pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/29/2016
Date of Incident: 11/12/2017
Date of Report to ChildLine: 11/12/2017
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, and Family Services

REPORT FINALIZED ON:
08/31/2018

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.

Blair County has convened a review team in accordance with the Child Protective Services Law related to this report. Blair County Children, Youth and Family Services convened the team on 12/08/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	[redacted] (victim child)	11/29/2016
[redacted]	Mother	[redacted]1995
[redacted]	Sibling	[redacted]2014
[redacted]	Maternal Aunt	[redacted]1991
[redacted]	Household Member	[redacted]2013
[redacted]	Household Member	[redacted]2017
[redacted]	Maternal Grandfather	[redacted]1970
[redacted]	Paramour of MGF	UNK
* [redacted]	Maternal Grandmother	[redacted]1950
* [redacted]	Maternal Uncle	[redacted]1996
* [redacted]	Maternal Uncle	[redacted]1993
* [redacted]	Daughter of [redacted]	[redacted]2008
* [redacted]	Friend of Maternal Aunt	UNK

* 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 (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged Blair County Children, Youth, and Families Services' (CYFS) Casework Supervisor and Caseworker to discuss the incident, subsequent findings, and the current status of the case. Due to a technical issue with email communication, the CROCYF Human Services Program Representative was not alerted to the date and time of the Act 33 meeting.

Summary of circumstances prior to Incident:

The family was known to Blair County CYFS. The agency received a General Protective Services (GPS) referral on 11/27/2014, reporting that the mother's one son had bed bug bites and that the home was in an unsatisfactory condition. There were concerns that the one year old child was losing weight and that the mother was cognitively delayed. The local Police Department conducted a welfare check at family's home and the responding officer did not find any validity to the allegations; the home was not in deplorable condition and the child did not have bed bug bites. The report was screened out by the agency on 12/02/2014.

On 11/11/2016, Blair County CYFS received a CPS referral involving the family. A son, after an exam with [redacted], was transported to the local hospital. [redacted] wanted [redacted] on the child due to [redacted]. It was reported that the child's mother made statements that indicated the child falls a lot on hard wood floors and that she had fallen on the floor and fell on to her child. A [redacted] was conducted to further define the injury. The [redacted] came back [redacted] and the [redacted] at the time of the hospital visit did not have any concerns of abuse. The CYFS agency initiated a family preservation referral and the case was unfounded on 11/18/2016.

On 11/17/2016, the mother contacted Blair County CYS requesting services for her family. The GPS referral involved that fact that she was pregnant with her second child and her due date was approaching. The CYFS agency initiated an emergency family preservation referral on 11/21/2016. The assigned Caseworker made only one contact with the mother. She informed that agency that she no longer wanted the family preservation service provider in her home. The private service provider reported that the mother's father prevented the services in the home. An agency Caseworker was unsuccessful in engaging the mother via telephone. A home visit was attempted only for the Caseworker to discover that the home that correlated with the address on record, was vacant. The agency closed the case on 01/04/2017 since there were no other current GPS concerns and that the previous reports were screened out.

A GPS referral was received by the agency on 05/08/2017 after the mother used Facebook to post a video that displayed the children and showed adult household members smoking a crack pipe. Concerns also included that the children are left unsupervised and that the children's maternal grandfather is a drug dealer. The family was noted as being transient; moving from one home to another ever couple of months. When the agency's Caseworker completed a home visit, she engaged that adult family members, and all parties denied that individuals shown in the video were not smoking anything illegal. When the Caseworker showed the video to the mother she immediately stated that they were not smoking anything bad. A maternal uncle and the grandfather's paramour denied they were smoking crack or marijuana but that it was tobacco in the pipe. The Uncle denied smoking pot and the grandfather's paramour admitted to frequently smoking pot. The mother and maternal grandfather also denied the use of drugs in front of the children. The

Caseworker discussed the concerns of drug use around the children and that if they are under the influence, can they effectively care / supervise the children. The Caseworker explained that smoking marijuana in the same room where a child is present can be reported as child abuse. The Caseworker noted that there were no signs of drug paraphernalia. According to documentation from Blair County CYFS, both children appeared healthy, there were no signs of drug use/sales in the home, and none of the adults appeared intoxicated by substances. The case was screened out on 05/08/2017.

