



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/01/2015
Date of Incident: 07/19/2015
Date of Report to ChildLine: 07/19/2015
CWIS Referral ID: [REDACTED]

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

Berks County Children and Youth Services

REPORT FINALIZED ON:
06/27/2016

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.

Berks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/04/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	07/01/2015
[REDACTED]	Sibling	[REDACTED] 2012
[REDACTED]	Mother	[REDACTED] 1993
[REDACTED]	Father	[REDACTED] 1995
[REDACTED]	Paternal Grandfather's Paramour	[REDACTED] 1970
[REDACTED]	Paternal Grandfather	[REDACTED] 2015

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Act 33 Program Manager on 08/04/2015. The regional office also participated in the County Fatality Review Team meetings on 08/04/2015.

Children and Youth Involvement prior to Incident:

Berks County Children and Youth Services (BCCYS) received four prior reports on this family. On 04/09/2014, a report was received in regards to lack of parenting skills as well as allegations of drug use by Mother. Report alleged heroin, [REDACTED] and marijuana use. Mother complied with urine drug testing. Mother tested presumptive positive for [REDACTED] but negative for [REDACTED] on 3 occasions. Mother had [REDACTED] at the time for [REDACTED] and this is consistent with a presumptive positive for [REDACTED]. She was negative each time for all other substances. The case was investigated and closed on intake.

In December 2014, another report was received with concerns regarding drug use by Mother and lack of appropriate parenting skills. The report was investigated and closed on intake. It was also alleged that the mother was pregnant and was not receiving prenatal care. The mother denied being pregnant.

BCCYS received two reports in February 2015 and March 2015. The reports were screened as low risk and not accepted for investigation. The one report says mother "lives somewhere on [REDACTED]", but other than that there is no reference to not knowing where they are. The reports reflect they were screened out because they were low risk not because anyone couldn't find them.

Circumstances of Child Fatality and Related Case Activity:

The mother, father and paternal aunt took 18-day-old-child to St. Joseph Medical Center on 07/19/2015. They reported that the victim child had been congested for approximately seven days. The mother reported that the victim child was not taking his bottle as per his norm and that made her decide to take him to the Emergency Room (ER).

Upon arrival in the ER, the victim child was [REDACTED]. His condition deteriorated and medical personnel decided to transport the victim child to Hershey Medical Center. St. Joseph Hospital medical team was considering [REDACTED] but when the Hershey Medical Center transport team arrived, the child was [REDACTED]. He was transported to Hershey Medical Center by ground transport and hospitalized [REDACTED]. The hospital determined that the victim child had [REDACTED].

After caseworker went over the allegations, the mother stated that she was never given [REDACTED] and that after a week she realized that she should have followed up by now. The mother states that she called St. Joseph Hospital and scheduled an appointment for the child. The hospital has no record of that call.

The mother explained that she was not sure that the victim child had signs of being sick for seven days; [REDACTED].

The hospital birth records show that the victim child was born at 39 weeks [REDACTED] after being born on 07/01/2015. The parents report that when he came from the hospital he still had that congestion. The mother and the father stated that they would do as the hospital did [REDACTED]. The caseworker asked the mother when she started to notice that the child was acting differently. The mother stated that late on 07/17/2015 into the next day, 07/18/2015, the victim child started eating less and then on 07/18/2015 he would not take his bottle. That is

when the mother took him to the Emergency room. The mother said that had she noticed anything before that she would have taken him to the doctors right away.

The case was unfounded; the incident did not endanger the child's life and health. The victim child was [REDACTED] Hershey Medical Center on 07/20/2016. He returned home to the care of his parents with [REDACTED] services in place. There was some controversy over this case being labeled as a near fatality. The victim child had [REDACTED] but his condition was not life threatening.

The caseworker followed-up with the Hershey Medical Center treating physician. The doctor states that he does not think this is a case of obvious abuse. When asked if he thinks that the victim child getting sick was a result of mother not coming in for a follow-up appointment the doctor stated that when mother would have had her appointment the child could have been perfectly fine and that he can become sick in one or two days due to his age. When the caseworker spoke with the social worker it was explained that this case was labeled a near fatality and the social worker stated that no medical team there would call this a near fatality. Case was labeled a near fatality at St. Joseph's Hospital as a result of medical neglect.

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

Strengths:

- Parents are present for caseworker visits and willing to accept help
- Parents receptive to services [REDACTED]
- Paternal family supportive
- Family has scheduled well child appointments
- Mother currently employed at [REDACTED]

Areas of Concern/Deficiencies:

- [REDACTED]
- [REDACTED]
- Parents may have limited understanding/ lack of knowledge of when to seek medical care for sick children.
 - Previous allegations of drug use with mother submitting urine for toxicology; in April investigation it took mother several weeks to complete urine screening
 - Sibling did not have Primary Care Physician
 - Pattern of missed and cancelled well child appointments
 - Denied pregnancy/late access to prenatal care for victim child's pregnancy
 - Inconsistent reports of employment/job history

Department Review of County Internal Report:

Berks County Children and Youth Services report was received on 12/01/2015. Surrounding issues were also discussed during the Act 33 review meeting. OCYF concur with the findings of this report.

Department of Human Services Findings:

- County Strengths:

MDT SWSM did a good job with the investigation and coordinating with the investigating officer from Special Victims Unit.

- County Weaknesses:

There is a need for better communication between County Agency and Provider agency to prevent breakdown in services.

DHS failed to provide in-home services to VC from January 2015 to April 2015. ■■■ SWSM did not attend closing meeting nor did ■■■ SWSM ensure that protocol was followed when he was not able to contact a provider agency.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
None noted at this time

Department of Human Services Recommendations:

There is a need to ensure that better communication amongst County and Provider agencies is achieved to prevent other disruption in services with a family in need.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agency: None noted at this time

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. There is a need for better communication between County Agency and Provider agency to prevent breakdown in services.

- County Strengths:

MDT SWSM did a good job with the investigation and coordinating with the investigating officer from Special Victims Unit.

- County Weaknesses:

There is a need for better communication between County Agency and Provider agency to prevent breakdown in services.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
None noted at this time

Department of Human Services Recommendations:

There is a need to ensure that better communication amongst County and Provider agencies is achieved to prevent other disruption in services with a family in need.