



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## **REPORT ON THE FATALITY OF:**

DeAndre Andrews

**Date of Birth:** 10-07-97

**Date of Death:** 1-27-14

**Date of Oral Report:** 2-14-14

### **FAMILY NOT KNOWN TO:**

Bradford County CYS

Family known to Montgomery County CYS

### **REPORT FINALIZED ON:**

6/12/14

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. 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, DPW 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. Bradford County has convened a review team in accordance with Act 33 of 2008 related to this report. Montgomery County CYS participated in Bradford's review.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
DeAndre Andrews	VC	10-07-97
██████████*	Mother	██████████73
██████████*	Father	██████████71
██████████*	Sister	██████████91
██████████*	Brother	██████████93
██████████*	Sister	██████████99
██████████*	Sister	██████████02
██████████*	Sister	██████████07

\*Indicates that the individual was not a Household Member

**Notification of Child Fatality:**

Montgomery County Children and Youth was made aware of the child's death on 1-27-14, the day it occurred. This case was not reported as a fatality through ChildLine until 2-14-14. DeAndre was residing in Firely Pediatric Services in Bradford County. DeAndre was medically fragile ██████████. On 2-14-14, ██████████. There was a concern that DeAndre did not have the required 2 to 1 staff for which Montgomery County had contracted. ██████████ ChildLine was contacted on 2-14-14 and the case was referred to the Northeast Regional Office (NERO) at that time both as a ██████████ and a Fatality.

### Summary of DPW Child Fatality Review Activities:

The NERO did a thorough case review, in conjunction with Bureau of Human Services Licensing (BHSL), of the child's file at Firely Pediatric Services. Interviews were conducted with the 2 staff that were working the day that DeAndre passed away. The director of the program was also interviewed. DeAndre's medical file was reviewed by NERO and NERO consulted (in conjunction with BHSL) with Dr. [REDACTED], a child abuse specialist/medical physician from [REDACTED], regarding DeAndre's condition. Montgomery County Children and Youth provided file information as well as firsthand knowledge of the case. The NERO coordinated an Act 33 meeting through Bradford County Children and Youth. Montgomery County Children and Youth also participated in this meeting. This was held on March 17, 2014.

### Children and Youth Involvement prior to Incident:

Case was referred to Montgomery County Office of Children and Youth (MCOCY) on 5/8/09 due to caretaker's inability to cope, inadequate healthcare, and inappropriate discipline. There were concerns [REDACTED]. Upon

assessment it was determined that the child often inflicts injuries to himself and he was not receiving adequate medical care. [REDACTED]

[REDACTED] could no longer provide for all of his needs. [REDACTED]

[REDACTED] and he was placed in foster care until he was taken to the Hershey Medical Center after injuring the foster mother's thumb, and the foster parents were no longer able to care for DeAndre. Aside from his being fed with a g-tube, DeAndre had a tracheotomy tube, CPAP ventilator, was autistic, intellectually disabled, had Cerebral Palsy, and had [REDACTED]

[REDACTED] Aside from his medical concerns, DeAndre could be physically demanding as his arms and legs were spastic and he constantly grabbed at his g-tube and tracheotomy tube. His spasticity and grabbing necessitated at times that he be placed in physical restraints for his safety. DeAndre remained at Hershey Medical Center from 8/19/09 to 11/16/09 as an exhaustive search for an appropriate placement was undertaken. During his stay at Hershey Medical Center, [REDACTED]

[REDACTED] As his stay at Hershey grew by days, so did his behavioral problems. As a result of his spasticity and grabbing his g-tube and/or his tracheotomy tube, DeAndre was frequently sedated and/or placed in physical restraints for his safety. During his hospitalization at Milton S. Hershey Medical Center, his mother failed to visit him once. DeAndre's father did not maintain contact with his son or the MCOCY. In addition, mother and DeAndre's three younger siblings moved to Reading, Berks County in late October 2009. Subsequent to mother's move to Reading, she became increasingly difficult to contact. DeAndre was [REDACTED]

[REDACTED] On 12/02/09, DeAndre was admitted to the Children's Hospital of Pittsburgh. At that time he was having frequent bleeding from his tracheotomy tube. On 12/07/09, it was reported [REDACTED]

[REDACTED] His mother was contacted and informed. Mother immediately drove to the Children's Hospital of Pittsburgh to visit DeAndre.

