



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 9/19/2010
Date of Incident: 4/25/2015
Date of Report to ChildLine: 4/25/2015
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Fayette County Children and Youth Services

REPORT FINALIZED ON:
October 1, 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. Fayette County Children and Youth Services (FCCYS) had convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 05/27/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1982
[REDACTED]	Father	[REDACTED] 1986
[REDACTED]	Half Sibling	[REDACTED] 1999
[REDACTED]	Sibling	[REDACTED] 2003
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Victim Child	09/19/2010
[REDACTED]	Sibling	[REDACTED] 2012

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. WERO staff participated in the Act 33 meeting that occurred on 05/27/2015 in which medical professionals and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

2/2011-8/2012 the case was closed.

General Protective Service (GPS) report was made on 2/23/11 [REDACTED] [REDACTED] the victim child as failure to thrive. FCCYS completed a GPS assessment and opened the case in March of 2011 for services. The victim child's medical records were obtained. The family was cooperative with the caseworker and services. FCCYS monitored the victim child's medical needs and

assured the parent's compliance with the doctor appointments. The agency tracked the victim child's progress through reports from [REDACTED]. The parents completed their goals on the Family Service Plan (FSP). They successfully worked with service providers to meet the needs of their children and attended all follow up appointments. There were no additional concerns and the case was closed.

1/2013-GPS assessment

FCCYS received a report 1/3/13 [REDACTED] on the family's poor housing conditions, concerns for no food and the use of physical discipline. The agency validated that the house was dirty, but the family cleaned it up during the Intake investigation. The other identified issues in the report were not validated. Case was not accepted for service.

2/2014-10/2014 the case was closed.

There were two reported [REDACTED], Child Protective Service (CPS) reports at this time. One sexual abuse and 2/24/14 one medical neglect case, the sexual abuse case was investigated alleging that the victim child's sister was being sexually abused by her uncle which has been expunged. This report was unfounded. The medical neglect referral was on the victim child who had a burn on his face which went untreated for around a month. The parents could not explain how the burn happened. It was determined by [REDACTED] physician of the victim child that the burn would have caused severe pain. The report was substantiated on both parents for medical neglect. The case was accepted for services. The oldest half-sibling and the oldest, daughter remained with their mother. The parents made arrangements for the other five children to live with a family friend. The parents again cooperated with the agency and the services offered were [REDACTED] parenting classes, family preservations, [REDACTED]. The parents attended all scheduled medical appointments. The parents successfully completed their FSP, the children returned on 10/29/14 to their parents and the case was closed.

2/2015-Case was assessed and accepted for services 4/7/2015

FCCYS received a GPS report on 2/7/15 that parents are very low functioning. The oldest daughter is left to care for the children for the mother and father. There were ongoing issues with the children's [REDACTED]. The children would come to school without [REDACTED]. It took the school months to finally get [REDACTED] and the children would go to school [REDACTED]. There were times where [REDACTED] was sent to school. The children would come to school complaining that they were not being fed at home and were physically dirty. The children would throw things and take their socks and shoes off and would sit under their desk and bite their feet and lick themselves. Parents were not responding to phone calls from the school. The oldest daughter had been absent for three days. The truant officer went out and

was told that the child was sick; however, the parents would send the other children to school sick.

This referral was opened for services on 04/07/2015 due to housing concerns, truancy, lack of food in the home and parenting concerns. Parents are intellectually limited. This is the last time a worker was in the home prior to the most recent report. [REDACTED]

There are seven children in the home. Mother is currently pregnant. [REDACTED]

Circumstances of Child Near Fatality and Related Case Activity:

On 04/25/2015, FCCYS was notified that the victim child had been transported via ambulance to Uniontown Hospital in Uniontown, Pennsylvania due to possibly ingesting pills. The victim child appeared disorientated. The Pennsylvania State Police (PSP) was also notified via request of the FCCYS supervisor. The victim child was then transferred to Children's Hospital of Pittsburgh (CHP) via ambulance [REDACTED]. The child's younger sibling was also transferred to CHP from Uniontown Hospital as a precaution.

