pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/26/2014
Date of Incident: 04/19/2016
Date of Report to ChildLine: 04/19/2016
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:

Family not known to Schuylkill County Children and Youth Services
Family was known to New Jersey DYFS

REPORT FINALIZED ON:
11/16/2016

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.

Schuylkill 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 05/13/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	08/26/2014
	Sibling	[redacted]2012
	Mother	1988
*	Father	1993
*	Sibling Father	1983
	Mother's Paramour	1988
	Mother's Paramour's Mother	1960
*	Maternal Grandmother	08/26/1966

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

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office of the Office of Children, Youth and Families (NERO) communicated with the agency via phone upon receipt of the report to review initial referral and allegations.

The NERO participated in the Act 33 meeting on 05/13/2016. A site record review was conducted by DHS/OCYF/NERO. In person interviews were conducted with the assigned Child Protective Services (CPS) caseworker and supervisory staff. Background information was secured regarding prior case involvement. Current case documentation was secured and reviewed.

Children and Youth Involvement prior to Incident:

No involvement with Schuylkill County Children and Youth or any Children and Youth agency in Pennsylvania.

On 04/20/2016 while the CPS investigator met with the family at Lehigh Valley Hospital (LVH), CPS Supervisor contacted New Jersey Division of Youth and Family Services (DYFS) to inquire if family was known. It was learned mother and children lived with maternal grandmother in Somerset County, New Jersey where there was one CPS intake 10/12/2015 for environmental neglect and inadequate supervision. Allegations surrounded family home being "trashed," dirty and with an odor and concerns sibling is often unattended in front yard of family home. Allegations were investigated, unfounded and case was closed 01/22/2016. Somerset County also received a no response call 02/25/2016 for sibling, [redacted], missing 37 days of school but due to child not being of mandatory school age they did not respond. Records were received 04/29/2016 from New Jersey DYFS outlining their home visit with family.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/19/2016 the agency received a Child Protective Services Near Fatality report for allegations of Causing Serious Physical Neglect of a Child. The referral source indicated the child victim has a complex medical history, [redacted] The child victim was born with a condition [redacted] The child victim was [redacted] where he [redacted] at the end of March 2016 [redacted] One hundred percent of the child victim's nutritional needs were to be given [redacted] The child victim's mother moved to Pennsylvania with her new boyfriend and she removed [redacted] and was feeding him through his mouth, whatever food he would take. The mother also was not giving the child victim his [redacted] When maternal grandmother visited the family home she found the child victim looking extremely dehydrated and recommended that he be taken to LVH. Lab test completed at the hospital showed the child's [redacted] Also, the child victim had reportedly lost almost 6 pounds since leaving [redacted] The child victim was admitted to LVH and [redacted] certified the child victim to be in serious condition due to severe neglect although he was expected to survive.

Agency staff met with LVH staff, victim child, mother, mother's paramour and maternal grandmother at the hospital on 04/20/2016. Mother indicated she and the sibling to the child victim had been living in [redacted] PA since January 2016. She reported she and her paramour attended training [redacted] prior to child victim's discharge. She indicated child victim's [redacted] She reported he pulled it out one time on the way to [redacted] and they

had to put it back in. She reported that he pulled it out again, and it was left out, and she was feeding him Similac from a bottle and first stage baby food. Mother indicated [redacted] doctors told her they could do that. Mother indicated once [redacted] that the child victim was on [redacted] for 5 days and then given a bottle and it worked so she gave him bottles for 3 days and started to add baby food. Mother indicated the child victim was alright for 2-3 days and then started to vomit. Mother stated child victim started to vomit the previous Sunday although she initially thought he had the flu bug. When the child victim continued vomiting she indicated she took him to Schuylkill Medical Center South where he spent 2 nights in the hospital. She indicated the doctor also thought it was the flu and recommended Pedialyte. She reported the hospital did not say anything about putting the child victim's [redacted] back in.

The mother reported the child victim has not attended any follow up appointments since [redacted] but stated there was an appointment scheduled at [redacted] pediatrician, however; the child victim was in the hospital at the time. The mother reported she was giving the child victim a [redacted] which was supposed to be stopped but she still gave it to him. She reports also giving the child victim his [redacted] the previous day. When the CPS worker informed mother there was no sign of [redacted] in the child victim's system, she indicated he was vomiting and also that she may have lost some of the [redacted] bottles. Mother provided an inconsistent story of what the child victim would ingest each day and a pattern of sleep from 7 PM until 8 AM. Numerous releases of information were obtained from the mother.

