pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/03/2010
Date of Incident: 04/01/2017
Date of Report to ChildLine: 04/04/2017
CWIS Referral ID: [redacted]

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

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:

11/03/2017

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))

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.

Allegheny County has convened a review team in accordance with the Child Protective Services Law related to this report. The preliminary county review team was convened on 05/01/2017 with the larger multidisciplinary team convening on 06/19/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	11/03/2010
	Biological Mother	[redacted]1986
	Half Sibling	[redacted]2007
	Maternal Grandmother	[redacted]1964
	Maternal Step-Grandfather	[redacted]1963

* 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 Department of Human Services Western Region Office of Children, Youth and Families (OCYF) participated in the preliminary county review team meeting on 05/01/2017 and at the larger all-inclusive multidisciplinary county review team on 06/19/2017. A comprehensive file review was conducted regarding prior case records associated with the family as well as the Child Protective Services investigation related to this report. Included was a review of the extensive history of medical records and case notes dating back to 2010.

Children and Youth Involvement prior to Incident:

Prior to the incident of report, the family was well known to Allegheny County Office of Children, Youth and Families (CYF). Between 2007 and 2016 there were 12 prior referrals on the family, one being a transfer referral from neighboring Westmoreland County Children's Bureau in 2013. This 2013 referral would trigger

the most recent case opening, which lead to an extensive placement episode for the victim child.

The prior referrals have been summarized below to include dates, referral reasons, provided services and notable details which were associated with the prior involvement.

In 2007 two prior referrals were received regarding the half-sibling of the victim child. Both referrals reported concerns associated with the then infant sibling presenting with possible medical issues reported by the mother. On 05/23/2007, the child was reportedly having [redacted] and the mother appeared overwhelmed. The referral was monitored until its closure on 08/10/2007. It is unclear what services were provided to the mother at this time. On 10/02/2007, a subsequent referral regarding the child was received after the child was brought to the Emergency Department for concerns that he was not [redacted], however after admission the child showed no symptoms to these concerns. It was documented that the child had been seen at the treating hospital four times since his birth on 04/17/2007. The case was accepted for services and the child was placed on 11/16/2007 into the care of his maternal grandmother, who was granted legal custodianship on 06/04/2008.

In 2008, there were two prior referrals that involved the same sibling child. One of these reports alleged the child was not being cared for properly in his grandmother's home. A field screen was completed ensuring the child was safe and the case was screened out. The second referral was a request to modify the [redacted]. This report was screened out without the child being seen. Another [redacted] was received in February 2010, which was also screened out.

On 11/16/2010, Allegheny County CYF received a referral regarding the then newborn victim child. The report indicated that the child was born on 11/03/2010 and was hospitalized a few days later due to a "difficulty with feeding". The agency offered [redacted] to the family and accepted the case for services on 01/10/2011. Documentation indicated that the mother's reported symptoms associated to the child's medical concerns were not observed by others and, per medical professionals, the child was feeding fine. The notes documented the caseworker's impression of the symptoms to be related to "the child having a brain development of a 30-week-old fetus" and not related to the mother's care for the child. It should be noted that this information was provided directly by the mother and not by a medical professional. In addition to the [redacted] service, the mother was receiving [redacted] at this time. On 08/17/2011, the case was closed as the mother and child moved into the home with the maternal grandmother, who continued to be the legal caregiver for the child's sibling.

On 03/12/2012, the mother contacted Allegheny County CYF requesting assistance with initiating "[redacted]" for the then 18-month-old victim child. The mother indicated that the child was displaying "[redacted]" such as head butting and throwing food. During this referral, the mother also alleged that the

victim child had been seen at the [redacted] for [redacted] (i.e. water) and that the child's weight had [redacted] for the previous three months. The case was accepted for services on 03/12/2012 to again implement [redacted] and to assist the mother with parenting and access to [redacted] and community services. During this involvement, multiple workers attempted to explain to the mother that the child seemed "normal" for her development and did not appear to have any [redacted]. The mother had difficulty with accepting this assessment and continued to present that something was "wrong" with the child. The case was closed on 05/09/2012.

