pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/05/96
Date of Incident: 07/25/13
Date of Oral Report: 07/30/13

FAMILY KNOWN TO:

Erie County Office of Children and Youth

REPORT FINALIZED ON:

December 31, 2013

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. 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, DPW 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. Erie County has not convened a review team in accordance with Act 33 of 2008 related to this report. Erie County was not required to convene a review meeting due to the unfounded status determination being submitted within 30 days of the oral report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Child	01/05/96
[redacted]	Mother	[redacted]77
* [redacted]	Father	[redacted]74
[redacted]	Sibling	[redacted]94
[redacted]	Sibling	[redacted]96
[redacted]	Sibling	[redacted]98
[redacted]	Sibling	[redacted]01
[redacted]	Half-sibling	[redacted]10
[redacted]	Half-sibling	[redacted]12
[redacted]	[redacted] father	[redacted]75
[redacted]	Mother's paramour	[redacted]79

* [redacted], the father, is currently incarcerated.

Notification of Child (Near) Fatality:

On July 26, 2013 the subject child was taken to Hamot Hospital in Erie, Pennsylvania and was then transferred to Children's Hospital of Pittsburgh that same date. It was reported that on the day prior, the child's [redacted] The caregivers reported that the child became thirsty after dinner so she was given water and sent to bed. The caregivers also went to bed. On the next morning, the caregivers went to check on the child and found her to be unconscious. The child's tongue was said to be hanging out of her mouth. The mother stated that it did not appear the child drank any of the water given to her the night before. The mother's paramour picked up the child and carried her to the car. The mother and paramour drove the child to the hospital.

The child's [redacted] were extremely high and were not able to be accurately measured. The [redacted]

The report was registered for medical neglect resulting in a worsening condition based on history the child had with the treating hospital. It was reported that the child has [redacted] and a long-standing history of poor control of her [redacted] The child [redacted] in January and April for related medical concerns. The child's [redacted] After the [redacted] in January, a plan was made with the child's mother to supervise the child's daily [redacted] because of the child's non-compliance.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Information gathering interviews were conducted with the Casework Supervisor, [redacted] and Ongoing Administrator [redacted] on July 31, 2013. The Western Region Office additionally reviewed the past records on both of the mother's paramours as well as the involvement of the family in Crawford County during January 2012-July 2012. Below is a brief synopsis of any and all involvement the Department was able to review.

Children and Youth Involvement prior to Incident:

Upon review of the subject family's history, it was uncovered that both paramours had a history with the agency; the following is a very brief synopsis of each history. In situation to both paramours, the children were interviewed numerous times regarding safety with each paramour.

[redacted]
2001: Mr. [redacted] was indicated as a perpetrator of physical abuse as a result of injuries he inflicted to the child of his paramour.
2011: The agency received two reports of physical abuse concerns regarding Mr. [redacted] children. The AP was the mother's paramour and Mr. [redacted] was only listed as the father.

[redacted]
2011: Mr. [redacted] is listed as the father on a placement case. Mr. [redacted] was in Florida at the time the agency detained the children and returned to Pennsylvania as a reunification resource. The children were returned to their mother's care in August 2013. The agency was aware of a criminal history with Mr. [redacted] while in Florida and did engage in conversation and information gathering regarding this history. The agency did determine it safe to allow his children to visit with him.

Subject Family

2006-2008

Report received regarding allegations of sexual abuse on the two daughters in the home. The father was the AP. The report was indicated; the AP was arrested and remains incarcerated. The case was accepted for services and remained open until 2008.

March 2010

Report received regarding concerns for medical care regarding two of the children in the home who have [redacted]. RS was concerned that the children were not receiving adequate medical care regarding the [redacted]. It was determined that the daughter had a history of lying regarding her [redacted]. The son was compliant and responsible for [redacted]. The agency consulted with the medical professionals who substantiated that the children were being treated. The case was closed at the intake level.

