



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 12/01/1999
Date of Incident: 05/14/2015
Date of Report to ChildLine: 05/20/2015
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT
OR WITHIN THE PRECEDING 16 MONTHS:**

Mercer County Children and Youth Services

REPORT FINALIZED ON: 11/12/15

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:

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, 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.

Act 33 of 2008 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. Mercer County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 07/08/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	12/01/1999
[REDACTED]	Biological Mother	[REDACTED] 1978
[REDACTED]	Biological Father	[REDACTED] 1969
* [REDACTED]	Maternal Great Aunt	[REDACTED] 1970
[REDACTED]	Half Sibling	[REDACTED] 2003
[REDACTED]	Half Sibling	[REDACTED] 2008
[REDACTED]	Half Sibling	[REDACTED] 2010
* [REDACTED]	Half Sibling	[REDACTED] 2007
* [REDACTED]	Ex-Paramour	[REDACTED] 1984
* [REDACTED]	Maternal Grandmother	[REDACTED] 1956

* 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 Western Region Office of Children, Youth and Family Services obtained and reviewed case records pertaining to the family. Follow-up interviews were conducted with the Mercer County Intake Director, Assistant Director and Intake Supervisor on June 4, 2015. Subsequent follow-up phone calls were made to obtain ongoing information from the Director, Intake and Ongoing Supervisor. The Western Regional Office also participated in the Mercer County Act 33 meeting on July 8, 2015.

Children and Youth Involvement prior to Incident:

The family's first involvement with Mercer County Children and Youth Services (CYS) dates back to July 24, 2000. Mercer County CYS received a referral alleging

that the mother was not meeting the victim child's medical needs. The child was 7 months old at the time of the report. The case was accepted for services on September 18, 2000 to allow the agency to monitor the family and ensure the mother was adequately addressing the medical needs.

While active for services, a Child Protective Services referral was received on September 7, 2001 reporting allegations the victim child had been hospitalized due to mother not providing victim child [REDACTED] for at least three days. Medical professionals confirmed mother had not been giving victim child his [REDACTED]

[REDACTED] The victim child [REDACTED] in September 2001 at which time mother had privately arranged for the victim child to reside with Maternal Great Aunt. The county investigation resulted in an indicated report on October 5, 2001 listing mother as the perpetrator of medical neglect. The family was referred to a [REDACTED] program with moderate compliance reported. The family case was closed on March 1, 2002 as Maternal Great Aunt was meeting the victim child's medical and basic needs.

On July 8, 2002 Mercer County CYC received a General Protective Services referral due to reports maternal great aunt was not meeting the needs of victim child due to work schedules and transportation. The case was reopened on July 11, 2012. Shortly thereafter, Mother moved into the home of maternal great aunt, and was able to complete [REDACTED] training. Mother and victim child moved out of maternal great aunt's home upon locating housing in October 2002. The case remained active with Mercer County CYC.

On November 25, 2002 Mercer County CYC received a new Child Protective Services referral stating the victim child was not receiving proper medical care while in the care of his mother. The lack of care lead to the victim child having developed [REDACTED] which placed him at medical risk and he was [REDACTED] Mother was again indicated as the perpetrator of medical neglect on December 19, 2002.

The maternal great aunt again agreed to care for the victim child, through a private agreement [REDACTED] in December 2002. [REDACTED]

[REDACTED] in the care of maternal great aunt.

[REDACTED] The family case was closed on July 21, 2003.

On February 16, 2007 a GPS referral was received regarding allegations of mother testing positive for marijuana approximately seven months prior to her giving birth to her new son, [REDACTED] was a result of mother admitting to use while pregnant. [REDACTED] the referral was

closed. Subsequently, a Juvenile Probation referral was received in October 2009 regarding one of the siblings in the family.

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

A referral was received on May 20, 2015 stating the victim child had been taken to have blood work completed on May 14, 2015 after complaining of back pains and that his ankle hurt for approximately the previous two weeks. Per mother, she had been giving the victim child Motrin for his ankle and back pain. [REDACTED]

[REDACTED] It was determined by physicians at Children's Hospital of Pittsburgh that the victim child's medical condition was life threatening and could have caused imminent harm. The victim child was then admitted to Children's Hospital of Pittsburgh on May 14, 2015.