On 09/26/2012, Allegheny County CYF received a referral reporting concerns of the victim child's admission to the Emergency Department due to the mother reporting the child had not had a [redacted] in 11 days. The mother was also reporting difficulty feeding the child due to her "[redacted]", such as biting and banging her head. The child was admitted to [redacted] for "[redacted]". A review of medical reports indicated a possible history of [redacted] and participation in feeding therapy programs. Upon further evaluation, the medical response was that the child was not [redacted] and there had been no documented diagnosis of this in the past. Hospital staff were reported to be "concerned with the mother's ability to care for the child". On 10/01/2012, Crisis In-Home services were implemented to address the concerns for the mother's [redacted] as well as an effort to provide [redacted] for both the mother and the child while [redacted] were initiated. During June 2013, the mother and child moved to Westmoreland County, ending case involvement with Allegheny County CYF for this service episode.

On 09/14/2013, Westmoreland County Children's Bureau (WCCB) referred the family back to Allegheny County CYF as the family had relocated back to Allegheny County. While involved with WCCB, the family had been receiving services related to home maintenance, budgeting, transportation and parenting. There were no concerns identified in the referral regarding the child's medical issues. The case was accepted for services by Allegheny County on 09/18/2013. In-home services were immediately initiated to help the mother reconnect with her [redacted]. Additionally, a referral was made for [redacted] for the child. The mother was also actively seeking evaluations for the child to be completed for [redacted]. During this case activity, the mother reported new diagnoses of glaucoma, sleep issues, [redacted] in regards to the victim child.

On 11/11/2013, Allegheny County CYF received a call from the mother that the victim child had fallen and [redacted]. The child had been seen medically, however the mother felt that she needed to return to the hospital as the child was "complaining of pain". The mother was concerned that child had a "[redacted]". The child was treated and placed in a [redacted] for what the mother reported to be a [redacted] that was not showing up on [redacted].

On 01/24/2014, the mother and child moved into the home of the newly presumed paternal grandmother. At the time of the child's birth the mother identified a man as the child's birth father; however, it was determined later that he was not the father and a newly identified man was named as the presumed father. It was this second man's mother's home who the mother and child began residing with, in 2014. The child's name was officially changed from the last name of the previous man ([redacted]) to the last name of the newly named father, [redacted]. It would later be determined that the second presumed father would not be the child's biological father.

On 02/04/2014, the caseworker and a medical professional at [redacted] discussed concerns related to the mother's noncompliance with the [redacted]. The doctor reported during this call that the child's diagnosis of [redacted] is directly due to the child's environment. The doctor reported during this communication that it was believed the mother had "[redacted]". There were noted concerns that the mother would change her primary care physician due to her conflict with the treating pediatricians and the doctor was insistent that the mother remain at the current clinic, with doctors who knew her history, to prevent [redacted]. A follow up conference occurred on 02/11/2014 between the caseworker, casework supervisor and [redacted] physicians, reiterating the concern of potential [redacted]. The notes indicate that both physicians on the call agreed that the child was "[redacted]". The physicians reported concern that any [redacted]. When challenged as to [redacted] No other person had reported seeing any of the symptoms. The child had 10 known specialists that were "treating" the child for medical symptoms. The physician reported the child had been seen 97 times in the Emergency Department and the mother continued to report [redacted]. There was no documentation that these concerns were ever reported to ChildLine. It was confirmed the child did have a [redacted] and she had an [redacted], which was minor and manageable per her pediatrician.

On 02/14/2014, an [redacted] This was in direct response to a physician calling Allegheny County CYF and stating that the child was "[redacted]". There was no documentation that this high risk concern of fatality was ever reported to ChildLine. Upon arrival at the paternal grandmother's home, where the child and mother continued to reside, the mother was shown the [redacted] The mother and paternal grandmother requested that the child

remain with the grandmother. Clearances could not immediately be verified for all household members, resulting in the child being [redacted]. On 03/11/2014, the child was moved to her maternal grandmother's home under a [redacted]. While in this placement setting, the agency [redacted] for the mother while she would attend visits with the child at the maternal grandmother's home. [redacted] was initiated in May 2014. Documentation indicated that unsupervised visitation between the mother and victim child was occurring by October 2014, with overnight visits beginning March 2015. Over the period of the open case status, there were regular interagency team meetings to coordinate the multiple in-home service providers and care management services in place to assess the identified concern of [redacted] and assist with the planned reunification goal. A Child Protective Services (CPS) investigation was never initiated into the report of possible [redacted].

