



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Elaine Bobick
Director
Western Region

11 Stanwix Street, Suite 260
Pittsburgh, PA 15222

(412) 565-5728
Fax: (412) 565-7808

Report on the Near Fatality of



DATE OF BIRTH: July 9, 1993
DATE OF NEAR DEATH: March 8, 2011

FAMILY KNOWN TO:

Clarion County Children and Youth Services

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 by [REDACTED]. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Clarion County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	07/09/1993
[REDACTED]	Mother	[REDACTED] 1961

Non-Household Members:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Father	[REDACTED] 1963
[REDACTED]	Maternal grandfather	[REDACTED] 1938
[REDACTED]	Maternal grandmother	[REDACTED] 1938
[REDACTED]	Paternal grandmother	[REDACTED] 1943
[REDACTED]	Paternal grandfather	[REDACTED] 1943
[REDACTED]	Sister	[REDACTED] 1984

Notification of Child (Near) Fatality:

On March 8, 2011, Clarion County Children and Youth Services received a report of a near fatality from [REDACTED]. The child was a patient at UPMC/Presbyterian Hospital for [REDACTED]. The child's condition was a result of her [REDACTED]. The child had not been diagnosed with a [REDACTED] prior to her [REDACTED]. She had been diagnosed with [REDACTED] which worsened and seriously affected the child's [REDACTED]. [REDACTED] was found in the family home. The child's backpack contained a phone with [REDACTED] on it. Reportedly, the mother and the child were [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. The Department obtained the child's medical records from the agency. The regional office participated in the County Internal Near-Fatality Review Team meetings on April 8, 2011, April 19, 2011, and May 5, 2011.

SUMMARY OF SERVICES TO FAMILY:

Children and Youth Involvement prior to Incident:

The first referral on the family to the agency was a [REDACTED] referral on 4/20/2007. The reporting source was [REDACTED]. He reported that the child, who was thirteen at the time, was having sex with a sixteen old boy, and the mother parties all the time, not adequately supervising the child. The child has been alone at midnight. The child misses a lot of school and her grades are down. The mother allows inappropriate people in the house including a known rapist. The mother was on probation for [REDACTED] in Sharon. The agency assigned a moderate risk tag with a three day response time.

The caseworker attempted two unannounced home visits on May 2, 2007, no one was home. The caseworker was able to meet with the mother on May 3, 2007. The mother told the caseworker that she knew that the [REDACTED] had told her that Children and Youth Service was called because of concerns for the child. During the interview the mother denied having inappropriate people in the home when the child was there. She told the caseworker that she had been brought before the District Justice two times within the past year due to the child's truancy. The mother told the caseworker that she was on probation in Mercer County for disorderly conduct; she denied that she was ever arrested [REDACTED]. The child's older sister, who lived next door to the mother, was the child's caregiver when the mother was not in the home. The mother said that the child's boyfriend was fourteen years old. The child had been taken to family planning but was not sexually active. The mother signed the [REDACTED] Family Service Plan and a release of information form for the child's school records. The agency determined that the child was safe in the home.

The caseworker met with the child on May 11, 2007. She spoke to the child at her sister's home. The mother did not want the child to be interviewed at school. The child denied the allegations and said that she felt safe in her mother's home.

The caseworker did not send for the child's school records or contact the school because the mother used an incorrect date when she signed the release of information form. There is no documentation in the file that the caseworker attempted to have the mother re-sign the release of information form. The case was closed on May 18, 2007.

The agency received an Information and Resource referral regarding the family on March 24, 2009 that stated that the mother [REDACTED] and the relatives were transporting the child back and forth to school.

On November 9, 2010 the agency received a referral from [REDACTED]. [REDACTED] the child had been brought to the emergency room because she was lethargic all afternoon with instances of twitching and shakes which were continuing. The child reported that she [REDACTED] around noon that day. The child's boyfriend reported that the child would stare when he talked to her. The child's father reported to the hospital personnel that the child was [REDACTED]. The hospital found [REDACTED]. The child denied that she was suicidal and said it was [REDACTED]. She was diagnosed with [REDACTED]. The child refused to be transferred to an [REDACTED] or to be admitted to the hospital. The mother signed the consent form that the child was being discharged against medical advice.

