pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/29/2015
Date of Incident: 02/28/2016
Date of Report to ChildLine: 02/29/2016
CWIS Referral ID: [redacted]

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

Crawford County Children and Youth Services

REPORT FINALIZED ON:
08/22/2016

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.

Crawford 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 04/22/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1988
	Father	[redacted]1985
	Biological Sister	[redacted]2007
	Biological Sister	[redacted]2008
	Biological Sister	[redacted]2013
	Victim Child	11/29/2015

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 04/22/2016 in which the County caseworker, medical professionals from the local hospitals, the District Attorney of Crawford County and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

A General Protective Services (GPS) was filed on 03/06/2009, and was closed on 05/04/2009. The allegations were the adults are drinking, ingesting pills, they grow marijuana and are "popping pills" around the children. There are three or four families living in a three-bedroom trailer. These families have plastic bags over their windows and brag about growing marijuana. They allegedly allow the children to smoke the marijuana. The youngest is 8-years-old. The children are between 3-months-old up to 16-years-old, a total of six children and seven adults live in the

home. A Crawford County caseworker went to the home and conducted the investigation; the home was found to be dirty and cluttered. The Crawford County caseworker made two additional visits, the home was found to be clean and the case was closed at intake.

Another GPS report was received on 01/16/2014 and was closed on 02/21/2014. The allegations were the child said they were staying at the grandmother's home. The child said that during the winter months they had to sleep close to a stove and had no blankets due to their parent's home not having any heat. The child said she burned herself on the stove. However, no burn marks were observed.

A home visit was completed on 01/22/2014 to the grandmother's home and the home was clean and appropriate and there were no health or safety hazards present. The home had all working utilities and it was warm inside. The Crawford County caseworker got all releases of information signed and took photos of all the children. The family does not have heat at their home and they are going to stay here until they have [redacted] the fuel oil. The relative was fine with this arrangement. The child that was burned explained she touched the electric heater the family was heating with and she had no signs of a burn. She reported the burn was a superficial burn which went away in a day or two and she has no lasting issue. The caseworker did a walk-through of the home to ensure it was a safe environment and it was deemed safe. The parents confirmed they would call Children and Youth Services if they get heat and move back to their trailer. The mother did express interest in obtaining services to address her daughter's behaviors. The county agency provided the family with a telephone number for a community based provider. The case was officially closed on 02/21/2014.

Another GPS report was received on 06/02/2014 and was closed on 06/03/2014. The allegations were the child had a large bruise on her upper right arm that was caused by her uncle punching her more than once.

A home visit was completed on 06/02/2014. The child stated she and her uncle were playing and she sustained a bruise. The child claimed the bruise did not hurt. The caseworker asked the mother if the uncle lived in the home and she stated that he did not live there and was just visiting. The case was screened out at the intake on 06/03/2014.

Another GPS report was received on 02/17/2015 and was closed on 03/18/2015. The allegations stated the child reported she and her family live in a trailer which has no heat. The home's windows were frosted and looked to be in poor condition. The child said that everyone has to sleep in the same bed to stay warm.

A home visit was completed on 02/17/2015. The father allowed the caseworker into the home and the caseworker met and interviewed the children. The children claimed they have ample food, heat and all of their needs were being met. The children were at the cousin's house and were going to eat dinner there. The family home has heat but the father chose not to run it during the day and they all stay at the cousin or the grandmother's home where there is ample heat. The caseworker