June 2010

Report received regarding home conditions. It was believed by the RS that the family was living in a condemned home. The agency investigated and determined that the home belonged to the family of the stepfather and was being remodeled. The family was not living in the home. The agency addressed any concerns regarding the children being in the house while remodeling and also addressed the daughter's [redacted] during this investigation. The child was being monitored and her [redacted] was being managed. The case was closed at the intake level.

November 2010

Report was received regarding the children's hygiene. The report stated that the children were often dirty and appeared hungry. There were several dogs, 6 children and 4 adults living in a two bedroom home. The home conditions were noted to be concerning. The agency investigated and found the home to be cramped with three bedrooms, however it was adequate. The family had relatives staying with them occasionally during this time. The agency received a supplemental report on December 16 2010 regarding the daughter's [redacted] and the sleeping arrangements of two of the children. The agency followed up regarding this report and found that the two daughters' bedroom was moved to the basement, allegedly per the children's request. The basement was found to be inadequate for a bedroom and the family was told to move the children back upstairs. The family complied and in addition, signed a release to rent out the apartment on the second floor of the house to better accommodate all of the people. The daughter's [redacted] was reportedly being managed and the case was closed at the intake level on January 5, 2011.

January 24, 2011

Report received regarding the daughter's [redacted] and concerns that the mother was not helping the child manage [redacted] at home. Over the course of 25 minutes, the child's [redacted] The child was admitted to the hospital. The agency responded and spoke to the child privately. The child very clearly understood how to control her [redacted] The child admitted to [redacted]. The child's primary care physician was contacted and reported the child self-sabotages [redacted]

and he was no longer willing to treat her. The child was referred to a specialist. The case was accepted for services on February 16, 2011.

Subsequent to case acceptance the agency confirmed that the child was being followed medically and that changes were made to her [redacted] In March 2011 the family became homeless for a short time and was living with friends. At the time the mother was pregnant with [redacted] Mr. [redacted] who is the biological father of [redacted] is also [redacted] father. In addition to services provided by the assigned case worker the agency also arranged for [redacted] program for the mother to assist her in monitoring the subject child's [redacted] as well as [redacted] service to provide assistance to the family [redacted]

In September 2011 the children were seen at school since the agency was not able to locate the family during the month of August. The daughter reported that she continued to have [redacted] The children were still being [redacted] and he was aware of the [redacted]. The son was compliant with [redacted] The caseworker attended a medical appointment with the children's treating physician and it was recommended that the children [redacted] During this time, the mother disclosed that she had left her paramour Mr. [redacted] and the unborn baby's father) and the family was living with a friend.

The agency referred the family to [redacted] and in September 2011 the family moved into [redacted]. The family was placed on [redacted], however it was noted that the list was very long and it would be some time before the provider could find the family [redacted]. The children were all up to date on medical and dental appointments at this time. Due to the time it was taking for the family [redacted], in November 2011 the paternal grandfather agreed to take all of the older children. [redacted] was the only child to remain with the mother [redacted]. The grandfather was living in another county; however Erie maintained contact and monitored the case while this transition occurred. In December 2011 the mother [redacted] in the same county as the grandfather and moved, taking the children back into her care. The agency monitored the case for another month and noted that the children's [redacted] than acceptable. The mother had given birth to the youngest child on January 21, 2012 and the agency referred the family to the neighboring county on January 24, 2012 and closed the case.

Crawford County January 24, 2012-July 25, 2012

Concerns continued to be truancy and [redacted] management of the subject child's [redacted] The agency referred the family for [redacted] services. The agency also provided short term placement services for the older son as there were identified child behavior issues. A [redacted] was provided to the daughters. During the course of activity, the subject child was again [redacted] for [redacted]. The child had been staying with her grandfather for a second time after the mother was evicted. The hospitalization occurred during the stay with the grandfather and was reportedly due to the child missing [redacted] The mother was staying in [redacted],

where the child returned to her care [redacted]. The child was [redacted] and referred for [redacted] however the family relocated back to Erie before services were initiated.

