



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



BORN: July 1, 1999
DATE OF INCIDENT: January 14, 2015
DATE OF ORAL REPORT: January 14, 2015

FAMILY KNOWN TO:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
9/17/15

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Allegheny County has not convened a review team in accordance with Act 33 of 2008 related to this report. The County unfounded this report within 30 days of receiving the report and did not convene a review team due to this.

Family Constellation:

<u>Name</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	07/01/1999
[REDACTED]	Father	[REDACTED] 1962
[REDACTED]	Mother	[REDACTED] 1962
[REDACTED]	Sibling	[REDACTED] 1998

Notification of Child Near Fatality:

[REDACTED]
 called in the referral on January 14, 2015 with concern that the victim child needed [REDACTED] due to malnutrition and growth failure. He alleged that the parents were refusing emergency admission of their son to Children's Hospital of Pittsburgh for full evaluation, nutrition status and possible [REDACTED]. It was alleged that the parents have not maintained contact with the Primary Care Physician (PCP) and did not return phone calls from the PCP's office. The victim child has [REDACTED]
 [REDACTED]

Summary of DHS Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Allegheny County Office of Children, Youth and Families (ACOCYF) Caseworker [REDACTED] on January 14, 2015 and January 28, 2015. The Western Region Office also read the case file and notes associated with this case.

Summary of Services to Family:

No Services were provided to the family. ACOCYF assessed the need of the family for services and deemed that the family was not in need of protective or general protective services at this time and the case was closed on February 17, 2015.

Children and Youth Involvement prior to Incident:

ACOCYF had no previous involvement with this family prior to the January 14, 2015 referral.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child is 15 years old and is [REDACTED]. He has a history of [REDACTED]. The Pediatrician felt that the victim child needed [REDACTED]. The parents refused both of these recommendations and failed to return calls to the Pediatrician. Pediatrician noted that the parents made "great effort" but were not adequately nourishing the victim child. Dr. [REDACTED] indicated that the victim child was in serious or critical condition based on suspected abuse or neglect. The victim child had lost 7 pounds since last appointment medical appointment on January 7, 2015.

On January 15, 2015, the ACOCYF caseworker went to the home and due to the nature of the referral spoke with the family about taking the victim child immediately to Children's Hospital of Pittsburgh (CHP) to be evaluated [REDACTED]. The family agreed to take the child to CHP. The caseworker followed the family to the local pediatric hospital. Upon arrival at the hospital the victim child was assessed and found to not be in imminent danger [REDACTED]. The parents were instructed to bring him back the following day [REDACTED].

January 16, 2015 the ACOCYF caseworker spoke to the PCP, Dr. [REDACTED], who advised that the referral should not have been classified as a near fatality. Dr. [REDACTED] stated that there was a huge amount of confusion. He advises that he felt that the parent's hesitation in following through with the [REDACTED] at Children's Hospital could have placed the victim child in danger of expiring but in no way was the victim child in critical condition. The victim child has been with his practice since November 2002. During victim child's last visit on January 7, 2015 he was found to have lost 7 pounds which was concerning to the PCP which is why he suggested [REDACTED]. Dr. [REDACTED] advises that the parents have "tried very hard" with attempting to encourage the victim child to eat more nutritiously, he reports they have been compliant and cooperative with following his recommendations with the exception of [REDACTED].

sending the victim child [REDACTED] to teach him how to eat nutritional foods instead of french fries and juice.

The victim child was admitted to CHP on January 16, 2015 for [REDACTED] his stay was anticipated to be less than 24 hours. [REDACTED] to determine whether the victim child had a [REDACTED]. Based on this [REDACTED] it was determined that he did not need [REDACTED]. He was [REDACTED] his parents care with a referral to the [REDACTED]. He was last evaluated in June of 2014 by the [REDACTED] and was found to be meeting his caloric intake but not consuming enough protein and PediaSure was recommended.

On January 20, 2015, the parents were interviewed and they advised that they did not agree with the PCP's recommendation that the victim child needed [REDACTED]. They reported their son is healthy and the PCP did not mandate that the victim child receive [REDACTED] so they did not follow through with it. The parents are willing to follow through with a [REDACTED] which the parents scheduled for February 16, 2015.

Current Case Status:

There is no current case activity. This case was unfounded on January 28, 2015 and the case was closed and not opened for services on February 17, 2015. There is no further activity with this family to date.

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

There was no internal Act 33 review on this case since the Agency unfounded the report within 30 days.

Department Review of County Internal Report:

There was no internal county report to review.

Department of Human Services Findings:

County Strengths: ACOCYF did make contact with the victim child and the family within 24 hours of the case being assigned. The victim child's safety was ensured.

County Weaknesses: This case was given a high risk rating however it appears that no one went to the home until January 15, 2015, the day after the report was received. It appears that the report came in on January 14, 2015 but was not assigned until the following day.

Also, this case appears to have been closed with no follow up from the County on whether the parents followed through with the [REDACTED] on February 16, 2015 at the [REDACTED].

Statutory and Regulatory Areas of Non-Compliance:

This case was given a risk and safety tag as high risk, child in impending danger, however he was not seen until January 15, 2015 the day after the report was made. An immediate response was warranted and it appears that this referral was not reviewed by a Supervisor the day it came in and sat until the following day. Safety could not be assured on January 14, 2015 and case should have been reviewed and assigned immediately.

The agency will be receiving a regulatory citation under 3490.55 (b) (2) which states that a county agency shall immediately commence an appropriate investigation and will see the child immediately if it cannot be determined from the report whether emergency protective custody is needed.

Department of Human Services Recommendations:

The Agency may want to look at how cases are coming in and being reviewed at the intake level internally. It appears that this case came in on January 14, 2015 at 3:26 PM however it was not reviewed by a Supervisor and assigned until January 15, 2015. It was assigned with a high risk rating and an impending danger tag as the safety of the child could not be assured based upon the report itself.