pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/10/2019
Date of Incident: 09/05/2019
Date of Report to ChildLine: 09/05/2019
CWIS Referral ID: [redacted]

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

Northumberland County Children and Youth Services
Cumberland County Children and Youth Services
Montgomery County Children and Youth Services

REPORT FINALIZED ON:
02/20/2020

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 the Office of Children, Youth and Families (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.

Northumberland County Children and Youth Services (NCCYS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/02/2019. The review included participation and input from Cumberland County Children and Youth Services (CCCYS) as a joint review. Montgomery County Children and Youth Services (MCCYS) had very brief involvement with the family and was invited to the county review team meeting but was not in attendance.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	05/10/2019
[redacted]	Half-Sibling	[redacted]2017
[redacted]	Biological Mother	[redacted]1993
[redacted]	Biological Father	[redacted]1986
[redacted]	Father's Paramour	[redacted]1998

Summary of OCYF Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] family. CERO staff reviewed various reports, assessments, and case documentation provided by Northumberland and Cumberland Counties. CERO staff discussed the case with the county on 09/10/2019 and 10/02/2019.

Summary of circumstances prior to Incident:
The mother of the victim child has history with Cumberland County CYS due to [redacted] homelessness, [redacted]

Cumberland County Children and Youth Services (CCCYS) received a referral on 05/04/2018 regarding the mother and her care of the half-sibling, [redacted] The mother was compliant [redacted] There were some feeding concerns with the half-sibling, as it was believed the mother was over-feeding her.

The mother moved in with a friend and that friend helped with the care of the child. During the course of the assessment, the mother and the friend moved out of the county. It was believed that they moved to Montgomery County, so a referral was made to that agency by Cumberland.

Montgomery County Children and Youth Services accepted the referral and worked with the mother and friend briefly as they were staying in a hotel and looking for permanent housing. This agency was in the process of opening the mother for services. During their assessment, the mother and the friend moved out of the hotel and into a home in Shamokin, Northumberland County.

On 08/23/2018, Northumberland County CYS received the referral from Montgomery County and continued with the open case. For ongoing monitoring of [redacted] and child's feeding, the agency opened the case for in-home services and worked with the family until 04/15/2019 when they closed. During agency involvement, the mother remained with the friend and had support.

On 05/10/2019, the NCCYS received a referral regarding [redacted] The parents had reported that they had previous CYS involvement, so a referral was made. While assessing this report, another referral was received on 05/14/2019 regarding [redacted] and housing concerns. The agency received a third referral on 05/30/2019 for similar concerns. When the child was discharged from the hospital on 06/22/2019, a home health nurse was provided, but not on an ongoing basis. The agency monitored the case throughout the general protective services time frame of 60 days and then closed the case as the mother [redacted] had supports in place. [redacted] but mother had the family supports to help [redacted] transportation to appointments.

<u>Circumstances of Child Near Fatality and Related Case Activity:</u>
On 09/05/2019, NCCYS received a report of suspected child neglect through ChildLine. It was alleged that the victim child was in serious condition by a physician due to failure to provide nutrition to the child by the mother, father and father's paramour, all who were caregivers for the child during this time [redacted] Due to his poor weight gain, the family had weekly check-ins with physicians. After several cancelled appointments, some weight loss and a lack of strict feeding schedule adherence, it was believed that the caregivers were neglecting the nutrition of the victim child. The victim child was hospitalized on 09/05/2019 for failure to thrive. It was also noted that there were malfunctions with his feeding pump.

[redacted] the child received a g-tube for feeding on 05/31/2019. The mother was taught the proper administration of the feedings at that time. In August 2019, after physicians noted concerns about the amount of weight the child was gaining, the mother was again instructed how to feed the child

and was to do so two times a day. The mother missed the first weekly check-in for the child in August but did attend the check-in the following week. The child had lost 0.5 ounces. The mother reported that the pump had been malfunctioning and also that they had been out of the home, so she was not able to adhere to the feeding schedule. The doctor did provide her with syringes of the nutrition to use while in the community, however she was not using them. When the child presented to the doctor's office on 09/05/2019, the child appeared hungry and was sucking vigorously on a pacifier. The child was taken by ambulance to the hospital and was admitted there until 09/10/2019. He did gain weight while in the hospital. The child was then consistently gaining weight.

The mother, father and father's paramour were cooperative with the investigation and agency involvement. They could all recite the appropriate recipe for the victim child's formula and were reaching out for support to help work with the child. Throughout the course of the investigation it was determined that, while it was concerning that the child was not gaining weight, his condition was never grave and the parents did have a willingness to learn how to provide the proper care for him and did well with some prompting. Additional services were definitely needed, but the parents had not been acting in a neglectful manner towards the child.

NCCYS filed their investigation report with ChildLine on 10/04/2019 with a status of Unfounded. The father, mother and father's paramour were all listed as alleged perpetrators on the report. It was determined that all parties had been acting according to doctor's orders and that the child's condition was not heightened by any neglect. No charges were filed against any alleged perpetrator. The agency opened the family for services to provide resources, early intervention and parenting. Family would continue with medical services that were already available in the home.

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;
- None Noted

• Deficiencies in compliance with statutes, regulations and services to children and families;
- No deficiencies were noted by the team regarding CYS compliance with statutes, regulations and services to the child and family.

• Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
- Stress the importance of having all other Agencies involved with the family present at the Act 33 meetings such [redacted] to give their professional input.

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

- No recommendation for change

• Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - No recommendation for change.

Department Review of County Internal Report:
The Central Region Office received the Northumberland County Child Near Fatality Team Report on 12/30/2019. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 10/02/2019. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Northumberland County Administration on 01/02/2020.

Department of Human Services Findings:

- County Strengths:
  - NCCYS worked with local medical professionals and outside county agencies to gather all information, and to gain comprehensive understanding of the needs of the child and family.
  - The agency recognized the need to open the family for ongoing services to monitor medical visits and other educational resources that are needed for ongoing success of the case.
- County Weaknesses:
  - None noted with the investigation.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - No citations noted.

Department of Human Services Recommendations:
While not noted as a weakness of the county agency, there is an area of concern that the victim child was not receiving ongoing nursing services after he was discharged from the hospital. The mother reported that this had been denied by insurance. It is recommended that CYS agencies consult with hospital staff and primary care physicians in these situations, prior to case closing, to assure continued success of the family without CYS involvement.