The maternal grandmother provided the CPS investigator with all the medications brought to the hospital with child victim. It appeared the child victim was not being provided with his medications regularly. The maternal grandmother indicated the child was to receive [redacted] care upon [redacted] but the child victim and mother moved from New Jersey to [redacted] so the services never began. The maternal grandmother reported she scheduled a [redacted] appointment at [redacted] after the family moved but they did not get to keep the appointment. Maternal grandmother indicated she visited the children in [redacted] when she could and the mother and paramour also brought the children to New Jersey to visit. Maternal grandmother indicated mother was [redacted] and believed to be [redacted] Maternal grandmother indicated mother graduated in 2007 with a high school diploma [redacted] The maternal grandmother reported she works in New Jersey and the mother, paramour and children came to visit her at work. Maternal grandmother stated child victim looked horrible but when she saw him later in the afternoon at her home, he looked better. Maternal grandmother reported that the mother indicated that the child victim had been vomiting and she told them to take him to the hospital which they did. Maternal grandmother reported the child had an appointment on 05/10/2016 with a [redacted] at LVH and 05/13/2016 with a pediatrician at [redacted] Maternal grandmother also indicated the child victim is involved with the [redacted] The maternal grandmother indicated she

takes child victim and mother to any medical appointment paramour cannot take her to. The maternal grandmother also indicated mother is 7 weeks pregnant at this time.

Mother's paramour confirmed he and mother went to [redacted] training prior to the child victim's [redacted] He reported at the time [redacted] the mother and sibling were already residing with him for around 3 months. He and his mother would drive the mother back and forth to [redacted] in New Jersey to visit with the child victim. He stated after [redacted] they stayed at the home of the maternal grandmother until [redacted] in Schuylkill County. He stated at the point of the referral, the child victim has been in [redacted] for approximately 2.5-3 weeks. He reported although [redacted] they were told to try a bottle and if he did well to keep giving it to him. He stated the child victim was always pulling at [redacted] and the tape on his cheek was making him sore. He stated due to the child victim always pulling on [redacted] they took it out one day to replace it but due to him doing well drinking from the bottle while [redacted] was out, they kept it out. He reported the previous week the child victim started throwing up with every feeding and they continued to provide him with bottles, baby food and mashed potatoes while sitting in the high chair. He indicated they took the child to Schuylkill Medical Center South after he threw up for a few days. He stated the hospital kept him for a few days and indicated they were told about the child victim's [redacted] issues. He indicated he works odd jobs during the day and his mother is home with the children if needed.

