REPORT ON THE NEAR FATALITY OF:

Date of Birth: 10/08/2005
Date of Incident: 03/20/2017 – 03/24/2017
Date of Report to ChildLine: 03/24/2017
CWIS Referral ID:

FAMILY 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:
09/01/2017

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))

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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 has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 04/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/08/2005
[redacted]	Biological Brother	[redacted] 2009
[redacted]	Biological Sister	[redacted] 2001
[redacted]	Biological Father	[redacted] 1979
* [redacted]	Biological Mother	[redacted] 1981
* [redacted]	Mother's Paramour	[redacted] 1982

* 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 Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current case records pertaining to the victim child's family. WERO staff participated in the Act 33 meeting that occurred on 04/20/2017, in which the Greene County caseworker, personnel from the child's school, the Assistant District Attorney of Greene County and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

The family's Children and Youth Services (CYS) involvement began with a general protective services (GPS) referral on 08/25/2011, alleging that the older sibling was missing school to stay home and watch the younger children while the biological mother slept all day. There were also concerns that the youngest child was not having his diaper changed, and that the victim child's [redacted] condition was not being appropriately managed. The Greene County caseworker completed a home visit the same day. The children appeared clean and dressed, and both of the older children denied staying home from school for the purpose of babysitting their

brother. The mother provided the caseworker with adequate for the victim child. The caseworker cautioned the mother about the children acquiring any more unexcused absences from school. The investigation was closed on 10/25/2011, after the agency determined that the allegations were unsubstantiated.

The Family Service Plan (FSP) outlined that the mother was expected to complete the following objectives by 06/13/2012: follow standard agency tasks, obtain needed/preventative health care for the children, The agency attempted to engage the children's biological father; however, he was incarcerated in state prison for manufacturing, delivery, and possession of a controlled substance, in addition to retail theft and false identification to law enforcement. It was reported that the father had been absent in the children's lives, as he had been in prison on and off since 1998.

In April 2014, a referral was received expressing concerns that the mother was using illegal drugs. The mother failed a subsequent drug test and admitted to the caseworker that she had been taking illegally for two years. The agency addressed this in the FSP, in addition to the services already outlined in the FSP. The case was closed briefly from 11/13/2014 until 04/09/2015, at which time the mother was compliant with services. However, the case was reopened on 04/10/2015 following the third referral for the victim child.

At this time, the family remained open for GPS services with the caseworker completing monthly visits and encouraging the mother to participate in services. Supplemental GPS referrals came in on 09/29/2015 and 01/06/2016, citing concerns that the victim child's The mother's cooperation continued to decline over the next several months,

A GPS referral was received on 02/05/2016, citing possible drug use, a lack of supervision, and unsatisfactory home conditions (i.e. the smell of cat urine and used needles). At the request of the Greene County CYS supervisor, the mother was asked to take a drug test. The screening came back positive in six categories: cocaine, methamphetamines, THC/Cannabinoids, amphetamines, Due to the mother's positive drug test, the agency determined that a safety plan was needed. Despite attempts to locate kinship placement, all three children were placed in a non-kinship foster home on 02/11/2016.

During this time, it was reported to the agency that biological father had been released from prison. His probation officer reported to the agency that he was maintaining employment and had tested negative on drug screens for the past three years.

it was reported that the children were doing well in their father's care. The mother had been cooperative with agency services, All parties were in agreement for termination of agency involvement and case closure.

Over the next month, in December 2016, it was reported that the mother still had not secured permanent housing; therefore, she did not have an approved residence for the children to visit. In order to have visitation, the father agreed for the mother to stay in his apartment with the children on weekends, while he left the home and made arrangements to stay elsewhere. Within this timeframe, called the agency several times alleging medical neglect, as the victim child had recently been hospitalized stated that the father was frequently leaving the children home alone through the week for days at a time, therefore, not appropriately monitoring the child's condition.

