pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/15/2000
Date of Incident: 04/16/2018
Date of Report to ChildLine: 05/25/18
CWIS Referral ID: [redacted]

FAMILY KNOWN TO JUNIATA COUNTY CHILDREN AND YOUTH AGENCY AT WITHIN THE PRECEDING 16 MONTHS:

Juniata County Children and Youth Services

REPORT FINALIZED ON: 04/11/19

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.

Juniata 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 06/19/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	12/15/2000
[redacted]	Sibling	[redacted]1999
[redacted]	Biological Mother	[redacted]1968
[redacted]	Biological Father	[redacted]1967

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 Juniata County Children and Youth Services (JCCCYS) personnel to discuss the incident: Agency Director [redacted] and Supervisor [redacted].

CROCYF Human Services Program Representative attended and participated in the Act 33 meeting that occurred on 06/19/2018 in which social service professionals were present and provided information regarding the incident, as well as historical information.

Summary of circumstances prior to Incident:

The child, who was born with [redacted], [redacted], and [redacted], was being treated for [redacted] when the agency first got involved on 09/17/2014. The agency was involved from 09/17/2014 until 10/17/2014 as the mother initially refused to have her child admitted to the hospital for suspected [redacted]. The mother changed her mind and allowed her son to be admitted to the hospital. She requested a transfer from [redacted] to He[redacted]

[redacted]. No further follow up occurred as mother was compliant with treatment for her son. The agency offered in home services, but the mother declined. The case was closed on 10/17/2014.

The agency received a second General Protective Service referral on 01/19/2018. The child had been hospitalized at [redacted] for the previous 6 months and was [redacted] on 01/11/2018. The child was admitted to [redacted] on 01/13/2018 for [redacted]. [redacted] recommended the child receive a [redacted] instead of being [redacted] and [redacted] so often however, the mother did not agree with a higher level of care but was otherwise cooperative. The medical personnel could not say that the [redacted] was medically necessary or that not receiving it was medial neglect, as such, the agency closed the case on 02/20/2018.

The agency received a third General Protective Service referral on 05/23/2018 with allegations that the mother was hospital shopping. The following dates and locations of hospital stays for the child were provided in the report:

[redacted] from 07/01/2017-01/11/2018
[redacted] from 01/13/2018- 04/16/2018
[redacted] from 04/17/2018 up until the date this report was made.

The concerns presented were that the child needed a [redacted] and that the [redacted] was causing damage to the [redacted]. The agency began to address this referral when a Child Protective Service (CPS) referral and Near Fatality report were made on 05/25/2018.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 05/25/2018 JCCYS received a CPS referral and Near Fatality report. The allegations were that when the child was [redacted] from [redacted] to home (04/16/2018), he was back in the hospital within 24 hours (04/17/2018). The mother did not give the child his [redacted] medication and did not use his Continuous Positive Airway Pressure (CPAP) machine and this caused the child's health to deteriorate and hospitalization. The report also mentioned the need for the tracheotomy.

JCCYS [redacted] for [redacted] of the child due to the concern for the child's need for a tracheotomy. The [redacted] took place on 06/01/2018. The parents agreed to the tracheotomy and JCCYS withdrew the [redacted], but continued to provide In-Home Protective Services.

The report was unfounded on 07/16/2018 as there was no medical evidence that the steroids were life sustaining. There was no contradictory evidence to say, that the child was not home long enough to use the CPAP machine. The mother reported that she called an ambulance as soon as she saw the child struggling to breathe. The agency

opened the case for In-home services in order to monitor the parents' compliance with medical needs for the child.

The parents [redacted] to be excused from agency services. It was reported that the child was placed at [redacted], where it was anticipated that he would live out the rest of his life, which was expected to be less than 6 months. On 10/25/2018 the [redacted] was granted.

No criminal charges have been filed.

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;

  Juniata County CYS complied with all statutes and regulations. The agency provided information to the Office of Children Youth and Families as per ACT 33 guidelines. The Near Fatality Meeting was held on 06/19/2018, within the ACT 33 guidelines. JCCYS obtained all necessary releases and records as allowed by the family over the course of the investigation. JCCYS interviewed and spoke with medical staff, Mother, Father, as well as Pennsylvania State Police (PSP) handling their own investigation. Notification letters were delivered in a timely manner.

  The agency provided notification to the PSP Department, Lewistown. Due to the report being received on a Friday evening, the agency gave verbal notification to the police on Friday, and sent a written copy of the report on Monday, 05/28/2018.

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

  JCCYS, jointly with the Act 33 review team, determined that there was a lack of good, clear communication between the parents and caseworkers involved with the investigation. Throughout the course of this investigation and past investigations, the family has been closed off to outside assistance and generally uncooperative with the agency. The agency has had to utilize the assistance of local Law Enforcement officials in order to make visits to the home due to concerns for multiple workers' own personal safety. This makes it difficult for the agency to obtain the appropriate records and information in order to assess the situation.

- 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 review team concluded that the agency could have better handled this situation if given easier access to children's medical records. In order to better monitor a child's health care and progress, it is imperative that the agency have updated information throughout the life of a case, both written and verbal from whatever health care facility in which a child may be residing.

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

  No recommendations provided by the county.

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

  The Act 33 review team suggested that JCCYS utilize the County's State Health Nurse from Juniata County's State Health Center for cases involving medically needy children. The hope with this collaboration would be for the State Health Nurse to provide insight and knowledge to caseworkers at home visits with families when handling cases such as these.

Department Review of County Internal Report:

The CROCYF received the Juniata County CYS Child Near Fatality Child Review Team Summary on 09/19/2018. 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. Written feedback was provided to the agency.

Department of Human Services Findings:

- County Strengths: The agency worked collaboratively with Law Enforcement and completed the investigation in a timely manner.

- County Weaknesses: The agency could have attempted to engage the father more than they did during the course of agency involvement.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no statutory or regulatory areas on non-compliance noted.

Department of Human Services Recommendations:

The CROCYF is in agreement with recommendations made at the Act 33 meeting.