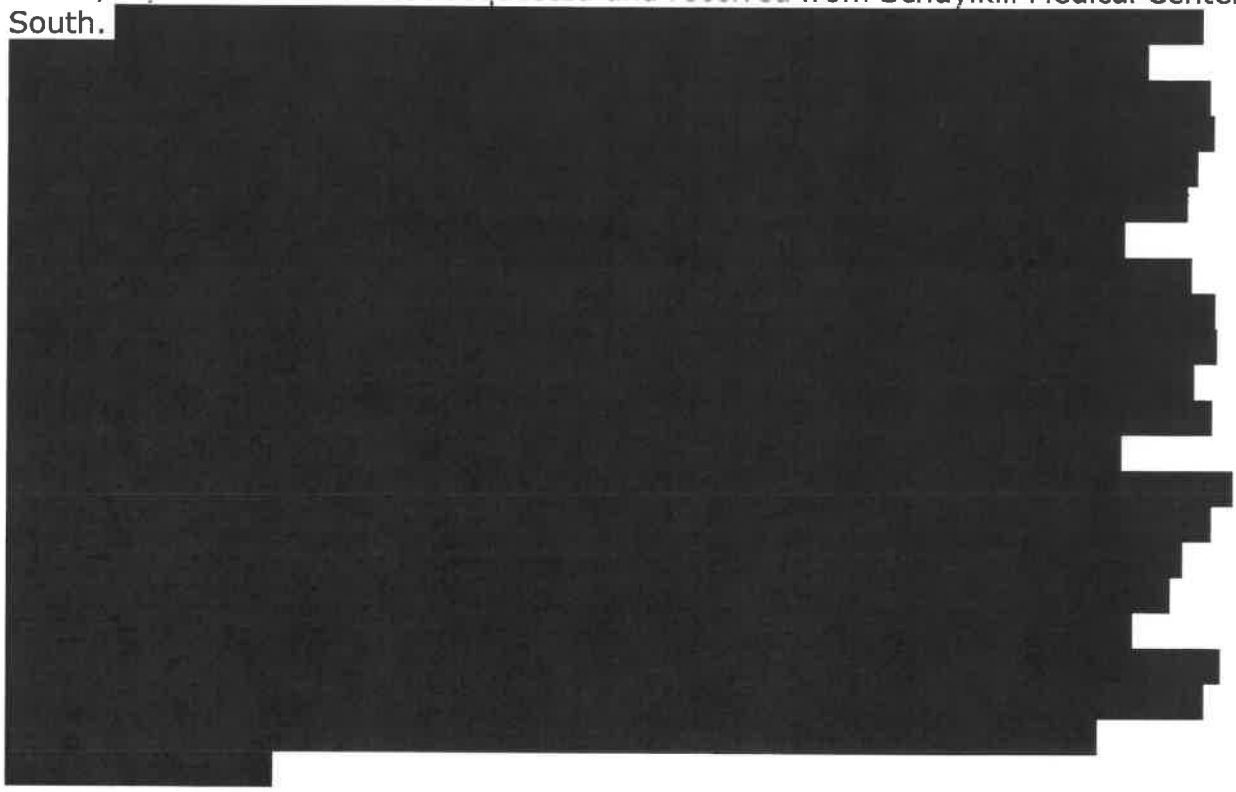
A meeting was also held with hospital staff 04/20/2016 who indicated they were attempting to have child victim transferred to New Jersey, if possible, as they are familiar with his medical history. [redacted] They did indicate, however, they obtained information [redacted] indicating child victim weighed 12.3 kg [redacted] and was weighing in at 10.5 kg on 04/20/2016 which was over a 4 lb. weight loss in 3 weeks. On 04/21/2016 LVH contacted the agency to report they were looking at possible [redacted] of the child victim on 04/22/2016. The agency expressed concern for the child victim being [redacted] his mother's care and also expressed concern surrounding the fact mother, maternal grandmother and paramour all indicate the child victim regressed developmentally since [redacted] Questions were raised with LVH as to whether this could be due to his dehydration and weight loss or whether something else was going on medically with the child victim. LVH was not able to fully answer the question. The agency expressed great concern surrounding [redacted] due to the current medical state of the child victim not being fully known.

On 04/21/2016 the agency explored options for the maternal grandmother to possibly become an emergency caretaker for the child victim out of state. A call was placed to Interstate to discuss options and several calls transpired between the maternal grandmother and the agency. Also on 04/21/2016 referrals for medical

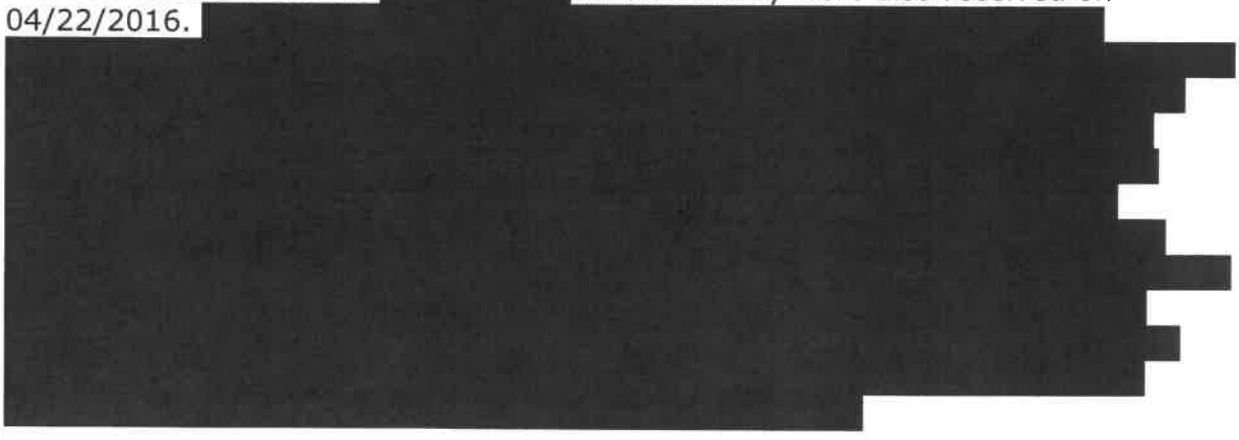
foster homes were made. On 04/21/2016 contact was made with [redacted] in New Jersey and medical records were requested.