A GPS report was received by the agency on 08/01/2017 and it was reported that an aunt is smoking marijuana in the home in presence of the children. The individual making the report to CYFS stated that he has a witness that will testify that the maternal aunt was smoking marijuana. A Blair County CYS Caseworker completed a home visit and engaged the children, the mother, the maternal aunt, and maternal aunt's children and the maternal grandfather. The maternal grandfather stated that he does not permit smoking in the home because he is allergic to the smoke. He stated that the mother and maternal aunt go outside to smoke their cigarettes. When the topic of marijuana of breached, the mother denied using, and the maternal aunt admitted that she does smoke marijuana but that she never smokes it around the children or in the home. The domicile was assessed as a "little messy and cluttered" but not to the degree of being ruled a safety hazard for children. The assigned Caseworker determined that the children were healthy and well cared for and the report was screened out on 08/03/2017.

Blair County CYFS screened out a GPS referral on 08/07/2017 that involved allegations that an adult male household member punched a child in the face. The reporting source informed that agency that he believes that adult in the mother's paramour and maybe the specific child's biological father. Substance use was also noted. The agency screened the case because a CYFS Caseworker was in the home less than a week prior due to similar concerns.

On 08/23/2017, a GPS referral was received by the agency that involved the maternal grandfather mentally abusing the mother and according to Blair County CYFS documentation, "he tells the mother she's retarded and if she ever tries to go out on her own, he will have CYFS take her children". It was reported that the children and the mother are forced to stay in the mother's bedroom and not permitted "out". The reporting source also stated that the grandfather, and maternal aunt and a maternal uncle all smoke marijuana in front of the children. It was noted that the adults beat the children constantly and that the adults are constantly screaming at the children. After Blair County CYFS personnel completed a home visit, there was no evidence to support the allegations. The mother stated that she is never forced to stay in her bedroom and the children appeared healthy and well cared for. There was no evidence that the children had marks or bruises. The home was appropriate with no safety hazards identified. Therefore, the case was screened out on 08/25/2017.

Another GPS referral was received by the agency on 09/11/2017 focusing on the same concerns the previous report detailed; mother has to stay in her room and maternal grandfather is abusive to the mother. This report stated that the mother

informed the reporting source that she and her children are being physically struck by the maternal aunt. Information within the report indicated that the children have bruises. The reporting source stated that the maternal aunt smokes marijuana and will scream at her own children that reside in the home. Blair County CYFS Caseworker responded to the home accompanied by two city Police Officers. They engaged the maternal grandfather, the mother, and the mother's children. The mother related that the maternal aunt "beats up on her all the time" and the agency Caseworker noted that the mother has several bruises on her legs. The mother also shared that the maternal aunt hits her one son when this child plays with toys that do not belong to him. The mother stated that the maternal aunt never leaves bruises or marks on the child when she "smacks" the child's buttocks and added that it is "not very hard". The Caseworker and Police Officers were informed that the maternal aunt is never alone with her children. Home conditions were assessed as appropriate and there was adequate food in the home. There were no services requested during the home visit and that report was screened out on 09/11/2017

Blair County CYFS received a GPS referral on 10/16/2017 with allegations that the mother was carrying her son in a storage container with the lid on it. It was reported that this incident was videotaped and that each occurrence lasted between 30 and 45 seconds. The referral source indicated that there were no holes in the container to allow the child to breath. The referral source stated that "the mother is not right in the head". An agency Caseworker responded to the home and engaged all household members. The mother stated that the incident was "nothing". From Blair County CYFS's documentation, "the mother stated the child asked to climb into a storage container for fun… that the lid was on the container and the child was "only in there for a minute, not even a second." The mother stated the child stood up on his own and the lid came off. The mother stated this was a one-time occurrence and she hasn't allowed it since." The identified child appeared fine and did not express fear of his mother. The case was screened out on 10/17/2017

Circumstances of Child Near Fatality and Related Case Activity:

