



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE Near Fatality OF:



BORN: November 4, 2004
NEAR DEATH: October 5, 2014
DATE OF REPORT: October 5, 2014

FAMILY KNOWN TO:
Allegheny County Children, Youth and Families

REPORT FINALIZED ON:
08/09/2015

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))

Summary of DHS Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families obtained and reviewed all the current records pertaining to the family. Follow up interviews were conducted with Intake Worker [REDACTED] on October 8, 2014 and November 4, 2014. The Regional Office also participated in the County Internal Fatality Review Team meeting on November 4, 2014 where the medical report was presented. Several other follow up interviews took place, as well as a review [REDACTED].

Children and Youth Involvement prior to Incident:

On July 23, 2009, Allegheny County CYF received a referral which was made by [REDACTED]. She alleged that her sister's paramour's son hit the victim child with a bat and he had a welt to his face. This case was screened out.

On September 9, 2009, Allegheny County CYF received a referral which was made by [REDACTED] that victim child age 4 ate a peanut butter and jelly sandwich at daycare. Mother and victim child told daycare staff that he was allergic to peanuts but "they forgot." The Mother called 911 and had him transported to Children's Hospital of Pittsburgh. This became a Western Regional Investigation for the daycare [REDACTED]. The report was unfounded.

On March 18, 2012, Allegheny County CYF again received a referral with [REDACTED] as the reporter. She reported that maternal aunt's stepson age 13 hit the victim child age 9 in the head. Mother had left the child in the care of her sister, the maternal aunt, while she went to visit a maternal uncle in the hospital in West Virginia. This referral was screened out.

On June 16, 2013, Allegheny County CYF received a referral with [REDACTED] as the referral source. She was calling to report that a neighborhood child was bullying the victim child. This referral was also screened out.

On December 2, 2013, Allegheny County CYF received a referral. [REDACTED] was the referral source. She alleged that Mother woke the victim child in the middle of the night on November 28, 2013 and walked five blocks to the maternal aunt's home. Victim child was wearing shorts, a shirt and a sleeveless fur vest. Mother was verbally abusive to [REDACTED], picked up a shovel and began throwing bricks at her home and car. The victim child witnessed Mother's behaviors and was crying. [REDACTED] Allegations that child misses a lot of school and [REDACTED] feels the victim child is being emotionally hurt by Mother's [REDACTED]. This case was accepted for intake only. Allegheny County CYF staff met with the mother. Per the investigation, Mother was involved with [REDACTED]. On November 29, 2013, [REDACTED] came to assess her and felt she was fine.

Mother was involved with the [REDACTED] program at the time of the referral. Case was closed at intake.

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

The victim child was hospitalized for an [REDACTED] exacerbation on September 30, 2014. He was initially [REDACTED] Children's Hospital on October 2, 2014 with the instructions to take [REDACTED] and follow up with his pediatrician within two days.

On October 3, 2014, the mother took the victim child to his Pediatrician and he was subsequently transported back to CHP due to continued respiratory distress. He was [REDACTED] and was diagnosed with [REDACTED].

On October 4, 2014, he was moved to [REDACTED]. On the morning of October 5, 2014 the mother removed the victim child from the hospital against medical advice. She claimed that the staff was disrespecting her and the victim child. She left the hospital without the appropriate medications. [REDACTED] was consulted and reported that the child would have been in serious condition.

Allegheny County CYF contacted the mother on October 5, 2014 and she refused to have the victim child seen medically and would not cooperate with Allegheny County CYF. She told Allegheny County CYF that she was going to West Virginia and could not meet with them until the following day.

Allegheny County CYF [REDACTED] and located the mother with the help of the [REDACTED] Police and he was transported back to Children's Hospital where he was admitted.

The victim child was interviewed by the Intake Caseworker's en route to the Hospital. He lives with his mother and disclosed no concerns in regards to living with her. He advised that they currently moved and he is sleeping on an air mattress on the floor with his mother currently. The victim child advised that his Mother got upset on the morning of October 5, 2014 because he was hungry and his mother did not like the way she was treated by the nurse and they left.

