pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/18/2006
Date of Incident: 12/25/2015 – 01/07/2016
Date of Report to ChildLine: 01/07/2016
CWIS Referral ID: [redacted]

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

Blair County Children, Youth & Families

REPORT FINALIZED ON:
07/17/2017

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))

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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.

Blair 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 02/10/2017**.**

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim child	01/18/2006
[redacted]	Mother	[redacted]/1983
[redacted]	Maternal Grandfather	[redacted]/1947
[redacted]*	Father	[redacted]/1966
[redacted]*	Half-brother	[redacted]/2010
[redacted]	Half-brother	[redacted]/2000

* 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 Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff conducted interviews with the staff at Blair County Children, Youth & Families (BCCYF) that were involved in this case. CERO staff participated in the Act 33 meeting that occurred on 02/10/2017 in which medical professionals, law enforcement, agency staff, and legal counsel were present and provided information regarding the incident.

Summary of circumstances prior to Incident:
BCCYF has had involvement with the family dating back to 2002, however the agency's computer system indicates that all family records prior to 2010 have been expunged.

A general protective services (GPS) report was received on 04/23/2010, regarding concerns that the children were being baby-sat by a maternal aunt who did not feed them, locked them in rooms and used inappropriate forms of discipline. BCCYF screened out this report after having a telephone conversation with the [redacted],

who informed the agency that the children have not visited their aunt in months and the [redacted] had no plans to send the children back to their aunt's home.

On 09/16/2012, a GPS report was received by BCCYF noting concerns that the child's [redacted] had cigarette burns between his fingers and that the father had propositioned the mother for sex and then paid an adult to watch this [redacted] while the parents had sex in the next room. This case was closed out at the intake level on 10/16/2012, as the concerns were unable to be validated. No services were provided to the family.

BCCYF received another GPS report on 12/07/2012, regarding concerns that the child's [redacted] was being locked out of the home in the cold and being refused food as punishment. The allegations were denied by the family and the concerns were unable to be validated. On 01/08/2013, this case was closed at the intake level and no services were provided to the family.

An additional GPS report was received on 02/24/2013, regarding concerns with unsafe home conditions and substance abuse by the mother. These concerns were also unable to be validated by BCCYF and the case was closed at the intake level on 03/15/2013.

The last report received by BCCYF prior to the near fatality report, was received on 04/01/2015. This report was a GPS regarding concerns for medical neglect of the child. The concerns noted that the child had a [redacted] in the summer of 2014 and that she was often sick with high fevers, pale, yellow, and fluffy, but the mother would refuse to follow recommendations to take her to the doctor. A caseworker from BCCYF completed an initial visit with the family. The family provided information regarding the child's medical care and providers. No safety threats were identified at this time and the case was screened out on 04/15/2015.

Circumstances of Child Near Fatality and Related Case Activity:

On 01/07/2016, the child was taken to the emergency department at Children's Hospital of Pittsburgh (CHP) for medical stabilization after her appointment at the transplant clinic identified concerns that the child was suffering from a significant rejection of her donor kidney. When the child attended her appointment at the clinic, she was visibly shaking, pale, and very ill. Medical providers also were concerned due to the child having a [redacted] and the family's failure to notify a medical provider for progressive symptoms concerning for a significant medical issue. The child was admitted to the [redacted]. The child had previously been diagnosed with a [redacted] in 2013 and had received a [redacted] in July 2014. She was prescribed a [redacted], as well as, [redacted] by medical providers to ensure that her [redacted].

Medical tests completed at CHP indicated that the child's [redacted] and would require at least [redacted]. During

the child's time in the hospital, the mother remained with her, but when medical staff tried to discuss the severity of the child's condition, the mother did not seem to understand or appear concerned. The mother maintained a flat affect and was not observed to be affectionate with the child. The child remained in the hospital receiving treatment until she was able to be stabilized and released on 02/02/2016. She will continue to require [redacted]. The child will also need to be [redacted].

