



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

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

[REDACTED]

**Date of Birth:** 1/12/2012

**Date of Incident:** 1/17/2013  
(Estimated beginning of medical neglect)

**Date of Oral Report:** 7/03/14 (as a child abuse)  
8/06/14(certified near fatality)

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

Pike County Children and Youth

### **REPORT FINALIZED ON:**

**3/6/15**

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.

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

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child (VC)	1/17/12
[REDACTED]	Mother	[REDACTED]/77
[REDACTED]	Twin Sister	[REDACTED]/12
[REDACTED]	Brother	[REDACTED]/06
[REDACTED]	Sister	[REDACTED]/06

**Notification of Child (Near) Fatality:**

On July 3, 2014, [REDACTED] contacted Childline to make a report of suspected child abuse related to medical neglect. [REDACTED] reported that the victim child (VC) was [REDACTED]. The mother was directed to follow up with a [REDACTED] and evaluation when the child reached one year old. [REDACTED] reported that the mother failed to provide the child with the needed care which resulted in the condition worsening to the point of becoming life threatening [REDACTED]. When the child was finally taken to the hospital [REDACTED] in May of 2014, the child nearly died [REDACTED] due to her worsening condition. [REDACTED] stated this was preventable with proper medical follow up by the caretaker.

[REDACTED] reported that the mother failed to follow through with the medical needs of the VC, despite the urging of medical professionals that the mother be consistent with care. It was reported that VC's medical condition may return due to [REDACTED]

**Summary of DPW Child (Near) Fatality Review Activities:**

The Northeast Regional Office (NERO) obtained and reviewed all current records related to the child. The family had no prior involvement with the agency. This included medical records and reports, as well as documented interviews with the parent and children, as well as discussions with the doctors and [REDACTED].

A CY 104 notification to law enforcement was sent to the Pennsylvania State Police, [REDACTED], on July 31, 2014. It should be noted that the report of suspected child abuse was received by the county on July 3, 2014, but the case was not certified as a near fatality until August 6, 2014.

The agency completed the CY 48 on July 29, 2014. The case was indicated for medical neglect. The NERO also participated in the County's Act 33 meeting held on August 26, 2014.

**Children and Youth Involvement prior to Incident:**

The family had no prior involvement with Pike County Children and Youth Services (CYS) or any other CYS agency.

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

The VC was born on January 17, 2012 at [REDACTED]. This was [REDACTED] during pregnancy. The VC was seen again at [REDACTED] at 3 months old at which time the mother reported she was doing well. The doctor requested that the mother bring the VC back at approximately 1 year old to [REDACTED] to assess any development of [REDACTED]. It was emphasized to the mother that [REDACTED]. The doctor informed the mother that he would not [REDACTED]. The mother did not return to [REDACTED] with the VC when she turned 1 year old.

During mid-2013, the mother contacted [REDACTED] to schedule a follow up for the VC to [REDACTED]. Due to the VC's age, [REDACTED]. After one cancellation, this appointment occurred on November 4, 2013. The mother never scheduled [REDACTED] and did not follow up with [REDACTED] until the following year.

In April of 2014, the mother contacted [REDACTED] seeking to schedule [REDACTED] due to the child having difficulty breathing, having fevers, and not eating. The mother was told to go immediately to the local emergency room. The mother reported she was meeting the VC's pediatrician at [REDACTED] in one hour and that this was also recommended by the local urgent care who had seen the child earlier.

██████████ followed up with mother who indicated the VC was being released with a viral illness and was under the treatment of her pediatrician. It was later determined that no visit to urgent care or the pediatrician had occurred.

██████████ continued to repeatedly follow up with the mother due to concerns that the ██████████ was the cause of the child's symptoms.

Upon ██████████ request, the VC was brought to their office on May 8, 2014. Due to her ongoing symptoms and the desire to evaluate ██████████ the child was admitted. ██████████

██████████ The child's normal respiratory rate should have been 20-30; her respiratory distress caused her rate to be 80-100. ██████████

On Monday, May 12, 2014, the VC ██████████ that with proper follow up as was directed, the situation would not have evolved into a life threatening situation.

██████████ The VC ██████████ on May 20, 2014. ██████████ arranged for a pediatrician appointment with ██████████ for June 2, 2014. The VC did not appear for that appointment. ██████████ inquired with the mother as to why the appointment was missed. The mother reported she was told not to come because ██████████ had not received ██████████ records. ██████████ learned from ██████████ that they did not cancel the appointment and they had the ██████████ records since May 23, 2014. Child was seen by ██████████ on June 3, 2014.

██████████ was to be completed on June 2, 2014 to check the VC's ██████████. This could have been done locally. Mother reported to ██████████ was unable to find any ██████████ records indicating the VC did have ██████████. It was stressed to the mother how important the ██████████ was to monitor the VC and ██████████

The VC attended ██████████ at ██████████ on June 11, 2014. She was to have a ██████████ follow up with the doctor that same afternoon, but did not attend. ██████████ subsequently explained to the PA state trooper (during the investigation) that the VC was ██████████ until approximately 4 pm and

missed the appointment with the doctor. The doctor's office confirmed the child [REDACTED] until 4 pm, but they would have been accommodating to see the child after [REDACTED].