On 06/10/2015, the victim child was returned via [redacted] to the care of her mother. In-home services continued to be in place upon the return home. Within two weeks of the child's return home, the mother reported taking the child to the hospital on more than one occasion and expressed a worsening of the child's [redacted], to include head banging, spitting and staying up all night. Prior to the return home, the child's sleep habits were of little concern and her [redacted] were minimal according to the daycare and the grandmother as well as on visits with her mother. On 07/01/2015, a CPS report was registered for allegations that the mother was calling multiple specialists with subjective complaints regarding the child's symptoms. These complaints were nearly identical to those reported prior to the child's removal. This report was indicated on 07/30/2015 for medical child abuse; however the finding was [redacted] on 02/01/2016 after it was concluded that the dates of incident, 06/10/2015-07/01/2015, failed to support a historical pattern of [redacted]. As of the date of the writing of this report, the referral remains in the CWIS system as an indicated report. The child was left in the care of her mother following the determination of the indicated report.

On 12/08/2015, a referral was received regarding sexual abuse allegations of the victim child. The report was received as a General Protective Services (GPS) report as it was unknown if the alleged perpetrator was a caregiver. Subsequently, there was a CPS report registered to Western Region OCYF for the sexual abuse allegations on the victim child naming her maternal uncle as the alleged perpetrator. Since the allegations occurred during the time the child was in placement with the maternal grandmother, the report was investigated by the Western Region OCYF. There was an unfounded determination made on 01/27/2016 regarding the allegations of sexual assault. The GPS report was investigated by the ongoing Allegheny County CYF caseworker, finding the report to be invalid. On 09/26/2016, the ongoing case was closed and the family continued with [redacted].

On 11/28/2016 and 11/29/2016, Allegheny County CYF received subsequent GPS reports that the mother was seen walking the victim child to the bus stop in clothes

that were too small and the child was always reporting she was hungry. A field screen was completed; the child was found to be safe in the home and the referral was closed on 01/23/2017.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/01/2017, the 6-year-old female victim child was admitted to [redacted] after being transported from her home following an unwitnessed fall down a flight of stairs. The child was evaluated upon admission to have pinpoint pupils, low heart rate and low blood pressure. She presented with no observable injuries, which prompted medical professionals to administer multiple tests. Results from the toxicology tests showed the child to have a toxic amount of Clonidine in her system. Upon further interviewing, it was reported that the child's mother, who was the person responsible for administering the child's medications, denied giving the medication on the date of the admission. The treating medical professional indicated that the concentration of Clonidine was consistent with either a large supra-therapeutic, toxic dose, being administered the night prior to the admission or the child was administered a therapeutic dose just a few hours before the procurement of the serum sample. The child was determined to be in critical condition based on the toxic levels of Clonidine and on 04/04/2017 a Child Protective Services (CPS) report was registered for causing bodily injury to a child through a recent act of providing drugs to the child.

Through interviews conducted by the Allegheny County intake unit with the mother, it was reported that the child and her mother had moved into a new home on 03/31/2017 after residing in a shelter for a period of time. The mother reported that on 04/01/2017, the mother administered a morning dose of two prescribed medications to the victim child, neither being Clonidine. Throughout the day, the mother and child left the home and went shopping on two different occasions, returning in the late afternoon. Upon their return, they began to watch a movie upstairs. During the movie, the mother reportedly went downstairs at which point she began to hear the child running up and down the steps. The mother reported hearing a "thump, thump, thump" and discovered the child at the bottom of the stairs, with her neck "thrown back". The child was reportedly whining and had vomited on one occasion. The mother phoned a car service, who transported the child and the mother to [redacted]. The mother denied that the Clonidine was one of the medications administered that morning, as she typically gave this to the child at bedtime. The mother's account did not align with the treating professional's opinion regarding the administering of the Clonidine.

Law enforcement officials were notified of the report of suspected child abuse and began a criminal investigation. In interviews with law enforcement, the mother confirmed that she was the only caregiver for the child on the date of incident. She again reported that she did not give the child any Clonidine on 04/01/2017. The mother reported to the detective that about a week following the incident she found a pill in the house. A picture was taken of the pill and was reportedly identified as penicillin.

