pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/16/2007
Date of Incident: 08/25/2016
Date of Report to ChildLine: 08/25/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Greene County Children and Youth Services

REPORT FINALIZED ON:
02/07/2017

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.

Greene County Children and Youth Services (GCCYS) did not have to convene a review team related to this report due to the fact that this case was unfounded within 30 days of the oral report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	11/16/2007
* [redacted]	Father	[redacted]1987
[redacted]	Mother	[redacted]1989
* [redacted]	Half-Sibling	[redacted]2011

* 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 Western Region Office of Children Youth and Families (WRO) obtained and reviewed all records pertaining to the family, including past history. WRO interviewed the caseworker, reviewed the entire file, including all medical documentation and collateral contacts.

Children and Youth Involvement prior to Incident:

Greene County Children and Youth Services (GCCYS) has a history related to this family as a report came into the agency on 07/23/2012 with allegations the victim child's father was using illegal substances. The report was investigated and closed on 09/04/2012. The victim child and the mother did not reside in the home with the father at the time, only the victim child's younger half sibling.

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

On 08/25/2016, GCCYS received a referral that the victim child was at Washington Hospital Emergency Department due to seizures. [redacted]

[redacted]

[redacted] the child's condition worsened in the ER and the victim child was [redacted] transferred to Children's Hospital of Pittsburgh (CHP). [redacted] The near fatality was called in at 4:30 PM and when GCCYS went to see the victim child at CHP at 9:30 PM the victim child was [redacted] up and walking around.

GCCYS immediately made contact with the victim child and the mother. The caseworker picked up records at Washington Hospital and then went to CHP to see the victim child. On the day of the incident, GCCYS put into place a safety plan that the mother would have no unsupervised contact with the victim child pending further investigation. The mother agreed and signed the safety plan. GCCYS obtained information from the mother in regards to the victim child's condition. [redacted]

According to the mother, the victim child had not had a seizure since February 2016. As part of [redacted] victim child was [redacted] Seizures can occur due to lack of sleep, growth spurts and many other factors. [redacted]

The victim child [redacted] on 08/26/2016, the day after the report was filed [redacted]

GCCYS made collateral contacts with [redacted]

GCCYS spoke to the victim child's [redacted] who advised she had no concerns for the mother's care of the victim child and felt the mother was appropriately meeting the victim child's medical needs and that she did not feel that [redacted] caused her seizure. The victim child was seizure free [redacted] so the two cannot be attributed. The child's [redacted] did not believe that that the report should have been called in as a near fatality after reviewing the victim child's medical charts and felt that the mother is an appropriate caregiver. GCCYS also spoke to [redacted] who

often sees the victim child. [redacted] reported that the victim child has been coming to the practice since 2011 and they have no concerns for the mother. She always makes appointments which the child attends, and is consistent with [redacted] She expressed that the victim child's seizures are intractable which means they are hard to control [redacted] the victim child will experience seizures.

[redacted] Barracks of the Pennsylvania State Police was assigned to the investigation. They closed their case on 09/02/2016 with no charges.

GCCYS submitted the Child Protective Services Investigation Report to ChildLine on 09/16/2106 with a status of "Unfounded". The evidence they gathered during the investigation was that the victim child's seizure could not be correlated [redacted] and that the mother was compliant with all of the child's medical needs. A risk assessment was completed on 09/16/2016 with a low risk and severity and the case was closed at the intake level.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:
No County report was done due to case being unfounded within 30 days

- Strengths in compliance with statutes, regulations and services to children and families;
  Not Required

- Deficiencies in compliance with statutes, regulations and services to children and families;
  Not Required

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  Not Required

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  Not Required

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Not Required

Department Review of County Internal Report:

No County Report was required due to case being unfounded within 30 days.

Department of Human Services Findings:

- County Strengths: GCCYS did make contact with the family and CHP immediately after receiving the report. GCCYS did also follow up with CHP and all of the victim child's medical professionals. Records were obtained from Washington Hospital and CHP.

  GCCYS implemented a safety plan appropriately until they could gather more information about the incident. The safety plan was appropriately lifted after gathering enough evidence to negate the need for the safety plan.

- County Weaknesses: GCCYS did not contact the father of the child during the investigation. The mother noted that he has supervised visits but has not seen the child in three years; however, he is known to the Agency and an attempt should have been made to contact him.

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

  None

Department of Human Services Recommendations:

- The Department recommends that the agency make efforts to locate and speak to both parents in all cases, even if the information that the agency has is that the parent is not involved.
- The medical community needs to establish a mechanism in that Community Hospitals should have the ability to obtain a child's medical history from their treating physicians prior to certifying a Near Fatality report.