On June 25, 2014, [REDACTED] did not appear with the VC for an appointment with [REDACTED] for an [REDACTED]. The appointment was rescheduled for July 2, 2014, and again was a no show.

On June 27, 2014 the child did not appear for a follow up appointment at [REDACTED].

On July 3, 2014, the [REDACTED] made a referral to Childline based on concerns for the VC considering the history of failure to provide consistent medical care and the need for follow up to [REDACTED].

Upon receiving the report of suspected child abuse, the on-call Pike County Caseworker made an immediate response to the home of the VC. The caseworker was allowed to observe all children. No immediate safety threats were observed at this time, and the children were allowed to remain in the home.

[REDACTED] was completed on July 3, 2014 and [REDACTED] at this time.

Following the holiday weekend, the caseworker was able to make contact with the referral source and requested information and documentation from [REDACTED].

On July 7, 2014, the mother reported that the VC's primary care doctor assumed care of the VC regarding the [REDACTED]. The child's primary care physician indicated to [REDACTED] that he did not assume care and that the mother had [REDACTED].

On July 25, 2014, the caseworker conducted a follow up visit to the residence. At that point, full [REDACTED] records and correspondence from [REDACTED] had not been received by Pike County CYS (PCCYS). Full correspondence was received on July 28, 2014. The correspondence detailed [REDACTED] continued involvement with the family upon the birth of the child.

On July 29, 2014, the case was opened for services by Pike County CYS. In early August, PCCYS made multiple attempts to visit with the family. PCCYS was eventually able to meet with the mother for follow up visits. The mother would repeatedly not appear for scheduled visits and not respond to unannounced visits. At various times, a vehicle with a [REDACTED] license plate was seen at the residence.

On July 29, 2014, Pike County CYS sent a CY48 Childline registry indicating [REDACTED] for medical neglect of a child.

At that time, the case was not certified as a near fatality. Initially a CY-104 was not completed based on a conversation with the State Police. The Pennsylvania State Police stated that they normally do not investigate cases of medical neglect. The issue was revisited with the State Police by the CPS Supervisor. After discussing the seriousness of the allegations and the

indicated status, the State Police agreed that due to the seriousness of this case, a notification to law enforcement (CY-104) should be sent.

On August 6, 2014, the County was able to ascertain, through conversations with the [REDACTED] personnel, that the child was in serious or critical condition based on medical neglect, and this case was certified a near fatality.

**Current Case Status:**

Currently the VC is doing well. Since the opening of the case the VC has been attending scheduled appointments. PCCYS continues to monitor the VC's medical needs and assists the family in making sure medical appointments are attended. PCCYS continues to monitor the safety of all the children in the home through home visits and coordination of medical appointments and follow up. The mother continues to refuse to sign the family service plan. [REDACTED] **The criminal investigation is ongoing.**

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

- **Strengths:** The County responded immediately to the referral in order to ensure the safety of the children. The agency and law enforcement had open communication and worked together of this case. The County had a timely and thorough Act 33 meeting regarding this case.
- **Deficiencies:** It took 25 days for children and youth to receive the [REDACTED] reports necessary to make a determination as to the child's safety. During that time, the child was not receiving [REDACTED] attention which could have led to serious [REDACTED] issues for the child.
- **Recommendations for Change at the Local Level:** Ongoing training for caseworkers in the area of medical records so that information can be processed in a timely fashion to help determine safety and case planning. Additionally, a recommendation was made that mandated reporters be educated in the need for providing requested records as expeditiously as possible in cases of alleged medical neglect.
- **Recommendations for Change at the State Level:** The team felt that the state should develop a General Protective Services reporting system which allows local agencies to inquire whether a family/ victim/ perpetrator has been involved with an agency in another county. The team was advised that there is a current [REDACTED] system that provides general information, but you must be an agency that has access to the system in order to view the information based on confidentiality restrictions.

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

The NERO received the County report on October 21, 2014. NERO concurs with the findings in the Act 33 report. A notice to the county informing them that NERO had reviewed their report and concurred with initial findings was sent to the county on October 23, 2014.

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

- **County Strengths:** The NERO concurs that Pike County CYS worked collaboratively with law enforcement on this case and conducted a thorough and comprehensive Act 33 meeting. The Act 33 meeting was comprised of various stakeholders and the team was able to do a critical analysis of the case and objectively look at strengths and weaknesses within the systems.
- **County Weaknesses:** NERO again concurs with the weakness cited by the Act 33 meeting. The delay in receiving the medical records necessary in order to thoroughly assess safety could have compromised the health and safety of the victim child in this case. The county did make recommendations it try to correct this in the future.
- **Statutory and Regulatory Areas of Non-Compliance:** There were no areas of noncompliance noted in regard to this case.

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

NERO has no further recommendations beyond those identified at the Act 33 meeting.