The child reported that she had a [redacted] since 12/25/2015. Due to the child's medical condition, it was required that the hospital be contacted any time the child was ill, but the mother had not been maintaining contact with the child's medical provider. A witness confirmed that the child was not being provided with her medications and that she had not been feeling well for a few months and had been reporting that she was in pain. The child was also [redacted] during the period between Christmas and her hospitalization. Information was also received that the child's [redacted] had told the mother to take the child to the hospital, but the mother did not.

During interviews with family members and medical providers, information was also received that the child had not been attending medical appointments, receiving needed medical follow-up, or taking her necessary medications as prescribed. When the child was seen at the [redacted] on 11/04/2015, the [redacted] in her system. An additional lab test was completed on 11/07/2015, which showed that there was no medication in the child's system. It was recommended that her medication doses be increased and that the child have two additional lab tests completed. The [redacted] made numerous attempts to contact the child's mother when she failed to have the child's lab tests completed. The child was required, at this point, to have at least monthly routine lab tests, which were also not being completed. The mother did not take the child for any lab tests or to the clinic for any follow-up until she was brought in on 01/06/2017.

When the concerns were discussed with the mother, she initially claimed to have been compliant in providing the child with all her needed medications, but was unable to provide the names of any of the child's prescription medications. She later claimed that she would give the child her medications on the weekends because she did not want to fight with her to take them during the week when she needed to get to school on time. The mother confirmed that the child was sick ([redacted]) for a week or more before she took her to the hospital. She reported that she did not think it was serious as the child has [redacted] "out of the blue." She later changed her story to say that the child was fine at Christmas time and appeared to be eating normally. The mother reported that she would attend the child's clinic appointments during the summer months, but during the school year, her grandfather would take the child because the mother had to be home to get the younger sibling on the school bus. The mother reported that she was the one responsible for taking the child to get her lab tests completed, but confirmed that she "may have missed a few."

When the [redacted] was interviewed, he reported that he was the one responsible for taking the child to her clinic appointments during the school year. He shared that he thought that the child was doing well and claimed that on the day she was admitted to the hospital, she was happy and fine. The [redacted] reported that he only administered the child's medications when the mother was not home. He was unable to identify what medications the child was on or what her dosages were though he claimed to have a good understanding of her treatment needs because of taking her to her clinic appointments. The week before the child was admitted to the hospital, she was [redacted] and reporting that she was not feeling well. The [redacted] stated that the mother was aware that the child was ill and that he told her to take the child to the doctor.

During the investigation, it was ascertained that the child's medications were last filled with a 30-day supply on 11/04/2015. Prior to this one of the child's medication was last filled in August and the other one in September. Information was also received that the grandfather had been the person most recently responsible for taking the child to her appointments at the transplant clinic. Records indicated that the last three appointments that the child attended, her grandfather had brought her, but he had no knowledge of the child's medications or routine. The child's doctor confirmed that the rejection was ruled as secondary to the child not getting her needed anti-rejection medications. The doctor also opined that if the child had been getting routine labs, taking her medications as prescribed, and if the family had been maintaining contact with her medical providers that the child would not have become this ill. It was the medical opinion of the doctor that the child's kidney has lost years of life. While a kidney might normally last for 20 years, this one may now only last for five years.

When the report came in, BCCYF completed safety assessments for the child's [redacted]. BCCYF was able to confirm that the child's [redacted] was with his [redacted] and would remain safely at this location. The child's [redacted] was seen at the home. He had no medical needs requiring intervention and the agency determined that he could remain safely in the home with the [redacted]. At the time the report was received, the child's [redacted] was not listed as an alleged perpetrator as his role in the child's care was unknown.

