pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/16/2017
Date of Incident: 12/06/2017-12/10/2017
Date of Report to ChildLine: 12/10/2017
CWIS Referral ID: [redacted]

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

Luzerne County Children and Youth Services

REPORT FINALIZED ON:
05/29/2017

Northeast Office of Children, Youth, and Families, Regional Office
100 Lackawanna Avenue, Scranton, PA 18503 | Phone: 570-963-4376 | fax: 570963-3543 | 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.

Luzerne County completed their investigation under 30 days with an unfounded status; therefore, the county was not required to conduct an Act 33 meeting.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	02/16/2017
	Biological Mother	[redacted]1984
	Biological Father	[redacted]1983
	Sibling	[redacted]2011
	Sibling	[redacted]2015

*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 Child Protective Services (CPS) referral file.

Children and Youth Involvement prior to Incident:

No prior children and youth involvement.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/10/2017, the reporting source reported to ChildLine that the mother brought the victim child to the hospital due to having a fever for the last four days of over 104 degrees and no diaper wetting. The reporting source stated that there was a pea-sized scabbed area on the child's lower, left abdomen surrounded by a twenty-two centimeter area of red skin that was hard to touch (cellulitis). When asked why the mother took so long to bring the child to the hospital, the mother responded

that she "was irresponsible." The reporting source stated that the child was air medevac transported to the hospital for evaluation and possible surgery. The reporting source reported that the child was shown as dehydrated in her lab work and still maintained a fever of 104 degrees. The attending doctor has certified that the child was in critical/life threatening situation. The prognosis for the child was unknown at that time and would continue to be evaluated at the hospital.

On 12/11/2017, the county agency went to the hospital the victim child was admitted to. Upon arrival, the doctor on staff at that time informed the agency caseworker that there were no concerns for child abuse or neglect. The doctor further reported, the victim child was never in critical condition and that should not have been reported when ChildLine was contacted. There was no surgery required - all that may have been needed was an incision and drainage of the pimple the victim child had. The doctor discussed with the caseworker that it is not uncommon for a parent to wait a few days before seeking medical attention. The victim child's condition did not worsen due to the time period that the mother waited before seeking medical care. As for the fever, the victim child's highest temp at hospital was 100.8 at 03:00AM. There was no suggestion that victim child had an ongoing fever, nor information that the child had a temperature of 104 degrees. The victim child was not medically cleared for discharge at that time as she was still on intravenous antibiotic.

On 12/11/2017 the county agency made a phone call to the initial attending doctor. The doctor discussed that the victim child should have been seen at the emergency room sooner due to the fever but that she was not in critical condition, nor was the condition life threatening. The doctor stated that the LPN made the report and there may have been a miscommunication between what the doctor instructed and what the nurse reported. The doctor reported he would send a letter to agency explaining what occurred.

On 12/12/2017, the victim child was discharged home.

Initially, NERO received notification of a near fatality on 12/10/17. A request for decertification was made on 12/12/2017 by the county agency. The NERO Human Services Program Representative initially assigned to the case had made the determination that the request and information provided did not meet the criteria for decertification and notified the county of that determination. On 12/15/2017, the case was reviewed at NERO by a supervisor, at that time it was noted the decertification request states the child was not in life threatening condition but did have a serious medical condition upon admission; whereas, the language in the Children and Youth-47 (CY47) which stated the child was in critical condition. The doctor assumed he needed to clarify that issue. At that time, it was determined that there was no specific information regarding the actual admission condition assigned to the child upon admission to the hospital, i.e. whether or not he was in fact admitted in "serious condition." NERO requested this information/clarification on 12/15/2017 from the county agency. NERO was informed that all efforts to obtain that specific information had not been successful. To stay within the timelines established in the bulletin, NERO forwarded the request for review. The NERO

recommendation at that time was to not grant the county request as the county information remained insufficient. The Department agreed with NERO and denied the decertification request on 12/18/2017. Case determination had been completed by the county agency as unfounded on 12/14/2017.

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

The case was unfounded under 30 days and there was no Act 33 meeting; thus, no further information to report.

Strengths in compliance with statutes, regulations and services to children and families:

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:

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

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:

Luzerne County completed their investigation under 30 days with an unfounded status; therefore, the county was not required to complete a county report.

Department of Human Services Findings:

County Strengths:

The agency completed thorough investigations of all reports. The agency gathered information from medical professionals directly related to this case. Collaterals were also made as additional follow-up to the Primary Care Physician and the school.

County Weaknesses:

None identified.

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

None identified.

Department of Human Services Recommendations:

It is recommended that the hospital obtain an interpreter for families much earlier in the process to complete thorough interviews and in order to obtain more accurate information. There was a lot of miscommunication between the initial report and the following day of what mother had stated.

Mandated reporters continue to struggle with the statutory definition of Near Fatality and often leads to classifications that were not the intent of treating physicians. Continued education of the medical community regarding the statutory definitions and reporting requirements is necessary.