July 2012

The family was referred back to Erie County OCY by Crawford County CYS when they were evicted from their home in Crawford County and moved back to Erie to the home of Mr. [redacted], the father of the two youngest children. Continued concerns existed with the subject child's [redacted] Some of the children were also behind on their shots. The agency followed up with the family and discovered that the children were seen just days prior and received their shots. The daughter was seeing an [redacted] for her treatment; she had also been recently diagnosed with [redacted] The child was not being treated for the [redacted] The family which had been working with a [redacted] service in Crawford County and was referred back to the Erie County [redacted] program which had worked with them previously.

The subject child was opened with a local [redacted] The family was again accepted for services on August 14, 2012 based on the history of medical concerns and housing instability.

In September 2012 the family moved out of Mr. [redacted] home. The mother and the children stayed in a hotel for a few weeks and then moved in with a friend. The daughter had been in contact with the [redacted] and was seen for an appointment [redacted] services were started with [redacted] and [redacted] services reactivated. [redacted] were not continued for the daughter and concerns arose regarding her trouble sleeping as well as her continued difficulty with [redacted] Very little documentation was provided regarding the daughter's [redacted] and in January 2013 she was [redacted] after she was found passed out in her room [redacted] The caseworker followed up with the service provider regarding this new information, however made no follow up visit or contact with the family. The case was recommended for closure on January 25, 2013. Before being approved for closure, a truancy referral was received regarding the older son. The closure was denied and the case remained open. In March the 16 year old son was arrested for Aggravated Assault, Recklessly Endangering another Person, Possessing an Instrument of Crime and Conspiracy to Commit Aggravated Assault. This occurred during an incident with a group of friends. The 16 year old was held in jail until it was decided if he would be charged as an adult or as a juvenile. Ultimately he was charged as a juvenile and released from jail. The truancy referral was addressed and the case was approved for closure on March 26, 2013.

April 2013

A second truancy referral was received on April 30 regarding the twelve year old sibling of the subject child. In addition, during the assessment of this referral a call was received on May 2 regarding the mother's new paramour having an extensive criminal history in Florida where he had been incarcerated for sexual assault on a minor. An intake investigation related to this allegation was initiated. The caseworker made a visit to the home to discover the family had relocated to another house. A visit to the school was completed on May 3 to speak to the children and determine their feelings of safety regarding the mother's paramour. The caseworker

made a visit to the home May 7, 5 days later; however, the caseworker did not discuss the criminal record of the paramour. A follow up visit was made on May 21 when the caseworker officially questioned the mother regarding her paramour's history. The mother was aware of his record and had no concerns regarding her children. The case does not document any interview with the paramour regarding the history. This writer noted that the paramour had a previous history with the agency regarding his three children's removal from their mother. The Western Region then reviewed the paramour's case history with the agency. That record did not reveal information which suggested that he would be a danger to the children.

The case was again accepted for services on June 12 based on the significant truancy concerns. [redacted] services which had remained involved during the preceding closure and had been involved for approximately the past 3 years remained active with the family, even though the provider had not been able to effectively address the problems that continued to negatively impact family functioning; particularly the [redacted] of the subject child and the chronically unstable living situation.

During this opening episode, the 12 year old son became involved with JPO after being arrested for breaking and entering. Upon opening through JPO, the child was drug tested and found to be positive for marijuana. The juvenile was referred to a [redacted] program after school and a local [redacted] program.

The daughter's [redacted] was addressed and it was reported that the three month average had gone down and the child seemed to be doing better with management. She was attending a clinic of [redacted]

On July 26 the agency made a home visit and was informed that the mother and subject child were at the hospital after the subject child had a [redacted] that morning. The agency subsequently received the near fatality report on July 30 regarding this child's [redacted]

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

Upon receipt of the near fatality report, the agency immediately responded to the family home to assess safety of the other children in the home. The assigned caseworker was able to meet with the mother at the home while she was preparing to get ready to leave the house. The mother reported that the child was found lying on her back on the morning of the day of incident. The child had foam like substance around her mouth and she had vomited. Additionally, the mother reported that the child had urinated herself. The mother stated that upon admission to the local hospital, the physician had [redacted] and reported this may have caused the spike in [redacted] The mother reported that the child had been doing well with her [redacted]

The last visit to the clinic was July 12, 2013. The mother was struggling financially to get to [redacted] to visit with the child and could not find transportation to assist her.