The [REDACTED] later confirmed that mother visited with DeAndre briefly on 12/08/09 at the Children's Hospital of Pittsburgh. On or around 12/18/09, DeAndre received further, necessary medical procedures at the Children's Hospital of Pittsburgh, [REDACTED]

[REDACTED] The Children's Hospital of Pittsburgh attempted to contact DeAndre's mother for consent, but was unable to reach her. Attempts by the MCOCY to do the same were similarly unsuccessful; however, [REDACTED]

[REDACTED] On 12/18/09, [REDACTED], Esq. was appointed DeAndre's MCAP (Montgomery Child Advocacy Project). On or around 01/13/10, DeAndre received further necessary medical procedures at the Children's Hospital of Pittsburgh, including a [REDACTED]

[REDACTED] Mother was again unable to be contacted to provide consent. OCY got the [REDACTED]

[REDACTED] At this point in time a change [REDACTED]

[REDACTED] With that change it was hoped that DeAndre's impulse to pull out his tracheotomy tube would end, and he would be more comfortable. [REDACTED]

[REDACTED] DeAndre's chronic bleeding and clogging of his tracheotomy tube became more frequent and acute. In addition to the more acute bleeding, DeAndre's [REDACTED] he became less active and less consolable. [REDACTED]

[REDACTED] On 2/19/10, at the Children's Hospital of Pittsburgh, DeAndre had a MRI of his brain and a red blood cell transfusion. At this time, palliative – end of life – care was also discussed. Mother had been reached by the Children's Hospital of Pittsburgh and requested DeAndre be moved closer to her. [REDACTED]

[REDACTED] DeAndre as a patient on their Progressive Care Unit (a unit specifically for patients with tracheostomies). [REDACTED]

[REDACTED] DeAndre had been medically stable and had been in the Acute Care Medical Unit [REDACTED]

[REDACTED] After ensuring [REDACTED], DeAndre was accepted to transfer to the Firely Pediatrics Home for Kids II located in Harleystown, PA, which is a residential care facility for medically and behaviorally needy children who require 24 hour nursing. Mother was in agreement to the transfer. DeAndre was transferred to Firely Pediatrics Home for Kids effective June 16, 2010. He remained there until April 14, 2011 at which time he was hospitalized at Children's Hospital of Philadelphia for about the 5th time since February 2011. Neither parent ever visited with him at Firely Pediatric Services nor had either been at CHOP to see him. DeAndre was [REDACTED] and placed at Firely Pediatrics of Bradford County. Child attended [REDACTED] High School; Life Skills class at the time of his death.

Mother did not visit with child since she refused to sign the do not resuscitate in December 2009; nor has she maintained any contact with OCY. Her whereabouts were then unknown until she was incarcerated at [REDACTED] for [REDACTED]. Father's whereabouts were unknown and accurate searches have been completed. Both parents were located in Montgomery County after DeAndre passed away.

### **Circumstances of Child Fatality and Related Case Activity:**

On January 27, 2014, DeAndre passed away. [REDACTED], this case was called in to ChildLine and numbered as a Fatality on February 14, 2014. Because it was in a facility that has a contract with Bradford County CYS, the case was assigned to NERO for investigation. A CY-104, notice to law enforcement was sent to the Bradford County D.A. on 2-18-14. A thorough investigation was done regarding this case. The staff at Firely Pediatric Services was interviewed by NERO and medical records were reviewed regarding DeAndre. DeAndre was known to Montgomery County Children and Youth and was in their custody at the time of his death. Montgomery county CYS provided extensive background information on the case, and a file review was conducted by NERO. NERO consulted Dr. [REDACTED], a child abuse expert located at [REDACTED] regarding this case to get an expert medical opinion regarding the circumstances of DeAndre's death. Bradford County CYS hosted an Act 33 meeting on March 17<sup>th</sup>. NERO was present at this meeting and Montgomery County Children and Youth participated by phone. Unfortunately, there was no autopsy done on DeAndre, so there was no autopsy report to review. Due to his extensive medical conditions, the doctor on call at the time of DeAndre's death felt that an autopsy wasn't warranted. On 3-31-14, after extensive investigation, the case was unfounded. It was determined that despite the concerns at Firely Pediatric Services, DeAndre's death was not due to abuse or neglect.

