pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/04/1999
Date of Incident: 08/17/2016
Date of Report to ChildLine: 08/18/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Schuylkill County Children and Youth Services

REPORT FINALIZED ON:
January 17, 2017

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 09/16/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Child Victim	02/04/1999
	Mother	[redacted]1981
	Father	[redacted]1978
	Maternal Uncle	[redacted]1983
	Maternal Uncle's Paramour	[redacted]1993

* 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 Schuylkill County Children and Youth Services via phone upon receipt of the report to review the initial referral and allegations.

The NERO participated in the Act 33 meeting on 09/16/2016. A site record review was conducted by the Department of Human Services (DHS) 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:

Child victim and mother have a history of involvement with Schuylkill County Children and Youth dating back to December 2006. On 12/19/2006 the agency received a General Protective Service (GPS) referral due to concerns with the child victim's school attendance, inability to regulate child victim's [redacted] and concerns the child victim was not [redacted] It should be noted that the child victim is a [redacted] There was no evidence obtained to support the child victim was not receiving [redacted] at home, as recommended. The agency intervention resulted in a log book for communication between mother and school regarding the child victim's [redacted] The family was closed from intake 02/20/2007.

On 05/04/2007 Schuylkill County Children and Youth received a GPS referral for concerns with unstable housing of the family, poor school attendance and allegations of physical discipline. The child victim denied physical discipline, the truancy policy was explained to the mother and the child victim in attempt to defer a truancy referral from the school, mother had stable employment and the family was residing with relatives, at the same residence during the prior intake, which did appear stable. The family was closed from intake 06/05/2007.

On 08/26/2009 the agency received a GPS referral due to the child victim being admitted to the hospital the prior day [redacted] This was reported to be the child victim's fifth hospitalization since January 2008 at said hospital. There was concern that the mother was continuing to be provided [redacted] however, the child victim continued to be hospitalized due to noncompliance. The child victim was [redacted] on 08/27/2009 [redacted] was secured, the child victim's cooperation [redacted] was monitored for a month [redacted] a communication board was secured at home to assist in keeping appointments and the prior communication log was reinstated [redacted] The family was closed from intake 10/13/2009.

On 10/24/2012 the agency received a GPS referral regarding inappropriate discipline by the child victim's mother toward a niece, age 5, who was residing in family home temporarily and of whom she had guardianship. Due to receiving 3 calls within 2 weeks during the intake assessment regarding the use of inappropriate discipline, the family was opened for agency services 11/21/2012 and a referral was made for [redacted] services. General protective and [redacted] services were provided to the family, [redacted] medical appointments was monitored for the child victim, appropriate parenting was monitored, and on 11/15/2013 the family was successfully discharged from [redacted] services; the child for whom the

child victim's mother had guardianship returned home with her biological mother on 01/31/2014 and the family was closed from agency services 03/20/2014.

On 05/22/2015 the agency received a GPS referral because the child victim was hospitalized [redacted] Contact with the hospital confirmed that the child victim was [redacted] The child victim [redacted] and failed to follow through with a follow up [redacted] appointment due to a lack of transportation. The allegation of inadequate health care was validated and the family was again opened for agency services 07/20/2015. The caseworker monitored the child victim's attendance [redacted] The case was closed from services 06/29/2016.

The agency had one intake involving the children of the other named perpetrator, the child victim's maternal uncle. On January 01/30/2015 the agency received a GPS referral with concerns for [redacted] of the mother of maternal uncle's children. The children remained in the care and custody of their father, the maternal uncle and his paramour until their mother's [redacted] The intake was closed 02/10/2015.

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

When the agency received the CPS referral on 08/18/2016, child victim and mother were at Geisinger Medical Center. Contact was made with the hospital and arrangements were made for the family to be seen at the hospital the next day.

The CPS investigator met with the maternal uncle and his paramour at their home at the end of the day on 08/18/2016. During the home visit it was learned that the child victim had been staying in their home off and on sporadically throughout the summer, but more frequently the past few weeks. Mother frequented the maternal uncle's home and was the primary caregiver for the child victim's medical needs. The uncle and his paramour reported they were aware of child victim's [redacted] but did not know a lot of specifics. They reported the mother and the child victim [redacted] and doctor appointments. They also reported that the child victim stayed at the home of the uncle's ex-wife from 08/14/2016 to 08/15/2016. The child victim's mother reportedly picked the child victim up from practice at the school on 08/15/2016 and brought her to their home in the evening. The child victim reported to the uncle and paramour that she and her mother [redacted] The paramour reported when the child victim was returned to their home 08/16/2016 she appeared ill and did not want to eat. The uncle's paramour reported she allowed the child victim to "sleep it off" but when the child victim woke in the morning and [redacted] she knew the child victim needed to be taken to the emergency room. The uncle's paramour

reported that she tried to contact the mother and could not so she took the child victim to the emergency room herself [redacted]