On November 10, 2010, [REDACTED] reported to the agency that the mother and the child's older sister were [REDACTED]. The child's nephews had found [REDACTED]. This referral was assigned to the sister's caseworker since the case was already open for services. Two agency caseworkers went to the mother's home on this date. The child was not there. The mother reported to the caseworker that the child's boyfriend brought her home and told the mother that the child had [REDACTED]. The mother called the ambulance and rode with the child to the hospital. The child told the mother that she [REDACTED]. The mother reported that the child had never done anything like this before. The agency told the mother that they were open for investigation on this serious matter. The agency expected the child to complete [REDACTED]. The caseworker gave the mother the name and phone number of where the [REDACTED] could occur. The agency agreed to help the mother with transportation if it was needed.

On November 12, 2010 the caseworker returned to the family home to meet with the mother and the child. The child told the caseworker that she [REDACTED]. The child said that she was at her boyfriend's house and could not stand up. He brought her back to her mother's house and she went to the hospital. The child said that she never did anything like that before and she attributed it to peer pressure. It was explained to the child the importance of [REDACTED] and following through with services. The mother and child signed the [REDACTED] Family Service Plan. One risk reduction goal identified for the family was to [REDACTED]. The specific step to achieve this goal was identified as [REDACTED] and follow through with recommendations. The mother and child were identified as the persons responsible for achieving this goal. The anticipated completion date was identified as January 10, 2011. The mother, child, caseworker, and supervisor signed the plan. The caseworker completed an In Home Safety Assessment that concluded the child was safe.

On November 17, 2010 the child went to [REDACTED] with [REDACTED]. According to the hospital records, during this visit the child told the hospital personnel that she had [REDACTED]. She had already [REDACTED] her that day and that she [REDACTED]. The [REDACTED] but she was out of it for forty-five minutes. On this date the child said that her mother witnessed [REDACTED]. The [REDACTED] that they did not have the [REDACTED] reports from the child's previous visit. The doctor was going to check her blood work and [REDACTED]. If they were still present she would be referred to a specialist.

Additional home visits were made to the mother and child on November 16, 2010 and November 23, 2010. The focus of these home visits was for the child to attend the [REDACTED]. The agency learned from the child that she still was considered to be in the eleventh grade because she did not have enough credits. The caseworker continued her contact with the family in December of 2010 when the agency learned that the child had cancelled her two appointments for [REDACTED]. The agency told the family that as soon as the child [REDACTED] they would close the case.

[REDACTED] records contained the [REDACTED] from the child's November 16, 2010 and December 17, 2010 [REDACTED]. Both times the child stated that the reason she was attending [REDACTED] was because Children and Youth was requiring her to do so. At [REDACTED]. The child said that her mother's PCP had [REDACTED]. The child said that this was a one time incident. During the [REDACTED] appointment on December 17, 2010 the child again said that it was a one time incident. However, at this appointment, she said that she [REDACTED]. The child did not attend the three scheduled follow-up [REDACTED] appointments.

On January 4, 2011, the agency received a referral from the school district that the child had missed 58 days of school since the beginning of the school year and was late another 22 days. Since the child was seventeen and the school district could no longer file a petition with the district justice office for compulsory school attendance, they were notifying the agency of the truancy. The caseworker made a home visit to the family on that day to discuss the truancy issue with the family. The child was under the impression that she had only missed thirty days of school since the beginning of the school year. Child said that she did not like attending school. She walked around town and went to her boyfriend's house during the school day. The child told the caseworker that she would speak to her guidance counselor about what steps that she had to take in order to graduate. The caseworker told the family that she intended to close the case.

During the investigation, the agency had obtained the child's school records and medical records from Clarion Hospital and [REDACTED]. The agency did close this [REDACTED] with a determination that the child was safe. A closing letter was sent to the mother on January 7, 2011. There was no documentation in the file that the child had a [REDACTED]. These records were obtained on April 8, 2011.

