pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/01/2002
Date of Incident: 1/19/16-1/25/16
Date of Report to ChildLine: 1/29/16
CWIS Referral ID: [redacted]

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

Northumberland County

REPORT FINALIZED ON:
08/02/2016

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:

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, 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.

Act 33 of 2008 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. Northumberland County has not convened a review team in accordance with Act 33 of 2008 related to this report. The county review team did not convene as the report was unfounded within 30 days of the initial report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/01/2002
[redacted]	Full Sibling	[redacted]2003
[redacted]	Full Sibling	[redacted]2005
[redacted]	Half-Sibling	[redacted]1998
[redacted]	Mother	[redacted]1977
[redacted]*	Father	[redacted]1969
[redacted]	Half-Sibling	[redacted]1996
[redacted]	Mother's Paramour	[redacted]1969

* Denotes an individual that is not a household member at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a preliminary meeting with the Multidisciplinary Team (MDT)/Act 33 Review board on 2/3/16 to discuss initial case information. Follow up discussions were conducted with the Caseworker Supervisor on 2/25/16 and the Intake Director and Administrator on 3/8/16.

Children and Youth Involvement prior to Incident:

Northumberland County Children and Youth had 7 intake referrals during the period of time from 5/19/05-10/18/11 which involved members of the household. All of

these referrals were closed on intake and at no point was the family opened for ongoing services.

A referral was received on 5/19/05 alleging an older sibling to the victim child smelled like "wet dog" when going to visit her father, where numerous animals were reported to be in the home. The case was closed 6/6/05 with no finding of child abuse/neglect (CA/N).

A referral was received on 6/6/06 alleging the younger sibling was underweight, another younger sibling was not potty trained, the victim child may have eaten dog feces, and poor home conditions. It also alleged that the mother threatened self-harm if father took the children and that she was physically aggressive to the father. A second referral was received 6/9/06, alleging that the mother threatened the maternal grandmother in front of the children. The report was assessed and the case was closed on 7/19/06 with no finding of CA/N.

A referral was received on 4/5/07 alleging the children sometimes wear the same clothes, the 10 year old watches the siblings sometimes, the children are allowed to walk alone and the 8 year old is sometimes in caretaker role. The case was closed on 4/9/07 with no finding of CA/N.

A referral was received on 5/9/08 concerning the mother's paramour's child who visited in the mother's home. There were reported concerns regarding the language the mother used with the child. The allegations were addressed and the case was closed 5/13/08, with no finding of CA/N.

A referral was received on 1/24/09 alleging the oldest sibling did not want to go home to her mother, the home was a mess, there was no heat upstairs and there was not always clean clothes to wear. The family home was assessed and the case was closed on 2/4/09 with no finding of CA/N.

A referral was received on 9/11/11 alleging the oldest sibling didn't want to return to her father's home alleging her father threatens her, throws things at her and leaves her home alone for long periods. The report was assessed and the case was closed on 10/18/11 with no finding of CA/N.

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

On 1/29/16, a report was received from Geisinger Medical Center regarding the victim child (VC) [redacted] According to the report, the mother contacted the VC's [redacted] who directed the mother to take VC to the emergency room (ER). The mother took the VC to the ER on 1/19/16 and 1/20/16 for care. The VC continued [redacted], however, mother did not contact the [redacted] Department after these ER visits or take the child back to the ER. It was alleged that during the same time frame, the family was not [redacted] routinely and not [redacted]

[redacted] On the evening of 1/24/16, the VC reported seeing yellow & that it was hard to breath. On 01/25/16, the VC was found unresponsive in the bathroom and taken to the ER and admitted [redacted] The victim child was considered to be in critical condition and the report was registered as a near fatality.

It was reported that the family is well educated on how to care for the victim child's [redacted] At the time this report was registered on 1/29/16, the victim child had been in the hospital since 1/25/16 and [redacted] home. The child had been in the care of both her mother and father in different households during the time of concern and both were listed as alleged perpetrators.

On 1/19/16, the VC and her siblings were seen in the mother's home by Northumberland County Children and Youth on-call personnel. The VC and her siblings live with the mother but visit the father. No immediate concerns were identified with the siblings or their care. With both parents being named as alleged perpetrators, a safety plan was put in place for the VC in that identified third parties will assist in assuring medical care of the VC at all times during the course of the investigation. The mother's paramour, her cousin/next door neighbor, and her adult son were identified while the VC was in the mother's home. The father lived at the paternal grandparents' residence, who were approved to assist with assuring medical care of the VC in their home when she is visiting.

The VC was interviewed and denied any neglect by the alleged perpetrators. The VC reported that [redacted] The alleged perpetrators were interviewed and denied neglecting the VC's medical needs. [redacted] Medical records were received and reviewed and no concerns for the child's care were documented prior to the report. The VC was admitted to the hospital on Monday, 1/25/16 and was in very serious condition. This report of suspected child abuse was not received until Friday, 1/29/16. It is documented in medical records that prior to the VC's hospital admission, the mother had taken the child to the ER on two occasions due to having concerns with the VC's health. On both of those occasions, the VC was treated and released. The mother also has documentation and phone records that she had many attempted phone calls to the VC's doctor regarding the her health concerns. The mother denied [redacted] which was the time frame in which the VC's [redacted] Both parents understood the requirements [redacted] of their daughter's condition and were not found to be negligent. The report was made unfounded and the family was closed at intake on 2/26/16.

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

Northumberland County Children and Youth did not convene a near fatality review team meeting as a determination was made within 30 days of the initial report.

Department Review of County Internal Report:

Northumberland County Children and Youth held preliminary meeting with the MDT/Act 33 Review board on 2/3/16. At the time only emergent information had been obtained and there was little to review or discuss with the team. The report was unfounded within 30 days therefore they did not hold another meeting or formalize a report.

Department of Human Services Findings:

- County Strengths:
  Northumberland County Children and Youth held a preliminary meeting to discuss the case at their regularly scheduled MDT meeting on 2/3/16. They had only completed the initial assurance of safety and had only minimal information concerning the situation. Consultation was obtained by medical providers on the MDT team that was useful in the investigation. They did not hold a formal Act 33 meeting as the report was made unfounded within 30 days of the date of report.

- County Weaknesses:
  No weaknesses identified.

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

Department of Human Services Recommendations:

- If the county is going to hold a preliminary Act 33 meeting, a formal report should be created even if the report is unfounded within 30 days.