The medical provider identified a discord between the mother's concern for the child's health and the child's actual medical conditions. It was noted that the mother often made [redacted] and physical health observations, not generally assessed by health professionals. It was also of great concern that the mother appeared to [redacted] These same concerns were also expressed by [redacted]. Based on the expressed concerns about the [redacted] of physical and [redacted] in regards to this child, medical child abuse was being considered as a significant factor to the incident. On 04/05/2017, an [redacted] to place the child with her maternal grandmother.

Through the investigation and review of the child's medical history, it was discovered that the child had a [redacted], which resulted in a fall down stairs. This was not reported as a suspected incident of child abuse and was considered a response to the [redacted]

On 05/15/2017, the mother was charged with one misdemeanor count of Endangering the Welfare of Children. On 05/23/2017, a preliminary arraignment was held, setting the mother's bail at $5000. The mother attended her preliminary hearing on 06/02/2017, which was continued until 08/25/2017. The [redacted] mother and the victim child.

On 05/30/2017, Allegheny County CYF submitted an investigation summary with an additional allegation of causing serious physical neglect of a child through a repeated or prolonged/egregious failure to supervise. This allegation was "indicated" against the mother due to the supporting documentation that the child's life and health was threatened by the medication intoxication. The allegation registering the mother for causing bodily injury to a child through a recent act of providing drugs was "unfounded" as the investigation could not substantiate that the mother directly gave the child the medication which caused the intoxication.

The child was [redacted] on 07/05/2017 and [redacted] of her maternal grandmother. The mother [redacted] to participate in recommended [redacted] related concerns. The [redacted] with the child and her mother once [redacted]

At the present time, the child remains in the care of her maternal grandmother. The child is only prescribed a single psychotropic medication and is reportedly doing very well and thriving in her kinship home placement. She is receiving no unnecessary medical services and continues to receive [redacted] supports in the grandmother's home. The mother's preliminary hearing was again continued on 08/25/2017. The next hearing has been scheduled for 09/22/2017.

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:
    - The CPS caseworker responded immediately to the regional pediatric hospital to ensure the child's safety and to begin the CPS investigation.
    - The CPS caseworker conducted collateral contacts with multiple physical and [redacted] providers who were linked with the family.
    - The county caseworker obtained an [redacted] from the court to ensure the child's safety. CYF also utilized kinship navigator to identify and assess maternal family as a placement resource.
    - The CPS caseworker filed a [redacted] for the child, and the [redacted] her in July 2017.
    - Following the service decision for case acceptance, the CPS caseworker conducted a transfer conference with the receiving caseworker and supervisor to ensure a comprehensive transfer of knowledge to guide continued assessment and planning.
    - The Review Team commended the assigned CYF South Regional Office caseworker for engagement of the Child Health Evaluation, [redacted] in the teaming process to gain insight and understanding into this family's complex needs.
    - CYF engaged a kinship navigator to assist with identifying kin as a placement resource early in the case.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following "Challenges" were identified by the County Review Team. Not all of these are deficiencies in compliance.
    - State regulation requires CYF to comply with established intervals for completion of safety assessments. The initial safety assessment was completed and approved ten days after the initial contact. The case was transferred to a CYF regional office on 04/06/2017; the case transfer safety assessment was completed and approved on 06/06/2017.
    - The case illustrated challenges with teaming formation and function, a core component in child welfare practice. Review of the previous case opening, from 2013 through 2016, demonstrated challenges with the team's knowledge and understanding of medical child abuse and families with complex needs. Team members, comprised of child welfare and [redacted] providers, held divergent positions from physical health professionals' assessment of mother's protective capacities and family strengths and needs. Physical health professionals were represented on the team during this case opening. Review also demonstrated the need for formal teaming mechanisms

for effective communication and understanding of varying perspectives to move in unison toward agreed-upon goals for the child and family.

- The Review Team discussed the challenges associated with the assignment of and coordination among multiple [redacted] providers for one family. There were multiple assignments of and lack of coordination among multiple [redacted] providers and with child welfare for this family.
- The system has an inadequate mechanism by which individuals with high risks and urgent needs are fast-tracked for timely and appropriate referrals to [redacted] services.
- CYF's timely planning with the family is now impacted by Family Court's deference to the criminal court proceedings that are anticipated to be prolonged.