The agency opened another [REDACTED] on January 7, 2011 on the truancy allegations. According to the [REDACTED] as of January 7, 2011, the child had missed 57.5 days of school she had 55 unexcused absences and 19 days she was marked as tardy. The caseworker made a home visit to the mother on January 7, 2011. The mother told the caseworker that the child had gone to school that day. The mother also agreed to a [REDACTED] conference with the school on January 13, 2011. The caseworker made home visits on January 10, 2011 with the child, and on January 12, 2011 with the mother to remind them of the [REDACTED] meeting with the school. In-Home Safety assessments were completed with a determination that the child was safe. The [REDACTED] meeting was held with the school on January 13, 2011. During the meeting, the child and mother were told that the child could not graduate this year. The child was failing all her classes. The child said that she wanted to graduate so she wouldn't disappoint her grandparents. She was told that she would have to come to school everyday and go to tutoring on Tuesdays and Thursdays. She agreed to do this.

On January 19, 2011, the caseworker spoke to the school. Since the [REDACTED] meeting the child had missed two days of school, was tardy one time, and did not show up for tutoring one time. On January 27, 2011 the mother told the caseworker that the child was attending school. On February 1, 2011 the caseworker met with the mother and the child. The caseworker presented to them that the child had either missed or been tardy for school everyday since the [REDACTED] meeting. The child told the caseworker that she was frustrated because it was going to take two years to graduate. The caseworker presented to the child the option of getting her GED. The child said that she wanted to graduate so she doesn't disappoint her grandparents.

The [REDACTED] Family Service Plan completed on February 1, 2011 with the family identifies the Risk reduction goal for the family and children to meet educational needs. The specific steps identified to achieve this goal were regular attendance and provide doctor excuses for absences. The persons identified as responsible for achieving these tasks is the mother and the child. The anticipated completion date was 30 to 60 days. This plan was signed the mother, child, caseworker, and supervisor. The plan did not include the goal that had been identified on the November 12, 2010 plan for the child to [REDACTED] and follow through with recommendations. There is no documentation in the case file that the caseworker addressed with the family during her contacts that [REDACTED] [REDACTED] still needed to be completed.

During the month of February of 2011 the school was reporting to the agency that the child was not attending school. The agency was unable to contact the mother and child by telephone or attempted home visits.

[REDACTED] from the February 2, 2011 [REDACTED]. The child again stated that she was attending the appointment at Clarion County Children and Youth Services insistence. She continued to maintain that it was a one time incident that occurred in November of 2010. The [REDACTED] [REDACTED]. Again she did not attend the follow-up [REDACTED] appointment.

[REDACTED] The child said that the onset of her illness was eight days prior to this visit. She was lying in bed one night when she got sharp pains in the right side of her chest, the pain got worst a few days later. There was also pain in her right arm and shoulder but it currently was not as bad, she hurt all over. She also [REDACTED]. She felt dehydrated and could not eat. The mother had [REDACTED]. The child was diagnosed with [REDACTED]. The recommendation was that she immediately go to an Emergency Room by ambulance. The child refused to go to the hospital by ambulance and said her boyfriend would take her.

On February 23, 2011, the mother called the caseworker and told her that the child had missed school because she was sick with [REDACTED]. She stated that she planned to enroll the child in a Cyber School.

[REDACTED]. She was diagnosed with [REDACTED]. It was noted that she had a [REDACTED]. The child denied [REDACTED] to the hospital staff. On February 28, 2011, the mother called and informed the caseworker of the child's hospitalization. On March 2, 2011 the school district called the agency and reported that the child had missed school the month of February 2011. On March 4, 2011 the caseworker confirmed that the child had been [REDACTED].

On March 7, 2011 the agency closed the case on the [REDACTED] referral that was received on January 7, 2011. The agency then opened a [REDACTED] on the child.

Circumstances of Child (Near) Fatality and Related Case Activity:

On March 7, 2011 the agency received a report [REDACTED] that the child was in UPMC –Presbyterian Hospital [REDACTED]. While at the family home [REDACTED]. The child's cell phone which was in her backpack had [REDACTED]. The door hangers that the agency worker had left during attempted home visits were tucked away. [REDACTED] had heard that the mother and child were [REDACTED]. The mother had reportedly waited a week to get medical care for the child. The report was assigned a moderate risk tag because of impending danger threats. Response time was to be immediate. The next day, March 8, 2011, the agency received a report from [REDACTED] that the child was [REDACTED] at UPMC-Presbyterian Hospital. The child had [REDACTED] because [REDACTED]. The mother had waited a week to get the child medical care. This time a high risk tag was assigned to the report for present danger threats. The response time was to be within twenty-four hours. The agency received two [REDACTED] reports. The first [REDACTED] was for [REDACTED]. The second [REDACTED] was for [REDACTED] for the mother and child [REDACTED].