Blair County CYFS received a referral on 11/12/2017 stating that the identified child was taken by [redacted] mother to the local hospital due to a foreign body stuck in [redacted] throat. The mother reported that her child choked on cheese and she believed that it was stuck in the child's throat. The patient was intubated for airway protection and the object was able to be removed. The object was a dime sized mesh filter that was suspected to be used to smoke marijuana. The lodged object resulted in injury to the child's throat. The identified child was subsequently transferred to [redacted]. Medical reports indicate that the identified child was experiencing labored breathing but was not gasping for air or suffocating. The mesh object was removed while the child was aboard the life – flight helicopter during transport to the hospital in [redacted].

On the same night of the incident, a Blair County CYFS Caseworker and two city Police Officers went to the mother's home. The mother was unable to arrange transportation to travel to [redacted] and was at the home. During the interview process, she reported that she placed the identified child in a booster seat where she

could eat cut pieces of cheese. She stated that she left the room where the child was located and proceeded to the upstairs to put laundry away. She estimated that she was away from the identified child between five to ten minutes. The child's mother reported that the booster seat was next to the maternal grandfather's bed and that the identified child's maternal aunt and a family friend were sitting on the bed smoking marijuana when she exited the room.

The identified child's mother stated that she heard excitement from downstairs and proceeded to return to the room where the identified child was in her booster seat. She reported seeing the maternal grandfather performing the Heimlich maneuver on the child. She stated that she attempted to remove the unidentified object the child was choking on from her throat but was not successful. It was at this point in time that the grandfather transported the identified child and the mother to the hospital.

When the medical staff informed the mother that the identified child had not choked on cheese, she stated that her child may have choked on a screen from a marijuana pipe. She reported that her maternal grandfather and maternal aunt told her to tell the medical practitioners that it was cheese stuck in the toddler's throat. The mother assumes that the maternal aunt and the household friend were cleaning out the pipe when the screen may have fell out to where the child was able to access it from the booster seat.

The mother has another child who is three years old. That child remained in the care of the mother, and CYFS agency indicated that there have not been any concerns identified to warrant further action at this time for that child.

The mother was unable to get transportation to [redacted] until 11/13/2017. While in the [redacted] hospital, medical practitioners performed a scope on the identified child's throat and identified two ulcers in her esophagus. The child was discharged from the [redacted] hospital on Friday 11/17/2017. The mother and the child where transported back to Blair County by Blair County CYFS staff. The mother agreed to a safety plan framing that her child will stay with the maternal grandmother. The safety plan also included provisions for the mother, maternal grandfather, and maternal aunt to be allowed only supervised contact with the identified child. According to Blair County CYFS documentation, the identified child has attended follow-up medical appointments and has been doing well; eating and breathing normally.

The follow-up information presented by Blair County CYFS assessed that the mother was not aware that the screen was loose, or had fallen out of the pipe as she was not in the room at the time of incident. The maternal grandfather was likely unaware that the screen was loose, or had fallen out of the pipe, as his view would have been limited from his location in the home at the time of the incident. And there has been no evidence or disclosures to show that the maternal aunt was aware that the screen was loose, or had fallen out of the pipe. The only disclosure related to the pipe was mother's statements that the maternal aunt and the maternal aunt's friend were using marijuana and had a metal marijuana pipe with them on the bed they were

sitting on. The child, in her booster seat, with the tray attached in front of her containing the cut-up cheese, was sitting next to the bed.

At the onset of the incident, the mother was identified as the responsible party, but Blair County CYFS made the decision to add the maternal grandfather and maternal aunt as responsible as well. At the conclusion of the investigation on 11/11/2017, the agency determined that "while their conduct caused the incident, there is no substantial evidence to support that their conduct was done intentionally, knowingly, or recklessly". The mother however has been charged with child endangerment and she subsequently waived her charges to the Commonwealth Court on 04/18/2018. The criminal investigation is still ongoing and no additional criminal charges have been filed for any of the other parties involved in the incident.