When the parties arrived at CHP, he was assessed by the nurses. [REDACTED] were the supervising Doctor's for the child. They spoke with the caseworker and indicated that based on the fact that the child had been admitted numerous times recently and that both stays were in [REDACTED] there would be a low threshold for admittance. Later on that evening, the caseworker was told that the child did not have [REDACTED] but they would be [REDACTED]. The victim child was moved to [REDACTED] at 12:55am.

On October 6, 2014 [REDACTED] reported that when the victim child was in the Hospital the goal was to space [REDACTED]. He was only receiving it [REDACTED] when the mother removed him from the Hospital. She reported that the victim child was re-admitted last night when Allegheny County CYF brought him into the Hospital. Currently he was only receiving [REDACTED]

The caseworker interviewed the Mother who admits to not giving the victim child his [REDACTED] overnight. She advises she was told to give it to him only as needed. She denied the allegations of not properly caring for him and had intended for the victim child to be seen by his PCP on October 6, 2014.

The case was transferred to the Ongoing Family Services Unit on October 5, 2014.

The county caseworker made a collateral contact with the child's PCP Dr. [REDACTED], who is a Pediatrician at [REDACTED]. Dr. [REDACTED] advised that she has spoken to the Mother along with Dr. [REDACTED]. Dr. [REDACTED] advised that she is child's PCP and has been treating him. She stated that the Mother is always vigilant, she brings him to all of his appointments and he is up to date on his immunizations. Mother brings him in if she believes he is sick and has been appropriate in all interactions she has had with the Mother. She follows through on recommendation that PCP makes. Dr. [REDACTED] had no concerns about the child returning to the Mother's care. Mother has a history of compliance and appears to have protective capacities.

[REDACTED]
describes Mother as very protective of the victim child and appropriate with him. The Mother actually picked her current housing based upon how close it was to victim child's medical care facilities.

[REDACTED]
On October 8, 2014 the victim child was [REDACTED] Children's Hospital to the Mother's care. He was [REDACTED]. He was to see his PCP on October 10, 2014. [REDACTED]

[REDACTED] The victim child was seen by his PCP on October 10, 2014 with another follow up scheduled for November 2014. [REDACTED] met with the family on October 20, 2014.

Current Case Status:

[REDACTED]

The CPS was unfounded on October 31, 2014 as the Agency did not feel that there was substantial evidence that that this case met the definition of serious physical neglect. An Internal County Fatality Review Team Meeting occurred on November 4, 2014. [REDACTED]

[REDACTED] The case was officially closed on November 24, 2014.

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. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

- Strengths: [REDACTED] and the victim child was involved with the Boys and Girls Club. [REDACTED]
- Deficiencies: There seemed to be poor communication between the Mother and Children's Hospital which could have exacerbated this case. It was noted during the Internal County Review that had Children's contact the PCP of record and discussed this case with her and asked for her help in speaking with the Mother, this CPS could have been avoided.
- There was also a concern that this case was not deemed a near fatality until the Mother signed the victim child out of the Hospital AMA. This was never called in for concerns when the victim child was re-admitted on October 3, 2014.
- Recommendations for Change at the Local Level: Better communication between the Hospital and the PCP were recommended in these types of cases, as the PCP obviously had a great relationship with the Mother and could have helped before the Mother signed the child out AMA.
- Recommendations for Change at the State Level: N/A

Department Review of County Internal Report:

The County report was received on December 23, 2014. The Department concurs with the county's findings in the report.

Department of Human Services Findings:

- County Strengths: The County responded immediately to this referral and assured safety of the child.
- The County investigated this case thoroughly and worked appropriately with the mother and child.
- County Weaknesses: The Department did not find any County weaknesses.
- Statutory and Regulatory Areas of Non-Compliance: None

Department of Human Services Recommendations:

None