asked the father why he does not heat during the day and he told the caseworker they have a pellet stove and they do not want to use too many pellets and have to buy more. The father stated the mother works during the day and is home around 10:00 PM. He turns the heat on around 8:30 PM and he stays at the home and monitors it as they are new at working with pellet stoves. Once he is sure that everything is cleaned out and working properly and the home heats up, he has the children come home. The case was closed at the intake case level on 03/18/2015.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/29/16 Crawford County Children and Youth Services received a Child Protective Services (CPS) report stating the victim child was seen in the Meadville Medical Center on 02/18/2016. The victim child came back to the hospital on 02/29/2016 with cold-like symptoms. He had lost 3 ounces since 02/18/2016 and weighed 5.95lbs. The victim child had diaper rash in his groin and on his buttocks. The mother claimed she fed the victim child two times a day, 2 ounces at a time. The victim child was unkempt with dried on dirt on his forehead, under his fingernails and toe nails. The mother was encouraged by hospital personnel to feed the victim child, but she simply stood there and appeared withdrawn from the child. Hospital personnel then fed the victim child. The mother held the victim child as he was crying, but she never consoled the child. The victim child was transferred to Children's Hospital of Pittsburgh due to concerns for failure to thrive. On 03/01/2016, the report was re-evaluated and the report was certified as a near fatal incident, Causing Serious Physical Neglect of a Child-Failure to Provide Child with Nutrition/Hydration, Dehydration, Failure to Thrive.

Upon receipt of the report, Crawford County Children and Youth Services requested Allegheny County Office of Children, Youth and Families conduct a courtesy visit to Children's Hospital in Pittsburgh to see the victim child. The Allegheny County caseworker conducted the visit on 03/01/2016 and met with the mother and took a picture of the baby. The Allegheny County caseworker spoke with [redacted] and was informed the mother has been very cooperative and was feeding the child as required. The mother was appropriate and cooperative with Allegheny County caseworker intake worker.

On 03/01/2016, the Children's Hospital of Pittsburgh medical staff reported how the victim child was doing [redacted] reported the mother has been feeding the victim child regularly and is currently giving him 3 ounces every 3 hours. She explained the mother's interactions with the victim child had been positive and she had given the feedings throughout the night. The victim child's weight had gone up during his hospital stay. The Crawford County caseworker spoke with the child's treating physician, and asked him about his concerns, regarding the victim child's weight loss and if there was anything done to address this. He claimed he did not feel that there were any issues with the formula and felt the lost weight was directly related to poor parenting. He did not indicate he had offered any recommendations to the family. He stated he had set up a follow-up appointment to see the victim child again. He was then asked if he had any concerns regarding the other children and he denied having any concerns of child abuse or neglect. He

stated that the family did miss a medical appointment the day prior but the physician stated the family had requested to have their follow-up appointments at Meadville Medical Center.

On 03/03/2016, collateral contacts were made with Children's Hospital of Pittsburgh. [redacted] commented it appeared as though the victim child was not being fed regularly. However, the mother did extremely well with the victim child while in the hospital. She stated that it does not appear as though the family had received proper guidance from the original primary care physician and now the parents are following a strict feeding schedule.

The victim child [redacted] on 03/03/2016 and [redacted] were scheduled as well as [redacted].

On 03/04/2016, a home visit was conducted, present were the parents and the victim child. The heating issues had been fixed in the home and the visit was conducted at their residence. The home was in poor condition and did not have water as the pine lines broke. The father claimed he was going to be repairing them. The family was using bottled water to make bottles for the victim child. There was plenty of water available as observed by the caseworker. The victim child appeared to be more alert and appeared to have his needs met. The family now has the victim child on a strict feeding schedule and he eats every 3 hours and whenever he appears to be hungry. The father became upset during this assessment and stated that he did not realize that he was doing anything wrong. The family was asked about their living arrangements at this time and the parents stated that they continue to spend the majority of the time at the father's parents' home. The father also stated that he has been taking the victim child over to his sister's home in the morning, so she can help him with the victim child throughout the day. They reported that they spend very limited time in their home and mainly use it to sleep at night. It was determined that the children were safe in their current living environment.

On 03/11/2016, a home visit was conducted, and the entire family was present for this visit. The family continued to clean up the home. The water lines still were not functioning and the father was working on replacing the broken water lines. The victim child was at the aunt's home as the father was helping his brother-in-law with a vehicle repair. The mother returned from work at this time and brought the victim child over with her to the home. The victim child appeared to be doing well and was alert during the visit. The family continued to use bottled water due to the possibility of lead being in all the water pipes. The family reported that the victim child was continuing to gain weight and was doing well. They were very concerned his previous primary care physician did not help them with their concerns of the child's low weight. The family reported they have continued to work with services, [redacted], and things have been going well. The family was informed at this time that the County will be opening them for services due to the severity of the incident. It was explained the home conditions were a concern as well and the

family stated that they spent the majority of their time at his parent's residence. The case was opened for ongoing services on 04/01/2016.

