REPORT ON THE NEAR FATALITY OF:

Date of Birth: 01/22/2000
Date of Incident: 10/02/2017
Date of Report to ChildLine: 10/02/2017
CWIS Referral ID:

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

Monroe County Children and Youth Services

REPORT FINALIZED ON:
February 28, 2018

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.

Monroe 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 10/27/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
	Victim Child	01/22/2000
	Biological Father	1965
	Biological Mother	1978
	Maternal Half-Sibling	2003

* 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 Children, Youth and Families (NERO) obtained and reviewed all case records pertaining to the family. NERO staff participated in the Act 33 meeting that occurred on 10/27/2017. Law enforcement was also present at this meeting and provided information regarding their investigation.

Summary of circumstances prior to Incident:

Monroe County Children and Youth Services (MCCYS) received two prior referrals regarding this family. In November 2011, MCCYS received a referral reporting that the victim child was hospitalized The referral source reported that the parents were refusing medical treatment The parents became compliant with medical recommendations and the case was closed upon completion of the intake assessment.

MCCYS received another referral in January 2013, reporting that the victim child was refusing to come to the doctor for a follow up visit after a recent hospitalization The referral source was concerned that the victim child may not have a primary care physician. An intake assessment was completed at that time. The assessment revealed that the victim child had been hospitalized at from early October 2012 to 11/24/2012. MCCYS was able to confirm that the victim child did have a primary care physician. The case was closed at that time as it appeared that the victim child was receiving appropriate medical care and the children appeared safe in the care of the parents.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/02/2017, MCCYS received a referral reporting that the victim child was hospitalized at Lehigh Valley Cedar Crest Hospital after presenting to the Emergency Department on 09/18/2017 It was reported that the parents of the victim child were difficult, aggressive, and combative. The child was reported to have prior The report was registered for causing serious physical neglect of a child / failure to provide medical treatment / care. The victim child was reported to be in critical condition. Therefore, the report was registered as a near fatality. The mother and father were identified as the alleged perpetrators.

MCCYS responded immediately to the report by visiting the hospital on 10/02/2017. The victim child could not be interviewed on that date The mother was interviewed and casework staff met with Law enforcement was notified of the report by MCCYS and verbal contact occurred between law enforcement and MCCYS on 10/02/2017. MCCYS interviewed the mother who identified multiple physicians for the child. The mother also reported that the parents feel that the child's current condition were caused The mother also reported that the child's physicians have been aware of his weight issue. The mother reported that the child and does not gain weight.

The investigation revealed that the mother is the primary caretaker for the children. The father has the children in his care two to three times a month. The victim child is home schooled. The sibling was interviewed on 11/03/2017 and identified no child abuse or neglect related concerns. The sibling reported the mother is the

primary caregiver, confirmed the victim child attends many doctor appointments, and eats regular meals and snacks at home.

On 10/03/2017, MCCYS learned that the parents were refusing at Lehigh Valley Cedar Crest. MCCYS made contact with the parents who reported that they were not refusing the treatment but requesting alternatives. They were not comfortable with the due to their religious beliefs and The father reported that he is a Jehovah's Witness. On 10/04/2017, MCCY was notified that the victim child was being moved to New York Presbyterian Hospital. The parents expressed distrust and dissatisfaction with the medical care provided in Pennsylvania and requested the victim child be moved to another hospital. On 10/05/2017, MCCYS made contact with the hospital in New York to inform them of the child abuse investigation and to request information pertinent to the investigation. The hospital would not release any information to MCCYS, stating they need to follow New York and federal laws and cannot release information as outlined in Pennsylvania law. The parents refused to allow release of information from the hospital to MCCYS. The hospital was willing to provide verbal updates

On 10/05/2017, New York Presbyterian Hospital agreed to have the victim child seen by their child abuse pediatrician. From 10/06/2017 to 10/15/2017, MCCYS received periodic verbal updates from the New York Presbyterian Hospital. During this time, the victim child's medical condition improved On 10/16/2017, MCCYS was notified that the New York Administration for Children's Services received a referral regarding the victim child due to the parents' refusal the child. The mother did consent for the victim child On 10/20/2017, MCCYS was notified that the victim child was doing very well On 10/24/2017 MCCYS was able to speak directly with the victim child's at New York Presbyterian Hospital.

On 11/17/2017, MCCYS determined the report to be unfounded based on the [redacted] findings. The case was closed with MCCYS as the family refused to allow MCCYS to provide home visits or services [redacted] current investigation revealed no evidence of child abuse or neglect, and interviews with the sibling revealed no safety issues.

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

- Strengths:
  -Compliance with statutes and policies.
  -Good cooperation with LEO and MHDS.
  -Opportunity to speak with agency solicitor throughout case.
  -CW did a fantastic job with diligence on case.

- Deficiencies:
  -Structural issue in crossing state lines. It's incredibly challenging to get information across states lines and accessing medical records.
  -Utilize school relationship more possibly. It could be beneficial to explore if some formal bridges of cooperation can be built.

- Recommendations:
  -Not seeing necessarily changes. There were challenges, but parents would eventually agree to whatever was needed for the care of the CH. Not seeing anything in the way that the case preceded for a recommendation for change. There may be some legislative issues with the interstate sharing of information.
  -Sharing criminal information across state lines. This would need legislative correction.
  -Would have beneficial for caseworker to make direct referral to ACS, in addition [redacted] making referral.
  -Collaboration with law enforcement was good, and it would be beneficial to further law enforcement relationships with agency.
  -Collaboratively, it may have been beneficial for the school district to be present for a meeting such as this one.

Department Review of County Internal Report:

The county review team report was received by NERO on 11/30/2017. The Department concurs with the findings and recommendations of the county review team.

Department of Human Services Findings:

- County Strengths:
  - MCCYS obtained all medical records from multiple sources regarding the victim child for review during the investigation.
  - MCCYS consulted with the victim child's [redacted] in making the determination of the investigation.
  - MCCYS worked in collaboration with law enforcement.

- County Weaknesses:
  - There was no representative from the school district at the Act 33 meeting.
  - MCCYS could have made a direct referral to the other state's child protection agency. This may have alleviated some of the information sharing issues experienced during the investigation.

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

  There were no areas of non-compliance by the county agency.

Department of Human Services Recommendations:

- The Department continues to recommend that counties develop and implement a formal process for the response to reports of child fatality and near fatality and completion of the county review team report. Specifically, it is recommended that a protocol be developed that will encourage a detailed review of child fatalities and near fatalities in an effort to identify solutions to address the service needs of all children and families served within the county, not just those served by child welfare. The protocol should include a process for educating Act 33 meeting participants regarding the purpose, confidentiality of information, allowance for sharing information, etc. The protocol should also include the sharing of the report with and approval of the report by team members prior to the submission of the report to the Regional Office.
- The activities of the county review team are essential and important. Review of child fatalities and near fatalities requires a tremendous amount of time, effort, and expertise. In order to ensure that these reviews are completed in a thorough and comprehensive manner, the Department is again recommending that the writing of the report be assigned to a team member who is not providing direct services to the family involved as caseworkers and supervisors must prioritize responding to and assessing the reports that they are receiving on a daily basis and ensuring the safety of children. Therefore, they may not have the ability to complete these time sensitive reports in the manner required.

- County agencies, especially those bordering other states could benefit from specific guidance related to service provision that is impacted by families crossing state lines. In this case, the county was initially unable to access documentation from the medical provider in New York.