pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 09/21/2004
Date of Incident: 02/11/2017
Date of Report to ChildLine: 02/11/2017
CWIS Referral ID: [REDACTED]

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

Northampton County Division of Youth and Family Services

REPORT FINALIZED ON:
07/31/2017

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))

Office of Children, Youth, and Families, Northeast Regional Office
100 Lackawanna Avenue, Scranton, PA 18503 | Phone: 570-963-4376 | Fax: 570-963-3543 | www.dhs.pa.gov

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.

Northampton 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 03/02/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	09/21/2004
[redacted]	Biological Mother	[redacted]1987
* [redacted]	Biological Father	[redacted]1983
[redacted]	Sibling	[redacted]2009
[redacted]	Sibling	[redacted]2013
[redacted]	Mother's Paramour	unknown
[redacted]	Household Member	[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 Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the prior Child Protective Services (CPS) referral file and the current CPS file.

Children and Youth Involvement prior to Incident:

Northampton County Division of Youth and Family Services reviewed prior records upon receipt of the CPS Near Fatality referral. The county agency was able to identify that they received a prior GPS report on 05/28/2015. The GPS report was screened out and the following reason was provided, "information only on an active

CPS referral currently open to this agency." The CPS had been expunged so no further information can be ascertained.

Circumstances of Child Near Fatality and Related Case Activity

On 02/11/2017 the mother had taken the Victim Child to the emergency room at Lehigh Valley Hospital due to severe constipation. [redacted] The victim child was seen 2 months prior by medical professionals and it was noted that the child lost nearly 20% of his body weight within the past 2 months. The doctor alleged serious physical neglect and failure to provide proper medical treatment. The doctor certified the child to be in serious condition [redacted] The mother and the mother's paramour were named as the alleged perpetrators in the report.

Northampton County Division of Youth and Family Services responded to Lehigh Valley Hospital. Northampton County Division of Youth and Family Services first met with the [redacted] The victim child is also non-verbal and non-ambulatory.

The victim child was transferred to Children's Hospital of Philadelphia (CHOP) due to the seriousness of his condition. Numerous family members were present at the hospital including biological mother, biological father, maternal grandparents, siblings, and mother's paramour. Northampton County Division of Youth and Family Services was able to gather information from various family members prior to the transfer to CHOP.

The victim child was previously home schooled until October 2016 when he started public school. The primary reason for this change was the biological parents' separation. The biological mother became the primary caretaker for the victim child and made the decision to enroll the victim child in school. The first time that the victim child had been away from home for any meals was when he began attending public school.

The biological mother had a routine in place when she was concerned for constipation issues. When the constipation does not resolve from treatment at home, the biological mother has taken the child to the emergency room where he would be treated and released.

The Maternal grandmother reports that the victim child's weight often fluctuated. The MGM also reports that the victim child is sometimes difficult to feed, but added that the family took great diligence in taking care of the victim child in assuring he would eat and drink.

The siblings were determined to be safe while at the hospital and the family made their own arrangements for care of the siblings so that the parents could be at the hospital with the victim child.

The case was assigned to a Northampton County Division of Youth and Family Services' CPS caseworker the following Monday. A request was made to have the victim child evaluated by the Child Abuse Team at CHOP.

The victim child remained at CHOP until home on 03/23/2017. Biological mother was noted to have positive interaction with the victim child throughout his stay at the hospital.

Throughout the investigation the SCAN (Suspected Child Abuse and Neglect) team and Northampton County Division of Youth and Family Services reviewed prior medical history, interviewed family members, and completed collateral contacts to educational providers. There was no evidence to support that either the biological mother or the mother's paramour were culpable in the victim child's resulting condition. The investigation was unfounded on 04/10/2017.

likely played a factor in the victim child's inability to maintain appropriate electrolytes. Northampton County Division of Youth and Family Services completed unannounced home visits to continue to monitor compliance with services.

The family was opened for in-home services on 04/17/2017. The family was recommended to follow through with the The biological mother has only agreed to work with the during this school year and feels that she can adequately meet needs when he is not in school. This plan is acceptable to the county.

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;
  There were no specific strengths or deficiencies noted per the Agency involvement with medical and law enforcement agencies.

- Deficiencies in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The Act 33 team discussed and recommends that for children with such severe needs, when appointments with specialists are missed, and there is no follow up for 8 months, refer to Children and Youth for at least General protective services concerns.

The review team also questioned if mother could have been set up for [redacted] prior to this incident, as this child has significant needs. We do not have info to suggest this was discussed between the doctor and the mother in records reviewed to date.

Recommend for children with such special needs, ability to work across agencies, transportation assistance for child with specialized wheel chair. Other supports to help attend frequent medical appointments when a parent has no transportation and relies on others.
Also recommended was help with housing supports, [redacted] Due to this issue, he cannot help and is not a visiting resource for these siblings. While he and mother are working together to care for the children, he is forced to go to the house with mother and new paramour or not see the children.

Final recommendation was a case manager be assigned for children with intense special needs if family has limited resources and limited transportation to coordinate appointments and transportation.

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

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

Department Review of County Internal Report:

The NERO received the county report on 06/15/2017. NERO concurs with the County Review Team Report and the county was notified in writing on 07/06/2017.

Department of Human Services Findings:

- County Strengths: The agency worked collaboratively with the hospital and law enforcement to complete the investigation.

- County Weaknesses:

  The file indicates that child had not had consistent follow through with the [redacted] and this concern was not reviewed with the parents.

  The Act 33 team recommended following up with the child's school [redacted] This does not appear to have been completed.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. The mother's paramour's son who is a household member, age 17, was not seen within 24 hours and was not interviewed during the course of the investigation.

Department of Human Services Recommendations:

It is recommended that Northampton County Division of Youth and Family Services continue to complete timely and thorough child abuse investigations.

It is further recommended that Northampton County Division of Youth and Family Services obtain verifying documentation when gathering information from medical providers and follow through on concerns that may arise during the course of the investigation.