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse</u>:
  - The Review Team reviewed a presentation on medical child abuse as both a child abuse allegation type and as a [redacted] to better understand the issues through the perspectives of the child protection and [redacted] systems
  - PA Child Protective Services Law
    - [redacted]The Review Team reviewed the 2014 changes in the PA Child Protective Services Law that redefined child abuse to include behaviors that result in [redacted]
      - The Review Team discussed, at length, mandated reporting requirements associated with this case and similar cases; i.e., whether the treating physical health providers are required to report every instance that a parent or caregiver seeks medical care for a child, or whether reporting a pattern of alleged abuse is sufficient. The team agreed that, while reporting individual incidents of suspected medical child abuse draws attention to the pattern and frequency of suspected abuse, mandated reporters satisfied the requirement to report child abuse by reporting patterns of suspended medical child abuse, rather than reporting each appointment or hospital visit that indicated an alleged over-utilization of medical care that caused harm to the child.
  - Professional Staff Development and Clinical Supports
    - The Review Team stressed the importance of education and understanding of medical child abuse as a type of child abuse and the implications for child protection assessment, planning and monitoring. The Review Team emphasized the need for all system partners working with families to have knowledge of and

understand that the focus child of an alleged medical child abuse report is a victim of a type of life-threatening violence inflicted by a perpetrator and that practice by all systems' partners require a focus on foremost ensuring the child's safety. Treatment interventions must address the perpetrator's abusive actions toward the child, regardless of the alleged perpetrator's possible [redacted] status.

Education and clinical supports for team members should include: identification of safety threats/risk factors associated with medical child abuse; professionals' roles as mandated reporters; effective teaming practices, including communication of differing perspectives and reconciliation of differences to move together toward unified goals and desired outcomes; imperative for monitoring when children are in the care of and/or when reunified with their families.

- Assessment, Planning and Monitoring
  - The Review Team discussed the need for the DHS Offices of Children, Youth and Families and [redacted] to join in the development of a practice model for cases involving medical child abuse. The Review Team recommended the inclusion of all systems' partners, including physical and [redacted], child protection, law enforcement and courts, to ensure a cohesive and unified assessment, planning and monitoring process. The Review Team recommended that CYF join with system partners, including physical health professionals, to build and implement an aftercare plan that provides needed supports and vigilant monitoring to ensure continued child safety, permanency, and well-being.
  - The Review Team discussed the need to develop treatment interventions that effectively address the unique needs of perpetrators and emphasized that traditional in-home, parenting and/or family-based [redacted] services are not adequate to address this type of violence inflicted on children. Prognosis for the perpetrator of medical child abuse is poor with traditional family or patient-centered service provision, through the child welfare and/or [redacted] systems. Moreover, research indicates a high mortality rate for victims of medical child abuse, illustrating the crucial need to link perpetrators with effective treatment, which may contribute to more positive outcomes and may enhance protective capacities for those perpetrators if they were to resume caring for their children.

        - The Review Team discussed the no-contact order ordered by criminal court. The Review Team acknowledged the life-threatening abusive actions inflicted on the subject child and recommended that consideration for visitation or custody between the perpetrator and child should occur after successful treatment and measureable enhancement of the perpetrator's protective capacities.
    - Teaming
        - The Review Team recommended that physical and [redacted] health team members be integrated throughout practice in cases involving medical child abuse and families with complex needs.
        - The Review Team further recommended that providers invite representatives from the [redacted] and physical health insurer agency to participate in integrated teaming meetings, when appropriate and needed, in complex cases that involve high or over-utilization of [redacted] and/or physical health services.
        - The Review Team highlighted the need for streamlining the number of service providers working with a family, as well as the need for a robust integrated teaming process.
        - The Review Team recommended that the Child Health Evaluation, Care Coordination and Support (CHECS) nurses, in partnership with the CYF health enrollment staff, track children with complex physical and/or [redacted] challenges and who have high utilization of health services.

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:</u>
    - The agency's internal quality assurance team will continue to monitor practice improvements and provide feedback to leadership and casework staff.

- <u>Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:</u>
    - The Review Team recommended development of a mechanism by which high-end users of [redacted] and/or physical health services are flagged by the assigned insurers for purposes of clinical oversight and identification of risk.
    - The Review Team recommended development of a mechanism by which those with high risk and urgent needs are fast-tracked to appropriate and necessary referrals for access to [redacted] health services.

<u>Department Review of County Internal Report:</u>

The Department received the draft version of the County Internal Report via email on 07/27/2017, within the required 90 day time frame. The report was very comprehensive and provided an extensive list of strengths, challenges and recommendations. In regards to the findings by the Review Team, the Department agrees with most of the stated recommendations.