The child's [redacted] was interviewed privately on 01/26/2016, and BCCYF became aware of concerns for the mother's drug use and received information that she would also take the children with her when she went to purchase drugs. Due to these concerns, as well as, the concerns for the mother and grandfather's inability to ensure that the child received the needed medical care that she required, [redacted] on 01/28/2016. The [redacted]. The [redacted] following her release from the hospital. She will continue to require extensive medical treatment and monitoring. The foster parents have been trained by the hospital staff on the child's medical needs and requirements.

BCCYF indicated the mother and grandfather as perpetrators of serious physical neglect on 02/23/2016 due to their failure to meet her medical needs and to seek medical attention when she became ill; leading to the child's [redacted]. The child's father was originally also listed on the report as an alleged perpetrator, but he has not been responsible for the child's care in many years and has had little to no contact with her. The allegations regarding the child's father were unfounded by BCCYF on 02/23/2016. The mother was formally charged on 01/13/2017 with endangering the welfare of a child and recklessly endangering another person and was released on bail. She is currently awaiting trial.

Note: While this child protective services report was received on 01/07/2016, it was not properly identified as a near fatality case thus triggering the Fatality/Near Fatality review process until 01/08/2017.

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

Information in this section is copied directly from the county report.

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

- Records review shows that there was compliance with statutes and regulations; the cooperation and communication between Law Enforcement, County Agencies and medical providers was proficient and timely.

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

- There were no deficiencies in compliance with statutes, regulations and services to children and families found during the review on 02/10/2017.

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

- During the review team meeting on 02/10/2017, there were discussions related to Agency practice for general reports received with allegations related to serious medical health concerns with a child, recommending that the Agency will seek medical confirmation of treatment even, in situations where there are no other concerns with the family or the case.

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

- There were no recommendations for changes at the state and local levels on monitoring and inspection of county agencies during the course of this meeting.

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 for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse during the course of this meeting.

Department Review of County Internal Report:

CERO received the BCCYF Child Near Fatality Team Report on 05/09/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 02/10/2016. Written feedback was provided to Blair County Administration on 05/30/2017.

Department of Human Services Findings:

County Strengths:

- The agency established immediate contact with the Multidisciplinary Investigative Team, involving law enforcement and medical staff as needed.
- The agency provided efficient referrals for service and follow up to those services for the child and her sibling, and subsequent placement when this was deemed necessary.
- The county review team conducted a detailed meeting regarding the intricacies of the case.

County Weaknesses: and

- Similar concerns were received in April 2015 regarding the child not having her medical needs met. BCCYF screened out this referral after an initial contact with the family without seeking confirmation of treatment from medical providers. As this case suggested some severe concerns for medical neglect that could have a serious effect on a child's health due to her medical condition, the agency should have sought counsel with the medical providers prior to making a decision to screen out the case.

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

BCCYF was found to be out of compliance in the following areas:

- 3490.232 (c) – On the previous GPS case received by BCCYF on 12/07/2012, the case was assigned a five day response time. There is no documentation of any attempts made to contact or see the family in order to complete the response time until 12/28/2012. The family was not seen until 01/07/2012, one month after the referral was received.

A Licensing Inspection Summary will be issued to BCCYF and they will be required to submit a plan showing how their agency plans to ensure that their future work will remain in compliance with this requirement.

Department of Human Services Recommendations:

The Department of Human Services (DHS) offers the following recommendations to practice as a result of the findings of this review:

- DHS will continue to work on improving its ability to ensure that all cases where a child dies or is in serious or critical condition as a result of suspected child abuse or neglect are appropriately identified when the reports are initially received so that the case can go through the appropriate fatality/near fatality review protocol.
- County children and youth agencies should ensure that they are completing thorough assessments of all received concerns for a child's health, safety, and well-being; to include making collateral contacts with medical providers and other service providers.
- DHS' collaborative work with the American Academy of Pediatrics should involve discussions around early identification of potential cases of medical neglect when appointments and routine or scheduled bloodwork is missed or when inconsistent information is repeatedly reported during doctor's visits.