A phone call was placed to [redacted] on 03/23/2016 to see how the victim child was doing, it was stated he had been coming in for weight checks and [redacted] had been meeting with the family for weight checks as well. [redacted] reported the victim child continued to gain weight appropriately. [redacted] had only met with the father and the baby and at the grandparents' home. She was concerned with the family's home conditions as she had not been allowed to go into the family's actual home. She said that the victim child was always dirty when he came in for his checkups and often had dirt under his nails. She stated they have not seen the other children at their office as of yet, but the results from victim child's [redacted] was appropriate and was not elevated as previously presumed. The pediatrician upped the victim child's caloric intake by having the family add an extra scoop of formula to the bottle. She said that the family was supposed to do this twice a day, but was only doing it once and this had to be reiterated to them.

On 03/24/2016, the caseworker met with the parents at the agency office to conduct interviews with the parents. The caseworker first spoke with the mother. She reported that when the victim child first came home from the hospital she was breast feeding. She stated he was doing very well and she went back to work on 01/05/2016. She began using formula to supplement her breast feeding. Once she returned to work she was unable to continue breastfeeding. The mother stated she felt like victim child was not growing but she did not know why. She explained the pediatrician showed no concern for his size during their appointments. The caseworker asked her if she knew what the victim child's feeding schedule was like while she was at work and she reported that the father never really told her how many times or how much he was eating while she was at work. She reported that when she would return home from work she would feed the victim child and he would consume about 5 ounces. She said a couple hours later she would give him about another 5 ounces of sugar water. The caseworker asked why she would give him the sugar water and she reported that it was to assure that he was hydrated and that it was something that she had done with all of her children. She mentioned the victim child would go to sleep shortly after drinking the sugar water and would wake up about two times per night and would consume 5 ounces of formula each time.

The caseworker asked the mother if she had any concerns regarding the father's ability to care for the victim child and she reported no concerns. She stated that he does well with all of the children. She reported that she takes on most of the responsibilities in the home. She claimed the children get baths every other day. The mother also stated that ever since they went to the pediatricians and the victim child was placed on a strict feeding schedule he is doing better. She explained before there was no actual feeding schedule and now the baby eats 3-4 ounces every 3 hours. She mentioned she never had a feeding schedule for her older children and did not think they were doing anything wrong. The mother reported she never has missed a doctor's appointment for the victim child and the previous

pediatrician never reported any concerns to her regarding his size or weight so she assumed he was just a small baby. The mother commented she was upset with the care they were receiving from the previous pediatrician so she transferred the children to [redacted]. She articulated she did not like his bed side manner and felt like he did not give them the answers to their questions or any guidance. The mother explained she had asked about the victim child's weight and size and was told he was fine and to continue feeding him. The previous pediatrician gave the victim child his scheduled shots. She reported that she found out once she got to [redacted] that he had forgotten to give him one of his shots and it needed to be administered there. The mother denied withholding food from the victim child and denied realizing that he was not getting enough nutrients although she did feel something was wrong. Hence, she took him into the emergency room the night that he was transferred to Children's Hospital of Pittsburgh for failure to thrive.