On March 8, 2011 the caseworker and an agency supervisor went to UPMC-Presbyterian Hospital. They were unable to meet with the child because she was [REDACTED]. The caseworker and supervisor met with the mother. The mother denied that she [REDACTED]. She also denied any knowledge of the child's [REDACTED]. The mother stated that when the child was [REDACTED] that they took her to Brookville Hospital where they ran tests that didn't show anything. They then took the child to UPMC-Presbyterian where a test showed that the child had [REDACTED]. The child had [REDACTED] on March 7, 2011.

On March 9, 2011 the caseworker spoke to the [REDACTED] Doctor at UPMC-Presbyterian Hospital who treated the child when she was brought to the hospital on March 1, 2011. The doctor told the caseworker that the child was in critical condition when she arrived at the hospital. The child [REDACTED] to have the condition and that one out of ten patients die from the condition.

According to UPMC-Presbyterian Hospital records, when the child was in the [REDACTED] she was diagnosed with [REDACTED]. The child denied [REDACTED] however the doctor believed that she had [REDACTED]. The physician's recommended treatment was [REDACTED]. The child was [REDACTED] of the hospital. On March 2, 2011, when her mother was not in the room, the child admitted to the physician that she had been [REDACTED]. She could not tell the doctor [REDACTED]. The last time that she [REDACTED] was February 21, 2011. The child wanted to tell her mother herself and she did not want her grandparents to know that she was [REDACTED].

[REDACTED]

Once her condition stabilized she would need [REDACTED]. On March 4, 2011 the child was taken to the [REDACTED]. Once the [REDACTED] was completed the child was sent to the [REDACTED]. On March 5, 2011 she was then assigned to a room on the floor. On March 18, 2011 the child was [REDACTED] with a diagnosis of a seventeen year Caucasian female with a history of [REDACTED]. The child had [REDACTED]. The Child was [REDACTED] for six weeks and a follow-up appointment in four weeks. The child was [REDACTED] to continue her recovery on March 18, 2011.

While the child was hospitalized, the agency continued conducting the [REDACTED]. On March 8, 2011, the agency had made the required Law Enforcement referral to the New Bethlehem Police Department. On March 10, 2011 the police notified the agency that they had [REDACTED] from the mother's home. The agency obtained pictures of these items from the police. There was contact with UPMC-Presbyterian Hospital to monitor the child's condition and discharge planning. The caseworker interviewed the child's sister who was in the Clarion County Jail. The sister told her that she [REDACTED]. The sister identified the family friend that [REDACTED]. She also stated that the mother had [REDACTED] with her when she was growing up but did not know if [REDACTED]. It was her belief that the mother needed [REDACTED] more than the child.

On March 22, 2011 the caseworker made an unannounced visit to the [REDACTED]. She was greeted by the mother who took her to the child's room. The caseworker asked the mother to leave and she interviewed the child. The caseworker noted that the child appeared to be healthier and was able to sit up and walk around the room while the caseworker was there. The child said that she had been at the [REDACTED] since March 18, 2011 and that she would be [REDACTED] on April 16, 2011. The child told the caseworker that she was receiving [REDACTED]. The child repeated to the caseworker what she had told the medical staff at UPMC-Presbyterian about [REDACTED]. She said that she started [REDACTED] in the summer of 2010. She began [REDACTED]. She said that she [REDACTED]. She would not tell the caseworker who [REDACTED]. She denied [REDACTED]. The caseworker confronted her with the seriousness of her medical condition and that it was caused by [REDACTED], she broke down and cried. However she then stated that she did not want help [REDACTED] and did not want to talk about it. The caseworker then

met with the Patient Care Manager from the [REDACTED]; who told the caseworker that the mother had told her that the child had [REDACTED]. The caseworker told her the status of the agency's [REDACTED].

