pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/30/2016
Date of Incident: 01/23/2017
Date of Report to ChildLine: 01/23/2017
CWIS Referral ID: [redacted]

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

Cambria County Children and Youth Services

REPORT FINALIZED ON:
07/05/2017

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.

Cambria County Children and Youth Services convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on February 16, 2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Son (victim child)	09/30/2016
	Mother	[redacted]1991
	Father	1972
	Half-sibling maternal side	2007
	Half-sibling maternal side	2009
	Half-sibling maternal side	2014
* [redacted]	Step-parent	[redacted]1974

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the [redacted] family. CROCYF representative engaged the following Cambria County Children and Youth Services (CYS) personnel to discuss the incident: Director, Casework Supervisor, and Caseworker.

CROCYF Human Services Program Representative attended and participated in the Act 33 meeting that occurred on February 16, 2017 in which medical professionals, social service professionals, school district representatives, and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

CROCYF was informed that this family has had previous General Protective Services (GPS) investigations since March 2015. A GPS report in March 2015 was a transfer from Westmoreland County Children's Bureau; the mother and child tested positive for marijuana and [redacted] This referral was rejected when it was confirmed that

the mother [redacted] and that child abuse/neglect was not indicated. During October 2015, a GPS report was received alleging inadequate hygiene and child behavioral problems. The report involved a half-sibling that has [redacted] in school. The child asked [redacted] to help [redacted] noticed 15 light red marks on the child's upper thighs. The marks were attributed to the family dog and the agency worked with the mother to ensure that the respective child had [redacted] in school.

During February 2016, a GPS report was received alleging concerns for the children's wellbeing and parental substance abuse. This report was rejected after no evidence of child abuse/neglect was identified and that it was confirmed that the mother [redacted] During August 2016, GPS report was received involving lack of supervision, inappropriate discipline, and parental substance abuse. This report was rejected when it was assessed that the children did not have any visible injuries and there was no evidence of the caretakers using inappropriate discipline or failing to supervise the children. The agency was informed that the respective child's bruises resulted when the child fell on steps.

During October 2016, a GPS report was received that focused on mental health concerns of the mother and parental substance abuse. An agency caseworker met with the mother and family members, and the mother admitted making comments about self-harming after receiving upsetting [redacted] This report was rejected when it was assessed that there were no concerns for the family. A GPS report was received by the agency on the same date as the near fatality, January 23, 2017. The report alleged concerns of inadequate nurturing, parental substance abuse, and conduct by parent that places the child at risk. The report addressed concerns that the mother was allegedly drinking while breastfeeding her infant son. This specific report was rejected as there was no evidence that the mother was drinking while breastfeeding the child and due to the fact that the family would be involved with ongoing services due to the near fatality incident.

Circumstances of Child Near Fatality and Related Case Activity:

The 4-month-old male child nearly died on January 23, 2017 due to serious physical neglect. The child was transported by ambulance to Conemaugh Memorial Medical Center located in Johnstown, PA due to a report of the child having "cough and fussiness". Upon arrival at the hospital, the child was pale, severely under nourished, and minimally responsive to stimuli. [redacted]

[redacted] The child was transported to Children's Hospital of Pittsburgh of UPMC (CPH) due to his condition. [redacted]

[redacted] Medical practitioners where unable to identify any organic reasons why the infant was not gaining weight. It was determined that the child was not being provided enough life sustaining calories. [redacted]
The infant is expected to have a full recovery.

The child's 2-year-old half sibling was put on a safety plan with a family member since this child is not old enough to provide self-care or obtain food for herself. The child's two older half-siblings, ages 8 and 9, stayed in the home with the mother's paramour and the father of the victim child as they are able to provide some self-care, obtain food and operate a microwave.

Cambria County CYS founded the case on March 01, 2017, naming the child's father and mother as the perpetrators by commission; Causing Serious Physical Neglect of a Child (failure to provide child with nutrition/hydration and failure to provide medical care). On March 16, 2017, The Police Department with jurisdiction charged the victim child's parents with Endangering Welfare of Children and Recklessly Endangering Another Person. Each party was remanded to the [redacted] Prison. The father of the victim child was released on March 28, 2017 when his bail conditions were amended. On April 07, 2017, his criminal case was transferred to the Court of Common Pleas. The child's mother was released from the correctional facility on May 8, 2017 when her bail was changed to unsecured status. Her court case was transferred to the Court of Common Pleas on May 12, 2017.

The victim child [redacted] continues receiving care with an agency approved resource family. He has been with this family since [redacted] on February 2, 2017. At the time of the report, the child's weight is reported at 16 lbs. Due to the parents' arrests, subsequent incarcerations, and unstable housing, the three half-siblings are now living with and being cared for by the victim child's mother's ex-husband. The ex-husband is the biological father of two of the half-siblings. On February 2, 2017, the CYS agency opened the family for ongoing casework services. Cambria County CYS has initiated referrals for family engagement, [redacted] services through a private service provider, [redacted] for the parents, [redacted]

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 Act 33 Team recommended that the CYS agency obtain school records for the half siblings that attend school.

  The Act 33 Team recommended that the CYS agency ensure that a referral for [redacted] has been initiated.

The Act 33 Team recommended that the CYS agency schedule [redacted] for both parents.

- Deficiencies in compliance with statutes, regulations and services to children and families

  The Act 33 Team did not reference any specific recommendations.

- 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 did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

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

  The Act 33 Team did not reference any specific recommendations.

Department Review of County Internal Report:

The CROCYF received the Cambria County CYS Child Near Fatality Child Review Team Summary on February 13, 2017. Upon review of the report, CROCYF assessed that the documentation efficiently described the incident, the actions taken by the agencies involved, and the current status of the case. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

  The CYS agency ensured representatives of OCYF's Regional Office were kept abreast on their investigation and subsequent outcomes.

  The resource family caring for the victim child has been supportive of the visitation schedule arranged by the CYS agency.

  The CYS agency's engagement with medical practitioners and the victim child's foster parents has ensured that the child's medical needs (including immunizations) are being met.

- County Weaknesses:

  At the time of this report, CROCYF has not identified any County weaknesses.

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

  At the time of this report, CROCYF has not identified areas of regulatory non-compliance.

Department of Human Services Recommendations:

The CROCYF has no recommendations in regards to this incident.