The physicians at Uniontown Hospital were not told by the parents how many or what type of pills the victim child may have taken, but his mother said it could have been [REDACTED]. The paramedics who responded to the home reported to [REDACTED] physicians that the victim child was found to be hypothermic, he had low blood pressure, was unable to be roused, had a low heart rate, and low respiration rate. The victim child required stat transfer to CHP via medical helicopter. [REDACTED]. The child's hygiene was very poor; he was covered in dirt and foul smelling. The paramedics reported the home was in deplorable conditions and that the family was heating the home with an oven.

When the victim child, arrived at CHP he had stopped breathing and had to be resuscitated. He was treated at CHP [REDACTED]. Two of the child's siblings were present during the incident. There was concern that they may have given him the meds. The victim child's younger sibling was thought to have taken the medications also but her toxicology screen was negative. The younger sibling had extremely low blood sugar and was transferred to CHP via ambulance. CHP attributed her condition to the lack of food. The victim child's younger sibling was [REDACTED] on the same day as the victim child.

The other children in the house were interviewed concerning the incident and claimed the medications were in a lock box and that the victim child's older sibling

got the box open with her finger. The mother claims she and father were sleeping. Father claims he was the only one sleeping and that the mother was awake.

The victim child and his four siblings were placed with a family friend who became their kinship provider. The victim child's oldest sister [REDACTED] she was placed in the same kinship home as her siblings. The oldest half sibling remains in the family home the agency did not identify safety threats due to age. There was food in the house and he knows how to prepare meals for himself.

[REDACTED] Ongoing services currently are [REDACTED], budgeting, parenting, truancy services and ensuring all medical needs of the children are being met [REDACTED]

On 6/18/15, the CPS report pertaining to this incident was submitted with an Indicated finding on both the mother and father due to the child overdosing [REDACTED]

The children are attending school [REDACTED]

There is no information pertaining to any criminal charges at this time.

Case remains open with FCCYS.

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

- Strengths in compliance with statutes, regulations and services to children and families; The Agency response times were appropriate based on the information received in the initial reports received. Safety was assured through the agency; all children are safe in kinship care settings.
- Deficiencies in compliance with statutes, regulations and services to children and families; FCCYS determined through the review of the family record that multiple services were in the home during the last year including Family Preservation, [REDACTED] Parenting class provider and Co-Parenting provider. The parents initially cooperated with the services, however with no intermediary enforcer to hold the parents accountable they quickly dropped each provider. There was gap in communication as despite obvious concerns with parents not utilizing needed services, no provider contacted the agency after the family quit working with their programs.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; No recommendations came out in regards to changes at state or local level
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; No recommendations were made.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. FCCYS is working on ensuring that communication between the county and providers does not break down and that when the county is no longer involved with a family but providers are that communication of concerns or issues are conveyed to the county.

Department Review of County Internal Report:

The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths: The County conducted a complete and thorough assessment of the family; they immediately ensured safety of all of the children. They also requested and received all documentation concerning records on this family. They found appropriate placements for the children and have services in place for the family. The FSP/CPP's have all been completed as required and have utilized family finding in this case.
- County Weaknesses: There was a gap in communication and despite obvious concerns with parents not utilizing needed services; no provider contacted the agency after the family quit complying. It should be noted the supports that were in place and the parent's level of cooperation with the services were a contributing factor to the agency closing the case. FCCYS is addressing this as an identified area to strengthen internally.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
None

Department of Human Services Recommendations:

FCCYS needs to continue to closely monitor this family. The mother is currently pregnant and if this child remains in the parent's care the parents will need to be supervised as to the care they are providing the child.

Fayette County Social Service agencies need to establish a protocol to prevent the breakdown in communication that occurred in this case between their office and the community providers.