After conducting interviews and a home visit with the father and children, Greene County CYS determined that there was no evidence of medical neglect. The father provided documentation that he took the victim child to the hospital

A complaint was also registered by the Western Regional OCYF Office on 12/22/2016, alleging that the agency did not follow proper protocol, as the children

were not interviewed privately. The children were re-interviewed at the regional office's request with no new information.

Within the span of two weeks (02/15/2017 to 03/01/2017), the victim child was hospitalized twice more The ongoing caseworker completed home visits after each hospitalization and ensured the child was safe and her medical condition stable. Although the victim child continued to have issues the father appeared to be managing her condition and ensuring she received prompt medical treatment.

Circumstances of Near Child Fatality and Related Case Activity:

On 03/23/2017, the victim child called her mother to report that she was ill The father was at work, therefore, the mother arranged transportation to take the child to a local hospital later that afternoon. Due to the severity of her symptoms during this visit, the victim child was transferred to a Children's Hospital of Pittsburgh. Upon receiving report, the Greene County CYS caseworker conducted a hospital visit. The case was registered as a near-fatality, as the pediatrician certified that the victim child was "in serious or critical condition due to medical neglect."

The victim child to a non-kinship foster home on 03/28/2017. During the investigation process, Greene County CYS interviewed all parties involved including the victim child, parents, and The father reported that the victim child had been to her Primary Care Physician (PCP) on 03/19/2017 for the flu, which he suspected caused The father also reported that the victim child was seen by her PCP on 03/15/2017 and 03/22/2017, The father stated that although he has been trying to comply with the victim child's as recommended by her doctor, he admitted that he is often at work and cannot stop the child from eating foods that exacerbate her

During her interview, the mother continued to blame the father for not adequately addressing the child's However, it was determined that the mother was aware the victim child was sick for three days before seeking medical attention. It has also been reported that while the mother was caring for the victim child on the weekends, she did not adhere to a healthy diet and frequently indulged the child with food she was not supposed to have. The mother has a longstanding history of not being able to effectively co-parent.

Prior to the child returning home, the agency procured additional services as well as a computer program that easily allows the father to keep track of the victim child's

Throughout the process of the investigation, it became evident that both parents bear negligence in not adequately meeting the victim child's medical needs. Because the child's condition occurred over a long period of time, and both parents share responsibility in caring for the child, both the mother and the father were indicated on the report on 05/17/2017. The agency continues to offer support via case management and regular home visits. The victim child has recovered fully and is expected to have no lasting consequences from the near-fatality incident, providing that her is appropriately managed in the future.

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;
  The response time was cited as a strength for the agency. It was also noted that having five people from the school district was beneficial to understanding more about the case.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:

  Transportation within the county and the distance to for care was cited as a weakness as well as the lack of in-home care to help monitor child's

- 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 recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse were brought to light at the meeting.

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

  No recommendations for changes at the state and local levels on monitoring and inspection of county agencies were brought to light at the meeting.

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

No recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse were brought to light at the meeting.

Department Review of County Internal Report:

The County submitted their report in a timely manner within the required 90 day timeframe. Included in the county report were recommendations for further case management efforts while working with this particular family, [redacted] The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:

  The Department found Greene County CYS to have a positive working relationship with other organizations in the community, including school personnel, law enforcement, and the district attorney's office. Each of these organizations was well-represented during the near-fatality meeting. The county appears to be very collaborative and accepting of feedback.

  It was also noted that Greene County CYS was responsive to the family's open GPS case in regards to regular, timely visits. Caseworkers provided thorough documentation of their contacts in their computer database.

- County Weaknesses:

  It was noted that Greene County CYS's near-fatality report lacked some important details from the family's history and the events leading up to the near-fatality. Some of the dates listed in the summary were inaccurate. The Department recommends that Greene County CYS complete a more thorough summarization of history in the near-fatality report and go back through case dictation to ensure all dates and details are accurate.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  There are no areas of non-compliance by the county.

Department of Human Services Recommendations:

The Department recommends guidance to county agencies specific to management with childhood [redacted] conditions.