The identified child was returned to the mother's care on 01/15/2018. The mother is the only adult in that home now as the maternal aunt and maternal grandfather have moved next door. Blair County CYFS opened services for the family on 01/29/2018. The agency has implemented family preservation services and parenting classes through private providers and the agency has made a referral for family group decision making. The agency is also encouraging the mother to contact a local victim's support advocacy service but she has not yet been willing to engage this support service. Blair County CYFS is also monitoring early intervention services offered to the identified child.

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 Review Team felt the Caseworker did a great job at presenting the information obtained thus far in the investigation.

  The Review Team determined that all of the agencies involved acted quickly and properly when they were notified of the incident/allegations.

  The coordinated and timely interview of the mother by Law Enforcement and Children and Youth was commendable.

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

  A concern was identified that many of the previous home-visits were not unannounced visits for the prior drug abuse allegations / previous ChildLine reports.

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

Make domestic violence counseling mandatory if a caseworker or other social service provider recommends it. Many incidents of child abuse occur in homes where domestic violence (in different forms) is/has taken place. Receiving treatment and empower victims to remove themselves and the child(ren) from domestic violence situations could result in decreased child fatalities / near fatalities.

Additionally, training on what domestic violence signs and symptoms can look like, would be a beneficial training for professionals working with children. The Review Team discussed that often times domestic violence does not just occur between spouses or partners, and it does not have to be visible (physical abuse).

Better coordination between the Drug Task Force, District Attorney's office, Children, Youth, and Families for drug related investigations. As with Domestic violence, many incidents of child abuse occur in homes where there is active drug use. Many times, these families have had previous involvement with Law Enforcement or Children and Youth, but the drug use was unable to be substantiated.

The Drug Task Force training community agencies, including Children and Youth, on the different procedures that can be (legally) done when conducting a drug related investigation, could hopefully result in more substantiated drug related offences prior to serious child abuse occurring. Once all parties are trained, having a coordinator between Children and Youth and the Drug Task Force would also be beneficial.

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies</u>

  There were no recommendations made at the County Review Team Meeting for changes at the state and local levels for monitoring and inspection of county agencies.

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

  Reducing the time frame between the time of the report and the actual home investigation could reduce loss of valuable evidence. Training mandated reporters to additionally contact Law Enforcement and/or Children and Youth directly if abuse is suspected could result in more timely response to abuse cases, which in turn could result in less tainted interviews and more (physical) evidence gathering.

  Another concern identified related to the child being discharged from a hospital to a party that he/she doesn't want to go with, may have been identified as the alleged perpetrator, and/or may be a caretaker that failed to protect the child in some manner. Ensuring the child's safety while in a hospital setting

provides the child with more ability to discuss his/her concerns with abuse/neglect privately.

A concern noted as a deficiency was the time lapse of an hour and a half between the child's initial hospital encounter and the actual home search by Law Enforcement and Children and Youth, which resulted in a recommendation at Childline, to have a system to better prioritize fatality/near fatality calls, so there is not a large time gap until the County Agency and Law Enforcement notifications are sent.

Department Review of County Internal Report:

The CROCYF received the county's Child Fatality Review Team Summary / Minutes on 03/28/2018. Upon review of the documentation, CROCYF assessed that the information efficiently described the incident, the actions taken by the agencies involved, and the current status of the case. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

  CROCYF has determined that Blair County CYFS effectively utilized safety plans to ensure the safety of the identified child and [redacted] three year old brother.

- County Weaknesses:

  The concern in this case, as also expressed by the county review team is around the numerous referrals in a short time period that were screened out after one visit, or not responded to based on prior visits to the home.

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

  At the time of this report, CROCYF has not identified areas of regulatory non-compliance.

Department of Human Services Recommendations:

The Department concurs with the recommendations of the county review team specifically around education and coordination related to investigations involving alleged drug usage. The coordination between the Drug Task Force, law enforcement, and CYS is critical. In addition to the coordination, utilizing the Drug Task Force trainings for all community agencies on the different procedures that can be utilized when conducting a drug related investigation or in interviewing families would help agency staff in assessing child safety in that environment.

The Department further recommends that the Screen Out disposition for referrals of a general protective service nature be further defined and address the level of

investigation and assessment that should occur when multiple referrals are received on a family.