pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/14/2017
Date of Incident: 11/01/2017
Date of Report to ChildLine: 11/01/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:
05/01/2018

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.

Westmoreland County Children's Bureau (WCCB) convened a review team in accordance with the Child Protective Services Law related to this report on 11/30/2017, and a subsequent meeting was held on 12/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Father	[redacted]1970
	Mother	[redacted]1979
	Sibling	[redacted]2016
	Victim Child	09/14/2017

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) was notified of the near fatality on 11/01/2017. WRO attended the Act 33 meeting on 11/30/2017 and a subsequent County Near Fatality/Fatality Review Team meeting on 12/20/2017. WRO reviewed documents provided by WCCB pertaining to the family's previous WCCB history, and the current Child Protective Services (CPS) investigation that relates to the near fatality. WRO corresponded and obtained additional case information from the WCCB caseworker.

Children and Youth Involvement prior to Incident:

The family was previously known to WCCB between 06/29/2016 and 09/02/2017 at the intake level. WCCB received three previous referrals relating to alcohol abuse by both parents. The first and third referrals were screened out at the intake level after one home visit was completed, and the child/children were seen. There was no evidence of child abuse and/or neglect. The second referral was closed after the family was assessed and closed without any services through WCCB. However, [redacted], an in-home service provider, was put in place to conduct unannounced home visits, and to work with the parents on concerns of alcohol abuse by the parents.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/01/2017, WCCB received a report of a Child Near-Fatality of a nearly 3-month-old male infant. The victim child was being seen for follow-up medical care for past health issues. On 09/14/2017, the victim child was born [redacted] and an [redacted]. The victim child was [redacted]. On 09/25/2017, the victim child was [redacted], and recommended by the victim child's pediatrician to go to [redacted] immediately. The mother waited four days to take the victim child to [redacted]. The victim child was [redacted] to [redacted] from 09/29/2017 to 10/01/2017. As part of the victim child's follow-up care, the victim child was seen on 11/01/2017 by his physician, and diagnosed with severe failure to thrive. The mother was instructed to take the victim child to [redacted]. The mother stated she had a ride. At the time the near fatality report came in on 11/01/2017, the mother had not taken the victim child to [redacted].

A WCCB caseworker and New Kensington Law Enforcement went to the victim child's home on 11/02/2017 at 12:35 AM as a result of the near fatality report. The mother was on the phone requesting an ambulance to transport the victim child to [redacted]; however, the mother reported there was nothing wrong with the child. Prior to the paramedic leaving the victim child's home, the paramedic noted the victim child was lethargic and appeared dehydrated. The victim child's skin was very dry. The victim child was transported to [redacted] by ambulance where the victim child was admitted to Pediatric Intensive Care Unit (PICU). The victim child's sibling was left in the home with the parents.

On 11/03/2017, the WCCB caseworker conducted a home visit with the mother. The father was at [redacted] with the victim child. The mother reported she fed the victim child 4-6 oz. every few hours. The WCCB caseworker asked the mother why she didn't take the victim child to [redacted] immediately on 11/01/2017, as instructed by the child's physician. The mother stated she didn't agree with the doctor about the victim child being underweight, and possibly sick. Mother reported that she "figured she would just bring him home and give him a few bottles." The mother stated "I'm 38 years old and I don't need anyone telling me how to raise my child, I do what I want. I'm a mother and I don't think he's sick." The mother admitted to [redacted] with the victim child. The mother also reported untreated [redacted] issues. The mother agreed to [redacted]. The mother also admitted to having six older children [redacted] in Allegheny County. The sibling was seen on this date and deemed safe to remain in the home.

On 11/07/2017, [redacted] physician reported to the WCCB caseworker the victim child was diagnosed with [redacted]. [redacted]. The physician stated this was what was causing the victim child to not gain weight appropriately. However, the physician suspected there might be social factors involved as well. The physician reported the victim child will be medically fragile, possibly forever. The victim child will require daily injections and medications, and if missed, the victim child could die. The

physician reported this condition is worse than [redacted] and there will be no room for error in the victim child's care. The physician stated the [redacted] social work department would work with the mother on getting transportation to and from medical appointments, but [redacted] wanted a service provider to be put in place to do daily home visits. The physician reported at that time, there was no reason to [redacted] the victim child, but it was crucial someone check on the parents to make sure the victim child receives the daily medication as ordered. [redacted] [redacted] wanted a plan to be put in place by WCCB prior to the victim child's [redacted].

On 11/08/2017, an in-home service provider was put in place. The service provider visited the victim child's home five-days per week.

On 11/29/2017, the victim child was admitted to the [redacted] again due to a fever and throwing up. The victim child's mother did not give the child the dosage of [redacted] he needed. The mother reported she felt uncomfortable doing that and assessing if she should give the victim child the medicine or not. The hospital was concerned the victim child's medical conditions were not being met in the home. On 12/01/2017, WCCB [redacted] of the victim child while the child was at [redacted]. On 12/01/2017, the mother admitted herself to [redacted] in Allegheny County. The victim child was discharged on 12/01/2017 [redacted]. The victim child remained [redacted] until 01/26/2017. On 01/26/2017, the victim child went to live with his mother and sibling [redacted] in Allegheny County.

On 12/12/2017, the victim child was [redacted] in Westmoreland County. The Judge reported that he would sign a [redacted] due to the mother and children residing in Allegheny County. The sibling was [redacted], as that child remained with the child's father until 12/12/2017.On 12/12/2017, the sibling was transported to the [redacted] to live with the mother.

On 12/20/2017, WCCB transferred the case to ACOCYF. The mother, victim child and sibling remained at [redacted] until recently when ACOCYF reported the family went "missing". ACOCYF did not have the exact date the family left [redacted]. ACOCYF reported to the WCCB caseworker ACOCYF took the victim child and sibling [redacted].

On 12/21/2017, WCCB filed the Child Protective Service Investigation Report with a status determination of "indicated". To date, no charges have been 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: Response time met, safety of children ensured, children seen every 30 days as per regulation, case to be transferred via court.

- Deficiencies in compliance with statutes, regulations and services to children and families: No

- Changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect: Earlier diagnoses of potentially serious medical concerns for infants; education for parents of children who are at high risk for serious medical issues.

- Changes at the state and local levels on monitoring and inspection of county agencies: No recommendations.

- Changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: Better communication between county agencies involving past history of child abuse and neglect.

- Recommendations for follow-up or additional services for the child and/or family: Services will remain in place until case is transferred to Allegheny County CYS.

Department Review of County Internal Report:

WRO received Westmoreland County's Near Fatality Report on 01/29/2018, and reviewed the report on 02/21/2018. The report contains basic minimal information, and is lacking detail as needed to understand the circumstances surrounding the related case activity as outlined on the County Review Team Report Template.

Department of Human Services Findings:

- County Strengths:

    - WCCB held the Act 33 meeting in a timely manner.
    - WCCB responded to assessing the safety of the other children in a timely manner

[redacted]WCCB consulted with a Physician from the [redacted]
    - WCCB worked with ACOCYF to ensure a smooth transfer of the case from Westmoreland to Allegheny County.
- County Weaknesses:
    - Westmoreland County's Review Team Report contained very minimal information, and lacked pertinent information.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - None noted.

Department of Human Services Recommendations:

The Department concurs with WCCB regarding recommending earlier diagnoses of potentially serious medical concerns for infants and education of parents of children who are at high risk for serious medical issues.