breathe on her own. All hospital tests were negative for trauma.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. Follow up was done with the ongoing caseworker, review of dictation and case notes. The regional office also participated in the County Internal Fatality Review Team meeting on July 23, 2014.

Summary of Services to Family:

Case remains open with Westmoreland County Children's Bureau (WCCB). [REDACTED] is currently working with the family on parenting and housing. Adult Probation is involved with both parents and the father is subject to random urines by the county.

Children and Youth Involvement prior to Incident:

- The Agency first received a referral on this family on April 7, 2011. The referral alleged that the mother had tested positive for THC at the birth of her child. The newborn's test came back negative. The mother admitted to THC use prior to the birth but denies regular ongoing use. The case was closed on May 25, 2011 after the Agency went to the home and found it to be appropriate; the caseworker saw all of the children and obtained medical records on the children. Collateral contacts had no concerns for the care of the children. It was noted that the family was not cooperative at the beginning of the case but then did work with the agency.
- The second referral was received on March 27, 2013 and alleged deplorable home conditions. There were also allegations of drugs in the home and the children being unclean. The parents were uncooperative in the beginning and refused to allow the caseworker access to the home or to see the children. On April 8, 2013 the family did allow the caseworker to see the children at the Agency office, and then did agree to a home visit on April 10, 2013. A home visit was conducted and there were no concerns noted in dictation. The parents did sign releases for the children's doctors. The case was closed with no concerns for housing or drug usage. It was noted that the mother was 18 weeks pregnant at the time of the referral. The case was closed at the intake level on April 16, 2013.
- The third referral was received September 5, 2013 alleging that a new baby was born on September 4, 2013 and that the mother was positive for marijuana. This would be the second time that mom gave birth and tested positive. Allegedly the parents admitted to regular marijuana use. There was concern that the parents were totally minimizing their drug usage and the possible effects on the baby. The parents were anti-government and not cooperative. This case was screened out with no assessment as the agency felt the baby was full term and healthy and deemed the mother's usage did not affect the baby.

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

- On June 22, 2014 the Agency received a referral that the victim child had been taken to Children's Hospital of Pittsburgh for a suspected near drowning. Child was found by paramedics at the home to be flaccid and blue upon their arrival. Victim child required [REDACTED] and CPR. She responded to the CPR and was transported to Children's Hospital as [REDACTED]. Upon arrival at the hospital she was upgraded to [REDACTED] because of her [REDACTED] and

possible seizure. The [REDACTED], near drowning and possible non-accidental trauma. The child [REDACTED] and transferred to the [REDACTED] and she was able to breathe on her own. All hospital tests were negative for trauma.

- A supplemental referral was received by the Agency on June 23, 2014 with allegations that the father had allegedly put the child in a dry bath tub and then left the child unattended and when he came back the child was face down unresponsive in water. The allegations went on to say that records suggest that the father had overdosed previously and [REDACTED] expressed concern with fighting constantly coming from the home. On the date of the incident, the father allegedly would not allow EMS or firefighters into the home.
- The Agency implemented a safety plan on June 23, 2014 that the father was to have no unsupervised contact with the children. [REDACTED] and the safety plan was amended to state that the father was to have no unsupervised contact with the two youngest children as they need constant supervision.
- Victim child was [REDACTED] on June 24, 2014 to the parents however the children were staying along with the parents at the paternal grandparents (PGP) home as their home had some safety concerns. Paternal grandmother (PGM) signed the safety plan. PGM's home was seen on June 25, 2014 and emergency clearances were done although PGM would not give Agency her SS#. Home visit to the parent's home was scheduled for June 27, 2014.
- On July 8, 2014 the case was indicated against the father for serious physical injury due to lack of supervision and the case was transferred to the ongoing unit on July 11, 2014.

Current Case Status:

- This case was transferred to the ongoing unit on July 11, 2014 for services. [REDACTED] was contracted to provide parenting and housing referrals. The safety plan was lifted on August 5, 2014 as the parents were completing parenting and it was no longer deemed necessary for the father to be supervised around the children. The parents have been much more cooperative with the Agency and have been cooperative with the [REDACTED]. The parents have completed parenting and had made great strides to make improvements to their home and keep it clean and safe for the children. The case remains opened at this time with the ongoing services unit, however they are looking to close the case in the next 60-90 days. The victim child has no lasting effects from her near drowning and is thriving and healthy.
- The children were never removed from the parents care as the parents agreed to a safety plan that limited the father's contact with the two younger children to supervised contact until he completed parenting and there were no juvenile court proceedings.
- The mother and father were both charged with felony child endangerment charges stemming from the near drowning and the home conditions. Their sentencing hearing was on January 13, 2015. The mother was found guilty and sentenced to

three years Accelerated Rehabilitative Disposition and the father was also found guilty and sentenced to five years of probation.

- The father has a probation officer due to drug charges in █████ County. However, he is compliant with probation and has provided WCCB with three random urines which have all been negative.

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

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. Westmoreland County has convened a review team in accordance with Act 33 of 2008. WCCB submitted the draft Child Fatality/Near Fatality Data Collection form to the Department. According to this document the following recommendations were identified:

- Strengths: The county worker handled a hostile family situation well and in compliance with regulations.
- Deficiencies: None
- Recommendations for Change at the Local Level: None
- Recommendations for Change at the State Level: None

Department Review of County Internal Report:

WCCB did not submit a Near Fatality report as required by Pennsylvania State Law; Act 2008-33. Section 6365(d)(4)(v) which require that within 90 days of convening the review team, the final written report of the child near fatality should be submitted to the Department. The report shall include identified strengths and deficiencies in compliance with statutes and regulations; and services to children and families. The agency is to include recommendations for changes at the State and local levels to reduce the likelihood of future fatalities and near fatalities directly related to child abuse and neglect; monitoring and inspection of county agencies and collaboration of community agencies and service providers to prevent child abuse and neglect.

Department of Human Services Findings:

- County Strengths: The Department is in agreement that the worker did an excellent job of working with the parents even though they were non-cooperative at the beginning.
- Also the ongoing caseworker is working well with the family along with the contracted provider and the family has been making great progress towards their Family Service Plan Goals.

- County Weaknesses: It should be noted that a referral was received when the child was born in September of 2013 due to the mother testing positive for marijuana. This was the second referral that the mother tested positive for marijuana at the time of a birth of a child. The first referral was accepted and assessed and then closed out. However, the subsequent referral was not accepted as the baby was healthy however this did show a pattern of drug usage and best practice would have been to assess the family again for services, particularly since there were other concerns expressed by the referral source in regards to the parent's demeanor and uncooperativeness in regards to the drug usage.
- Statutory and Regulatory Areas of Non-Compliance:
The agency is not in compliance with regulation 3130.21(b). The agency did not submit a written report to the Department within 90 days of convening the Near Fatality review team as required by Pennsylvania State Law; Act 2008-33, section 6365(d)(4)(v).

Department of Human Services Recommendations:

Agency needs to ensure that they are in compliance with all state laws and review their policies and procedures for assessing families on whom they have received previous referrals to determine if any changes are needed to those policies/procedures.