On 08/19/2016 the CPS investigator met with the medical professionals and hospital social worker at Geisinger Medical Center before meeting with family members. [redacted] that the family has also been non-compliant with [redacted] appointments. The mother was sent letters on 04/04/2016 and 06/06/2016 informing her that the child victim is overdue for medical appointments. The child victim was last seen by her [redacted] on 11/17/2015. The child victim was to have a follow up in 3 months, which would have been February 2016, with [redacted] The social worker reported it appeared that the child victim's [redacted]

After meeting with hospital staff, an interview was completed with the child victim. The child victim did not remember what day she was admitted to the hospital but reported her uncle's paramour over reacted and took her to the local emergency room. The child victim reported her uncle's paramour came into her room that morning and noticed she was vomiting and had no color. [redacted] The child victim stated she tried to explain to her uncle's paramour that she did not need to go to the emergency room and that she just needed to wait for her mother [redacted] but the uncle's paramour would not listen. The child victim reported her mother came to the emergency room shortly after her arrival, [redacted] The child victim explained she and her mother moved into a home in [redacted] in August 2015 but shortly thereafter had to stay with friends and family due to problems with the landlord not fixing things. [redacted]

On 08/19/2016 an interview was completed with the mother at the hospital. She indicated the child victim was with her on 08/15/2016 and didn't report anything was wrong. On 08/16/2016 the mother reported that the child victim told her she was not feeling well and that she had a headache and belly ache. The mother bought her a Lunchable, gave her Tylenol, and allowed her to nap at her uncle's home. The Mother reported she transported the child victim [redacted]

appointment in the late afternoon and the child victim reported she still did not feel well afterward so she took her back to her uncle's to sleep. The mother indicated the child victim texted her throughout the evening and verbally asked her to take her to the hospital tomorrow if she still wasn't feeling well in the morning. The mother reported the child victim messaged her on the morning of 08/17/2016 and was later contacted by the uncle's paramour to report the child victim was being taken to the emergency room.

During the interview with the mother, she was not able to provide the CPS investigator with a complete list of the child victim's the child victim keeps the list and her purse was not on her person. The mother reported either she or the child victim Mother indicated that she took the child victim to the pharmacy on 08/16/2016 to get her medication refilled and The mother reported she went home on 08/16/2016 and contacted the child victim's and scheduled an appointment for the child victim to be seen 09/20/2016. The mother indicated the child victim stayed with her uncle and his paramour sporadically but she saw child victim daily and was responsible for caring for the child victim's daily needs. The mother reported that the child victim would tell her if she felt ill or dizzy and the child victim or mother would check The mother indicated the child victim is responsible for her own medical needs as she is almost 18 years of age. The mother reported the child victim needs to tell her what is needed and the child victim has received nutrition and supportive education over the years. The mother indicated the child victim has been in the hospital before due to noncompliance issues but the child victim has never been this bad before.

The CPS investigator kept a close watch on the child victim's and her attendance at medical appointments. During the course of the CPS investigation medical records were obtained The records were examined thoroughly. A pattern was noted regarding the child victim being labeled as a non-compliant

[redacted] Prior to the child victim's most recent hospitalization in August 2016, the child victim was last seen by [redacted] 11/17/2015. [redacted]

On 09/29/2016 the CY48 was completed and submitted to ChildLine with the case status of Indicated, identifying the mother as the perpetrator. The maternal uncle and his paramour were Unfounded as alleged perpetrators of abuse/neglect, as all individuals admitted neither the uncle nor his paramour were responsible for the child victim's medical appointments or [redacted]

[redacted] mother and child victim removed all the child victims' belongings from the home of the uncle and his paramour. The mother and the child victim continue to place blame on the paramour for taking the child victim to emergency room. The family continues to move between relative's homes but both mother and child do appear to be taking a more active part in [redacted] g the child victim's follow up medical [redacted] appointments. The family was opened for General Protective Services on 10/14/2016 and the agency will continue to monitor the family until child victim turns age 18 in February 2017. There is also a plan to have a Family Group Decision Making Conference prior to case closure to ensure the child has the supports needed to successfully address her medical issues when she turns 18.

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' 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 and to ensure the coordination of the victim child's medical treatment.

- 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;

  Recommendation was made to have CYS staff receive training on [redacted] and monitoring.

- 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 12/16/2016. The NERO had conversations regarding the report on 12/29/2016 and 01/06/2017. The NERO received the final report on 01/06/2017 and does concur with the findings in the county report.

Department of Human Services Findings:

- County Strengths:

  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 NERO has validated that there has been extensive collaboration and information sharing on the part of medical personnel 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.

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

Department of Human Services Recommendations:

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