### **Current Case Status:**

Currently there is no involvement with either Montgomery or Bradford County CYS. Bradford County never had involvement with the VC. They were only involved with the death review of the child because it occurred in a facility in Bradford County. Montgomery County had no involvement with DeAndre's family because they had virtually abandoned him and moved out of Montgomery County years ago. When DeAndre passed away, the case in Montgomery County closed due to no family members residing there.

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

As a result of the County's Act 33 Meetings, the following findings were noted.

- **Strengths:** The Act 33 Meeting highlighted involvement by Montgomery County CYS. They were very invested in DeAndre. Bradford County had no involvement with the child so Strengths were not discussed related to Bradford County.
- **Deficiencies:** There were no deficiencies noted related to either County agency. There were deficiencies noted with Firely Pediatric Services, but these were reviewed at the Act 33 meeting which was attended by BHSL. BHSL has issued citations in relation to the findings. These include:

1. Regulation 55 Pa. Code 3800

3800.32 (b)- A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

2. Regulation 55 Pa. Code 3800

3800.53 (b)- The director shall be responsible for administration and management of the facility, including the safety and protection of the children, implementation of policies and procedures and compliance of this chapter.

3. Regulation 55 Pa. Code 3800

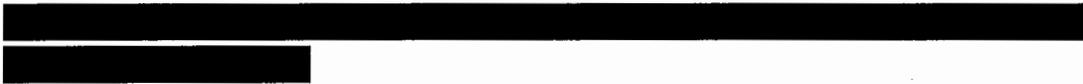
3800.213- A record of each use of a restrictive procedure, including the emergency use of a restrictive procedure, shall be kept and shall include the following:

- (1) The specific behavior addressed.
- (2) The methods of intervention used to address the behavior less intrusive than the procedure used.
- (3) The date and time the procedure was used.
- (4) The specific procedure used.
- (5) The staff person who used the procedure.
- (6) The duration of the procedure.
- (7) The staff person who observed the child.
- (8) The child's condition following the removal of the procedure.

4. Regulation 55 Pa. Code 3800

3800.227- An ISP shall be implemented as written.

Firely Pediatric Services must submit a plan of correction to BHSL.



- Recommendations for Change at the Local Level: There were no recommendations for change at the local level.
- Recommendations for Change at the State Level: The first recommendation is that the State Complex Case Team Review should meet on a regular basis. Currently this Team only meets at the time of the initial placement. It was felt that regular meetings to discuss the placement and child's need would be beneficial. The suggested frequency for such a meeting is quarterly.

The second recommendation is that facilities such as Firely Pediatric Services that take medically needy and fragile children should be inspected and licensed by the same entity that licenses and inspects medical facilities. Currently Firely Pediatric Services is inspected and regulated under the 3800 Regulations. The concern regarding this is that the individuals conducting inspections do not know medical regulations to properly ensure that all the child's needs are being met.

### **Department Review of County Internal Report:**

The County report was submitted by Bradford County CYS on May 14, 2014. The NERO concurs with the findings in the Act 33 report.

### **Department of Public Welfare Findings:**

- County Strengths: Montgomery County CYS had extensive involvement with DeAndre and was invested in his care. His placement was the result of a Complex Case Review. It appears that overall DeAndre was thriving at his placement and had made significant strides in communication and decreasing aggression. Montgomery County CYS was very helpful to NERO and Bradford County CYS in explaining the history of the case. Montgomery County CYS also actively participated in the Act 33 meeting held by Bradford County CYS. Additionally, while Bradford County CYS had never had involvement with DeAndre and did not handle the [REDACTED] investigation, they conducted a thorough Act 33 meeting and actively participated in the critical analysis.
- County Weaknesses: No weaknesses were noted at the County level.
- Statutory and Regulatory Areas of Non-Compliance: As state above, the regulatory violations were related to Firely Pediatric Services and the citations issued were through BHSL. Despite the Agency's shortcomings, it was determined that DeAndre's death was not a result of abuse or neglect.

### **Department of Public Welfare Recommendations:**

The NERO is in complete agreement that facilities that deal with medically fragile children should not be licensed under 3800 regulations alone. These programs operate as medical facilities. The 3800 regulations do not address medical care/issues. There are issues related to medical care (i.e. feeding tube procedures, sterilization, etc.) that the 3800 regulations do not address. Medical regulations do not appear to be addressed through a 3800 licensing procedure alone and the state should consider a medical licensing component in addition to the 3800 licensing.