[REDACTED] made a referral six days later to Mercer County CYIS, on May 20, 2015. The report was registered as a CPS investigation listing mother as the alleged perpetrator. After consulting with medical professionals on May 26, 2015 the case was also registered as a near fatality due to the victim child being in serious or critical condition.

Mercer County spoke with mother and maternal great aunt while the victim child was at Children's Hospital. Mother reportedly stated the victim child missed medical appointments due to a lack of transportation and only required blood work as needed. Mother also reported the victim child has a history of throwing out his [REDACTED]. Maternal great aunt reported she returned the victim child to his mother after she allegedly consulted with medical staff who felt mother was able to meet his medical needs. Maternal great aunt also reported she contacted Mercer County CYIS in 2009 to inquire about returning the victim child to his mother's care. She stated CYIS reportedly informed her it was permissible for the victim child to return to his mother's care. CYIS did not have any record of maternal great aunt contacting the agency CYIS. CYIS did acknowledge a past practice of allowing caregivers to return custody of children to the parents without investigating or reviewing [REDACTED]. The county has taken ownership of this and has since remedied this practice. Similar scenarios now require an investigation and review of case history [REDACTED].

[REDACTED] and the victim child was placed in a non-relative [REDACTED] Foster Home. [REDACTED]

[REDACTED]

Maternal great aunt has recently been certified as a foster parent by a private foster care agency.

During the CPS investigation, it was discovered that the victim child had missed numerous appointments over the past three years and given the report of his [REDACTED] it would be highly probable that he would have to receive [REDACTED]

[REDACTED] even though the victim child had missed nine out of twelve appointments over the past three years, had not had any bloodwork since September 2014 and the mother could not be reached by phone or certified mail. [REDACTED]

[REDACTED] Mercer County CYS completed the abuse investigation on 06/16/2015 with an indicated status determination.

Currently the victim child has reportedly not missed any [REDACTED] appointments. He is up to date with his immunizations however two Well Check Up appointments were not attended in June and July of 2015. Western Region has discussed this information with CYS and the County reported this will be addressed immediately.

[REDACTED] The victim child's basic needs are being met in the home environment.

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 County Act 33 report did not identify any strengths.
- Deficiencies in compliance with statutes, regulations and services to children and families: The County Act 33 report did not identify any deficiencies.
- 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 County Act 33 report did not identify any recommendations.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: The County Act 33 report did not identify any recommendations.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: The County Act 33 report did not identify any recommendations.

Department Review of County Internal Report:

The County Internal Report was received and reviewed. The report was lacking with detail of prior case history, services provided, strengths and deficiencies and any follow up recommendations for changes on the state and local levels.

Department of Human Services Findings:

- **County Strengths:**

- The county presented a diverse multidisciplinary review team for the Act 33 meeting
- The county is providing services to mother and kinship caregiver to ensure all needs are continuing to be met—an initial FGDM conference has taken place and a provider is providing in-home services to mother. It is reported that is currently compliant.
- The county has discussed concurrent planning with the family and kinship caregiver. The county has made the family aware of the current goal being reunification with a concurrent goal of adoption

[REDACTED]

- **County Weaknesses:**

- The Department has noted concerns regarding the historical involvement of the case. Based on the length of time the case was open on and off through 2000-2003 and considering the lack of compliance and noted concerns from medical professionals, [REDACTED]
- As noted earlier in the report, the county previously did not investigate [REDACTED] to verify placement/ongoing custody orders. This practice has since been changed to reflect strong casework practice.

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

No statutory or regulatory areas of non-compliance issued by the Department.

Department of Human Services Recommendations:

Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to the Department of Human Services and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the following:

- Deficiencies and strengths in compliance with statues, 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 child abuse and neglect;

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

The county report failed to illustrate the above information. It would be the recommendation of the Department that future reports be structured to meet all Act 33 bulletin requirements.