The Department would challenge the county review team recommendation stating "the Review Team discussed the [redacted]. The Review Team acknowledged the life-threatening abusive actions inflicted on the subject child and recommended that consideration for *visitation* or custody between the perpetrator and child should occur after successful treatment and measureable enhancement of the perpetrator's protective capacities". The Department would challenge that this recommendation, when added to the assessment recommendation of a need "to develop treatment interventions that effectively address the unique needs of perpetrators and emphasize that traditional in-home, parenting and/or family-based [redacted] health services are not adequate to address this type of violence inflicted on children" along with, the recognition that the "prognosis for the perpetrator of medical child abuse is poor with traditional family or patient-centered service provision, through the child welfare and/or [redacted] health systems" appears to allow for a discontinuation of visitation between the child and the parent, in specific to the victim child and her mother in this case, until the treatment needs are developed and then successful with the parent. The mother in this case has a history of supervised and unsupervised visitation with her child, which was viewed as a positive and safe encounter. It would be the concern of the Department that suspension of visitation between a parent and a child during cases of medical child abuse, based on the theory that these parents typically do not successfully [redacted] Although custody consideration may more often be a direct safety concern, visitation between a child and parent should be individually assessed and not generic to the finding of medical child abuse.

<u>Department of Human Services Findings:</u>

- <u>County Strengths:</u>
    - The County Review Team did a commendable job highlighting the concerns directly related to the challenges associated with medical child abuse cases. The Review Team did a brief presentation to the group outlining the differences between medical child abuse and [redacted] prior to beginning the discussions associated with the review. This case involved an incredible history of medical and [redacted] health involvement. The Review Team coordinators and presenters were thorough and inclusive in the sharing of this information.
    - Upon receipt of the [redacted] from the mother's care, the agency immediately utilized a kinship resource identified earlier in

the case history. This placement also allowed the child to live in the same home as her half-brother.

- Collaboration across all systems; CYF, law enforcement, medical and [redacted] health, was respectable during the investigation regarding the near fatality. The multiple providers being utilized by the family required extensive review and collaboration in order to complete a thorough investigation.

- County Weaknesses:
  - During the ongoing case activity in February 2014, the ongoing worker and supervisor had more than one conversation with treating pediatricians regarding the medical concerns of [redacted] in regard to the biological mother. No report was made to ChildLine to register the concerns as a CPS report of child abuse, by neither the physicians nor the agency. The information was accepted in the form of case dictation and the child was removed for the concerns.
  - In regards to the 07/01/2015 CPS registering the mother for [redacted], the county neglected to include the historical dates of incident ranging back to at least 2014 when the [redacted] physicians expressed concerns for the mother's "[redacted]" and [redacted]. This resulted in [redacted] of the indicated status of the report.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no findings of statutory or regulatory non-compliance in regards to the investigation of this report.

Department of Human Services Recommendations:

- In agreement with the County Review Team, the Department would recommend the development of a flagging method which alerts the assigned insurers of high-utilization medical and [redacted] health users to allow for potential clinical oversight and assessment of risk in regards to the volume of services being sought/utilized by the insured.
- In agreement with the County Review Team, the Department would recommend a need for improved education around the understanding of medical child abuse as a type of child abuse and the implications this type of abuse has on children as victims. The Department would recommend education be made available for all system partners in an effort to assist in identifying safety threats and risk factors related to medical child abuse, teaming implications/practices as it relates to the system partnership, and allow for improved training in identifying factors of medical child abuse as it relates to mandated reporters.

- In addition, further guidance is needed regarding the requirement of mandated reporters as it relates to medical child abuse and the expectation of reporting caregivers when a pattern of excessive services is recognized versus each individual treatment sought. The question was raised during the Review Team meeting if the treating hospital should be mandated to report every medical visit the caregiver made to the treatment clinic or, if once a report of suspected medical child abuse has been made, does this satisfy the mandated reporting requirement.
- It would be recommended that medical and [redacted] health providers across the Commonwealth develop a procedure to begin communication and teaming efforts immediately upon identification of a potential case of medical child abuse or over-utilization of services in an effort to impede unnecessary service delivery and to develop a unified goal and treatment plan for the identified child.