pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/28/2017
Date of Incident: 09/07/2017
Date of Report to ChildLine: 09/08/2017
CWIS Referral ID: [redacted]

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

Bradford County

REPORT FINALIZED ON:
02/21/2018

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.

Bradford 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 09/25/2017.

Family Constellation:

First and Last Name	Relationship:	Date of Birth
[redacted]	Child/Victim (C/V)	07/28/2017
	Sibling of C/V	[redacted]2012
	Biological Mother	[redacted]1990
	Biological Father	[redacted]1983
	Paternal Grandmother	[redacted]1959
	Paternal Grandfather	[redacted]1959

Summary of OCYF Child Near Fatality Review Activities:

On 09/11/2017 OCYF/Northeast Regional Office (NERO) conducted a preliminary collateral case conference review of case/circumstances of Near Fatality with the supervisory personnel in Bradford County Children and Youth Services. Background information and safety planning for the C/V and sibling of C/V was reviewed. A copy of Initial Notification of a Child Near Fatality was received from Bradford County Children and Youth Services on this date.

OCYF/NERO program representative conducted a site visit to Bradford County Children and Youth on 09/13/2017. The case file was reviewed and interviews conducted with the Child Protective Services (CPS) supervisor and assigned CPS caseworker. Prior record of agency case activity was reviewed and a copy of the record secured.

OCYF/NERO supervisory personnel and assigned program representative attended the Act 33 Review at Bradford County Children and Youth on 09/25/2017.

OCYF/NERO had collateral contact with Bradford County Children and Youth Services on 10/12/2017. The CPS investigation was completed and assigned an Indicated Status determination on 10/11/2017.

OCYF/NERO program representative conducted a site visit to Bradford County Children and Youth Services on 12/18/2017. The completed CPS case file was reviewed for compliance with DHS and CPSL regulations.

OCYF/NERO received and reviewed Bradford County Children and Youth's Act 33 internal county report on 12/22/2017.

Children and Youth Involvement prior to Incident:

Bradford County Children and Youth Services has a record of prior involvement with this family. Bradford County Children and Youth Services documents prior case involvement with the biological mother of the C/V in 2009. At that time the county agency was involved due to the biological mother failing to maintain a safe household for her two older children. The concerns related to biological mother's inability to protect the children from a Megan's Law sex offender who was frequently allowed access to the home. Following repeated requests by Bradford County Children and Youth casework staff to prohibit the Megan's Law offender access to the home both children were removed from the care/custody of the biological mother and placed into foster care. [redacted]

The agency again received a referral in 2012 when the biological mother gave birth to the sibling of the C/V. Following short term intervention and linkage of the family to a community social service agency, the case was subsequently closed with no safety issues present.

The family remained closed to the county child welfare system from 2012 until the present incident involving the allegations associated with the failure to thrive of C/V on 09/08/2017.

Circumstances of Child Near Fatality and Related Case Activity:

Bradford County Children and Youth Services received a referral on 09/08/2017 [redacted] alleging that the Child/Victim was not gaining weight while in the care/custody of the biological parents. The Child/Victim required hospitalization [redacted]

The county child welfare agency immediately initiated the CPS investigation in collaboration with the law enforcement agency.

Bradford County Children and Youth Services immediately commenced a CPS investigation of the allegations. During the course of the CPS investigation, serious concerns were raised as to the capacity of the biological parents to care for the Child/Victim within their home. Information secured by Bradford County Children and Youth Services intake staff from the family and various service providers indicated that following the birth of the Child/Victim on 07/28/2017, the parents had 2 contacts with the medical provider for the Child/Victim due to weight gain issues. It was only after the second consult that a referral was made to a pediatrician for a more in depth assessment of the feeding issues.

Given the age of the Child/Victim and the inability of the parents to provide consistent information surrounding the feeding schedule for the Child/Victim, Bradford County Children and Youth determined that the Child/Victim was not safe in the parental household. [redacted] the Child/Victim was placed into foster care immediately [redacted] the medical facility.

Concurrent with the CPS investigation of the Near Fatality, the county agency also conducted a comprehensive safety assessment regarding the sibling of the Child/Victim. It was determined that the sibling of the C/V was safe within her biological home. Bradford County Children and Youth Services opened this case for ongoing protective services at this time.

The Child/Victim was provided with [redacted] medical follow up upon [redacted]. He subsequently gained weight in the foster care placement. During the time that the C/V remained in out of home care, the parents were provided additional training and guidance regarding the feeding of the Child/Victim. Given the progress evidenced by Bradford County Children and Youth the Child/Victim was returned to the care/custody of his biological parents with intensive support services provided by Bradford County Children and Youth casework and case aide staff as well as a private social services agency. Additional referrals were made for [redacted]

On 10/10/2017 Bradford County Children and Youth Services completed the CPS investigation and assigned an Indicated status determination naming both biological parents as perpetrators. Through the investigation, it was determined that although the parental grandparents also resided in the home, they did not have a caretaking role with regards to the children.

The law enforcement agency completed the criminal component of the CPS investigation and concluded that there was no criminal culpability. The criminal investigation was closed with no charges being filed.

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;

  Bradford County Children and Youth Services initiated the Child Protective Services investigation in a timely manner. There was evidence of collaborative efforts with the investigating law enforcement agency.

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

  There were no recommendations made in this area.

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

  There were no recommendations made in this area.

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

  There were no recommendations made in this area.

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

  There were no recommendations made in this area.

Department Review of County Internal Report:

The county agency submitted the County Internal Report on 12/22/2017. OCYF/NERO has reviewed the county submission and determined that it comports with the overall Act 33 guidelines for composition and timeliness. However, OCYF/NERO has also determined that the county agency's submission would benefit from additional detail. While the summary provided a broad overview of the case, the county report required a more expansive elucidation of Bradford County Children and Youth's involvement with this family at the onset of the agency's involvement. This information was shared with the Bradford County Children and Youth Director.

The OCYF/NERO review of the Bradford County Internal Report submission indicates that a more extensive discussion of the information shared during the Act 33 Review is in order.

Department of Human Services Findings:

- County Strengths

  Bradford County commenced an investigation conjointly with the law enforcement agency that was timely and thorough. The relationship between both agencies was collegial in nature as evidenced by the free sharing of information between all parties during the Act 33 Review. Case file documentation also clearly reflects this conjoint endeavor.

- County Weaknesses:

  As referenced previously, OCYF/NERO review of the Bradford County Children and Youth's Act 33 internal report determined that the county submission did not provide a sufficiently detailed narrative commensurate with the case specifics. The internal agency review document did not set forth the details associated with the onset of county child welfare agency involvement to the degree that was presented in the Act 33 meeting.

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

  N/A

Department of Human Services Recommendations:

NONE