On March 23, 2011, the police told the caseworker that they had received an anonymous report that the mother and the child [REDACTED] and that they witnessed [REDACTED]. This reporting source went on to say that [REDACTED]. The reporter further alleged that [REDACTED]. The police investigation is ongoing; however specific details were not made available by law enforcement investigators.

The caseworker had ongoing contact with the [REDACTED] concerning the child's [REDACTED]. The [REDACTED] did not offer [REDACTED] however the child was [REDACTED]. These discussion included [REDACTED]. The caseworker obtained the child's medical records, [REDACTED], and school records.

After multiple unsuccessful attempts to contact the father, the caseworker spoke to the father on April 8, 2011. The father told the caseworker that he [REDACTED]. The child denied that she was [REDACTED] whenever he questioned her. He wanted to be considered as a caregiver for the child.

Later that day the caseworker met with the mother and child at the [REDACTED]. The caseworker told them that [REDACTED] would be coming to the facility to [REDACTED] on the child. The child said that she would refuse [REDACTED] if it was recommended. [REDACTED]. The mother said that her parents [REDACTED] could care for the child. The child started crying and said that she just wanted to go home and she would refuse [REDACTED]. Furthermore, [REDACTED] would be coming to the facility to conduct a [REDACTED] on the child. [REDACTED] would also be contacting the facility.

On April 12, 2011, [REDACTED] for the child. Both the mother and child rejected this recommendation. On April 13, 2011 the [REDACTED] informed the agency that the child would be [REDACTED].

[REDACTED] was unable to locate a [REDACTED] facility that was willing to take the child. Pennsylvania does not have [REDACTED] for adolescents. The child's complicated medical history that not only included her [REDACTED] which put her at risk for an infection in a congregate setting, but also [REDACTED] that she had in November 2010 resulted in [REDACTED] facilities being unwilling to take her unless a physician cleared her. Due to this reason, the child was placed with her maternal grandparents at the [REDACTED]

[REDACTED] The grandparents agreed to these conditions.

[REDACTED] The caseworker went to the facility and transported the child to her grandparent's home.

[REDACTED]

On April 14, 2011 the caseworker made a home visit to the maternal grandparent's home and completed an Out of Home Care Present Danger Assessment. The grandparents agreed to provide a home for the child and to supervise her at all times. The caseworker noted that she was concerned that the grandparents were in denial of [REDACTED]. The next day, after the caseworker and child arrived at the grandparents' home, an Out of Home Safety Assessment worksheet was completed. The areas of concern noted was the child's functioning since the child and mother refused to follow through with the recommendations of the [REDACTED] assessment. Furthermore the child was returning to the community that she had used drugs in. The child continued to refuse to supply the name(s) of the people who [REDACTED]. Even though the grandparents said that they were willing to cooperate with services, especially [REDACTED], they told the caseworker that they would need help with transportation. Even though the mother was not to live in the same residence with the child she would have access to her. The safety plan developed with the family reiterated [REDACTED] that the grandparents were to supervise the child, the mother was to live in her own residence and the family was to follow through with [REDACTED] recommendations. All the parties agreed to the safety plan the completed plan was mailed to all parties.

The Assessment caseworker completed a Placement Family Service Plan with the mother and child on April 19, 2011. The goals on the plan included the mother and child [REDACTED] evaluation and following the recommendations,

the child was to [REDACTED], the child was to continue to attend [REDACTED] appointments, child was to enroll in Cyber school or attend her regular school. The mother, child, caseworker and supervisor signed the plan. A copy of the plan was provided to all parties. [REDACTED]

[REDACTED] The agency [REDACTED] the two [REDACTED] reports. [REDACTED] Since the child refused to testify against her mother Clarion County did not challenge the mother's [REDACTED]

[REDACTED] The caseworker confirmed that the child was re-enrolled into her regular school. Her grandparents assured that she would attend daily.