The caseworker spoke to the father. The father was spoken to privately as well. He said when the victim child was first born the mother was the main caretaker as she was breast feeding. He reported the mother went back to work sometime in January and the victim child was placed onto formula. When the mother went back to work he was home alone with the victim child and would often rely on his sister for assistance. The victim child would wake up around the time the mother would be leaving for work. Once the victim child awoke, the father would make him his first bottle of the day but he hardly ever ate. The father claimed he only would consume about a 1/2 oz. to an ounce of formula. The father said that he would go back to sleep at this time as well and both would sleep until around 10:00 AM. At 10:00 AM, he would prepare another bottle for the victim child and then either go to his sister's or his parents' residence for the day. He said the victim child would drink about 1-2 ounces around 10:00 AM and then would take a binky. He reported he would then go to his parents' house where his mother would feed the victim child and would yell at him [the father] as she felt like he was not feeding the victim child. He claimed his mother was able to get him to eat 1 ½ to 2 ounces. At around 12:00 PM, the father would give him sugar water and the victim child would drink about 2 ounces. The caseworker asked why he would give the victim child sugar water and he was not sure but stated it was something he and his wife did with all of their children. The victim child would then fall asleep and he would let him nap for about two hours. When the victim child would wake up from his nap the father would sometimes give him a little bit of baby cereal with some sugar on it and about another ½ ounce of formula. He mentioned that sometimes the victim child would take another nap around this time until 4:00 PM. The mother would get home around 4:00 PM from work. He reported when the mother would get home he would usually leave and go to his parents' house and she would care for the victim child until he would come back around 7:00 PM. He reported that he did not realize he was not feeding him enough. He said now they have the victim child on a strict feeding schedule and he appears to be doing better. The father now makes certain the victim child is finishing 3to 4 ounces every three hours. He said that he is paying much closer attention to what the victim child is eating. The father claimed he only fed the victim child when he appeared to be hungry and was always told never to wake a sleeping baby.

On 03/30/2016, the Crawford County caseworker contacted the [redacted], it was reported the family has followed all guidance from their services and were doing well. They also stated they believe the family was let down by their Primary Care Physician and were not provided enough guidance in the matter of the feedings and they also believe the family was unaware the victim child was not receiving adequate nutrition.

On 04/12/2016, a follow-up collateral contact was made with [redacted] physician. She stated with the 20 ounces that the victim child had reportedly received he would not be receiving enough nutrition and would lose weight. She stated the parents are not at fault here as much as the primary care physician for not recognizing the victim child was not receiving proper nutrition and no guidance was given to the family. A review of the medical records from the primary care physician was completed.

Based on the information from the investigation and collateral contacts with the service providers and consulting with the [redacted], this report was determined to be unfounded on 04/29/2016.

The county completed a diligent search on the family as well as put in motion a Family Group Decision Making meeting. This has been a slow process due to the mother filing for divorce from the father as well as trying to gain adequate housing. She currently is living with her aunt. The county reports that all of the children are doing well and the victim child is gaining weight and is healthy. The victim child has made all of the follow-up appointments.

The case remains open for services.

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:

Relevant information in regards to the status and well-being of the victim child was gathered diligently and timely by the Crawford County CYS intake department in order to make an informed decision about the safety and well-being of the children and the family. Intake investigations began immediately and within the time frames on all received reports in regards to the family and children. The family utilized family supports to alleviate potential risk and safety factors on previous investigations. It is unknown at the writing of this report if family supports continue to be an appropriate and safe alert as to the safety of the children. On previous investigations all intake investigations were completed in a timely manner. Mandated paperwork was completed timely. Collaboration between the [redacted] and CYS occurred routinely and in a timely manner. Services were offered to the family to alleviate potential safety and risk concerns. The

safety assessments were completed within the necessary time frames. All risk assessments were completed within the necessary time frames.

Deficiencies in compliance with statutes, regulations and services to children and families:
No deficiencies noted.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
At the conclusion of the writing of this report and prior to the multidisciplinary team meeting, Crawford County CYS offers no recommendations for change at the county level. At the conclusion of the writing of this report and prior to the multidisciplinary team meeting, Crawford County CYS offers no recommendations for change at the state level.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
No recommendations noted.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:
No recommendations noted.

Department Review of County Internal Report:

The county submitted their report in a timely manner within the required 90 day timeframe. 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.

County Weaknesses:
None noted at this time.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:
No areas of non-compliance noted.

Department of Human Services Recommendations:

Even though the county agency received multiple reports for concerns for heating in the family home, the family had depended upon family members to assist them in having their needs met. However, there appears to have been no consideration in connecting the family to local community supports to assist the family in repairing

their family home to ensure the family's safety such as weatherization program [redacted], and that the county needs to ensure community services are utilized for their families.