On 04/21/2016 a visit was made to the home in [redacted] and contact was made with mother, paramour, mother's paramour's mother and sibling. A safety assessment was completed on the child victim's sibling and there did not appear to be any safety concerns as she had no ongoing medical needs and appeared developmentally more mature than child victim.

On 04/22/2016 records were requested and received from Schuylkill Medical Center South.



Medical records from the [redacted] in New Jersey were also received on 04/22/2016.



[redacted] Also it should be mentioned an additional discussion was held with [redacted] staff on 05/23/2016 requesting subsequent information regarding the training received by the mother and her paramour [redacted]

[redacted]

On 05/02/2016 the maternal grandmother, who had been spending every day with child victim at LVH and CHOP, indicated she was not able to be a resource for victim child as she could not realistically do it long term long, as needed. On 05/06/2016 additional referrals were made for medical foster care homes. On 05/09/2016 a medical foster home was found and the foster parents completed training at CHOP 05/11/2016.

[redacted] On 05/12/2016 child victim was placed into medical foster care home.

Additional home visits were made with the mother and sibling 05/09/2016, 05/11/2016, 05/31/2016 and 06/21/2016 to discuss victim child's circumstances, obtain additional releases of information and assess safety of sibling in the home. Foster home visits were made with victim child 05/12/2016, 05/31/2016, and 06/24/2016. Victim child is progressing developmentally and medically in foster

home. [redacted]

The case regarding child victim and sibling continues to receive agency placement and general protective services. The goal for victim child at this time is reunification with mother, however, the agency is scheduling [redacted] assessments for mother to determine if she is able to meet victim child's needs. Adoption is victim child's concurrent goal. Safety of the sibling is continuing to be assessed in the home.

After a full examination of all medical records, on 06/16/2016 the agency determined the case to be INDICATED with [redacted] as the perpetrator as she failed to provide the child victim with proper nutrition resulting in the child victim's weight decreasing and sodium levels indicating dehydration. [redacted] not replacing child victim's [redacted] when the child victim removed it and her admitting to feeding child victim strictly via mouth, was against [redacted] recommendations.

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;

  Schuylkill County Children and Youth Services' Fatality/Near Fatality Report submission presents a very detailed analysis of the investigation of the incident. The staff also worked diligently to obtain all relevant medical information.

- Deficiencies in compliance with statutes, regulations and services to children and families;

  There was no identification of deficiencies in compliance with statutes, regulations and services to children/families.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  No changes were recommended.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

  No changes were recommended.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  No recommendations were made regarding the collaboration between community agencies and service providers.

Department Review of County Internal Report:

The NERO received the county report and requested clarification on 04/19/2016. The NERO had conversations regarding the report on 04/19/2016, 05/13/2016 and 06/13/2016. The NERO received the final report on 08/02/2016 and does concur with the findings in the county report.

Department of Human Services Findings:

- County Strengths:

  DHS/OCYF/NERO has determined that Schuylkill County Children and Youth Services commenced the CPS investigation of the victim child's case in a timely and thorough manner. The county agency has followed all established protocols for referral to law enforcement agencies and collaboration established by statute and DHS regulations. Site record review by DHS/OCYF/NERO has validated that there has been extensive collaboration and information sharing on the part of medical personnel, law enforcement and county child welfare personnel regarding this case. No county weaknesses were identified and no statutory or regulatory violations were found.

- County Weaknesses: and

  No areas of weakness were found.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  No areas of non-compliance were found

Department of Human Services Recommendations:

DHS/OCYF/NERO has no recommendations and concurs with the county's report.