Current Case Status:

The family was accepted for service by the agency on April 15, 2011. After the assessment worker completed her work with the family the case was transferred to ongoing services. During this transition time the agency received two referrals [REDACTED] that the grandparents had allowed the child's boyfriend and mother to be unsupervised with the child. The ongoing worker made her first home visit to the grandparents on May 10, 2011. The grandparents told the caseworker that they had already told the child her boyfriend could not be in their home when they are not home. All family members denied that the child was alone with the mother. During this home visit the caseworker tried to get the child to do [REDACTED]. This failed because the child could not [REDACTED]. In subsequent conversations with [REDACTED] the caseworker learned that [REDACTED] had concerns about the child's cooperation with their services. They also informed the caseworker that they had identified a facility that would take the child.

On May 17, 2011 the grandparents, the caseworker and the local police were called to the school because the child was [REDACTED] at the school. Initially, the child said that she had [REDACTED]. The child then admitted that she had [REDACTED]. When confronted with the fact that the police would be checking the school's video; the child admitted that she had [REDACTED]. She then gave the police [REDACTED]. The next day the child had another [REDACTED]. This time the child [REDACTED]. The child was expelled from school.

On May 25, 2011 the child had a follow-up [REDACTED] appointment with the [REDACTED]. This appointment went well and they provided written [REDACTED]

documentation that the child could participate in the activities [REDACTED]. The child was placed at [REDACTED] on May 31, 2011.

The child was at [REDACTED] from May 31, 2011 to June 28, 2011. The caseworker was in contact with the facility and made an on-site visit to the child at the facility. The facility provided the caseworker with reports that said that the child was compliant with the program. During the caseworker's visit on June 23, 2011, the child told the caseworker that she would [REDACTED] past her eighteenth birthday which is July 9, 2011.

After the child's discharge from [REDACTED] the caseworker made two home visits with the family. The family supported the child's decision to discontinue her involvement with the agency when she turns eighteen. The child told the caseworker that she would be returning to her mother's home when she turned eighteen.

The ongoing service caseworker did two Family Service Plans with the family. The first one was signed by the child on May 16, 2011 and the mother on May 21, 2011. The goals of the plan remained that the mother and child [REDACTED]. The Plan was provided to all parties. The closing Family Service Plan was completed with the family on July 8, 2011. [REDACTED]

[REDACTED] The case was closed.

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Clarion County has convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths:

1. The review team met for the first time on the thirtieth day from the date of the [REDACTED] report. The Review team met three times. The members of the team were invested in the process.
2. The review team included representation from a mental health professional, a representative from a county school district, a representative from the Health Department, a representative from Clarion Drug and Alcohol and a Drug and Alcohol Treatment Program, the Director of the County Children and Youth agency, a representative from Office of Children, Youth and Families, and the District Attorney attended one of the meetings.

Opportunities for Improvement:

- 1 The assigned caseworker and supervisor did not participate in the review team. Therefore the review team did not get the insight of the individuals who were directly working with the child and the family.
- 2 The child's school district did not participate in the review team. The truancy referral form that the school district completed stated that truancy had been a problem for years and that the district had tried numerous interventions with the family over the years. However, the school district did not provide the review team with the [REDACTED] records citing confidentiality. The school district referral to the agency for truancy was in January of 2011 when the child was seventeen and over the age of compulsory school attendance. Their absence from the table resulted in the review team not having access to critical information on the child's and the families functioning and interventions that were tried with them. It demonstrated a serious breakdown in communication between Children and Youth Services and the school district.
- 3 The District Attorney attended only the last meeting of the review team. The review team was missing input from the local police department as to their involvement with the family. The review team expressed their concern to the District Attorney that the local Police Department did not appear to want to pursue charges against the mother even though the child almost died and there was [REDACTED]. The review team believed that communication with law enforcement was inadequate.
- 4 According to the Bulletin the chair person of the review team must not be a county agency employee. The chair person of the review team was the agency director.

Recommendations for Change at the Local Level:

- 1 The County needs to broaden the members of the review team to include representation of the entities identified in the bulletin. This includes representations from the agency's Advisory Committee, an attorney at law trained in legal representation of children, the County Coroner or Forensic Pathologist, a representative from a domestic violence program, and individual who has represented parents.
- 2 The Review team needs to have someone other than a county employee chair the Review team.
- 3 The Review team should include current and past caseworkers and supervisors who worked with the family.
- 4 There needs to be improved communication between school districts and the agency. The report states that under the direction of the President Judge that the Children's Roundtable is in the process of developing a county-wide truancy policy. The County believes this will help improve communication between the county school districts and the County Children and Youth agency.

Recommendations for Change at the State Level:

There is a level of care missing for adolescents in Pennsylvania. There are no [REDACTED] facilities in the state. Therefore, a child who is suffering from significant medical problems along with [REDACTED] can not get the level of care that they need. The Department should explore the need for this type of program and potential providers of the service.

Department Review of County Internal Report:

- The written report from the County contains an error. During review team discussions one of the review team members stated that the mother had three daughters. The agency accepted this information as a fact. A review of case file documents contradicted this fact. The mother stated that she had two daughters on the [REDACTED] Social History form. The woman, who was identified as the mother's third daughter, identified herself as a family friend on one of the referrals to the agency. The agency had a case file on this woman and her family. The Department conducted a second file review on October 20, 2011 and reviewed this woman's case file and found that she was not the mother's daughter. Her Adult Probation report confirmed this information.
- The County Team did not conduct interviews. Interviews with at least the caseworker and supervisor may have clarified the family constellation.

Department of Public Welfare Findings:

County Strengths:

- This case illustrates the difficulty working with families that are [REDACTED]. The family's unwillingness to share information with the agency prevented the agency from providing the family with effective services. At the agency's insistence the child had [REDACTED]. The child refused to follow through with [REDACTED] and the mother enabled her child not to [REDACTED]. The family's denial of the child's [REDACTED] provided the county with a challenge in providing services to them. Even though the child developed a life threatening medical condition the family was still resistant to the child needing [REDACTED]. The agency had to have Court intervention and take custody of the child in order for the child to [REDACTED]. The child [REDACTED]. [REDACTED]. The agency and Clarion [REDACTED] were able to work as a team to ensure that the child got [REDACTED].

County Weaknesses:

- The county's primary weakness in serving this family was the lack of communication and collaboration between the school and the child welfare agency. This allowed the family to be isolated in their [REDACTED]. According to the child's school attendance records, the child had a pattern of poor attendance. However, the school district's first referral to the agency for truancy was in January of 2011. The child had already turned seventeen and was over the age of compulsory school attendance. The school district did not provide the agency with information about the services that had been offered to the family. Therefore the agency did not have any information on whether the family worked with services. Improved communication between the school and the agency could have resulted in the child being referred to the agency sooner which could have resulted in a more timely intervention with the family. The agency was put in the position of reacting to the child's current crisis instead of being proactive.
- The case was in the [REDACTED] Department from the initial referral on November 9, 2010 to May of 2011. The agency accepted the case for services on April 15, 2011 but it was not transferred to the Ongoing Service Unit until May of 2011. This was due to the fact that the [REDACTED] [REDACTED]. The agency conducted [REDACTED] during this time. Valuable time and resources were spent on repeating the [REDACTED] instead of allowing the family case to be transferred to Ongoing Services. The Ongoing Service staff only had the opportunity to work with the family for two months before the child turned eighteen. This did not afford the Ongoing Service staff the opportunity to establish a rapport with the family to assist them in alleviating the circumstances that lead to the family's involvement with the agency.
- The agency should have reviewed the case files of all of the identified parties to ensure that the report submitted to the Department was accurate.

Statutory and Regulatory Areas of Non-Compliance:

Please see the attached Licensing Inspection Form for the regulatory violations.

Department of Public Welfare Recommendations:

- The agency needs to improve its communication with the School districts within the County to identify children with truancy issues at an earlier age. The Agency and the School districts need to establish a truancy protocol for when these cases are referred to the agency.
- In their report the agency stated that since there is a link between truancy and [REDACTED] that the agency is considering referring truancy referrals they receive [REDACTED]. The County needs to establish a work group with members from the different systems in order to turn this idea into practice.
- The agency needs to establish protocols with local law enforcement and the District Attorney's office in order to better their working relationship with them.

- The agency needs to ensure that all agency records are reviewed in order to ensure that the information in the report submitted to the Department is accurate.