On July 31 the child was still considered critical, however was [redacted] The child was awake and alert however was not talking with medical staff. On August 2 the child was moved from [redacted] and placed into a [redacted]. The child was still being assessed at this time [redacted].

The intake worker recorded [redacted] over the month of July [redacted]

The social service department at [redacted] assessed the child and determined that she needed a longer stay based on her sabotaging behavior. The [redacted] leading up to the episode were basically manageable, except in the mornings. It was a concern of medical professionals that the child was using her [redacted] The child was determined to be [redacted] on August 6, 2013. Based on the child's history of refusing services, she was transferred to a [redacted] to better assess her [redacted] due to her refusal to care for her [redacted], with strict supervision and management of her [redacted]

On August 6 the agency submitted an unfounded determination regarding the allegation of medical neglect based on the child's self-sabotaging behavior.

Current Case Status:

The child [redacted] into her mother's care on August 16, 2013. The agency developed a plan with the family to provide daily visits twice a day to monitor the child's [redacted]. A [redacted] was also started in the home. [redacted] provided strict and clear [redacted] guidelines to the child and the family. During the next several weeks, the caseworker and aide provided daily visits and noted the child's [redacted]

The child has been [redacted] and had an intake for [redacted] The family has remained open with the family preservation service and was referred for [redacted] The child was not compliant with her [redacted] and her [redacted]. The child is under medical recommendations to [redacted], with some assistance from monitoring at the school. It is likely she is not [redacted] The agency gave the child a [redacted]. The child is not always compliant in making these recordings. On some occasions, the recorded number did not match the history on the [redacted]. The agency continues to make regular visits to monitor the [redacted]. In October, the mother reported she was pregnant again to her current paramour. The case remains open at this time. The agency continues to make at least weekly home visits.

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

- Strengths: No internal review report submitted as no review was required, therefore no strengths were provided.

- Deficiencies: No internal review report submitted as no review was required, therefore no deficiencies were provided.

- Recommendations for Change at the Local Level: No internal review report submitted as no review was required, therefore no recommendations at the local were provided.

- Recommendations for Change at the State Level: No internal review report submitted as no review was required, therefore no recommendations at the state level were provided.

Department Review of County Internal Report:

County internal report was not submitted.

Department of Public Welfare Findings:

- County Strengths:
  - Upon return home from the child's [redacted] the agency made visits to the home twice a day to monitor the child's [redacted]
  - During every intake, the investigating caseworker was aware of the subject child's [redacted] and made reference to the issue in case notes. Additionally, the workers addressed any status regarding the condition with the child and the mother.

- County Weaknesses:
  - During the August 2012-April 2013 opening, the caseworker recommended closing in January 2013. During that time interval, the subject child [redacted] the hospital for an emergency episode regarding her [redacted]. The agency made a follow up contact with the in-home provider following the child's admission but did not conduct its own assessment of the child's situation. Without a safety assessment, the caseworker continued to recommend the case for closure. The closure was only denied because a truancy referral, related to a sibling, was received on February 7. When that truancy referral was resolved, the case was closed on March 26, 2013 without addressing the subject child's (of this report) progress related to her [redacted]
  - During the current case opening (April 13 to present date) the caseworker went to the home on two different occasions to see the children in June 2013. At both of these visits, the subject child was upstairs in her bedroom and was never seen.

- The same [redacted] service provider was involved for over 3 years. Very little progress was made with the family goals and yet the services extended to the family were not adjusted.
- A referral received in May 1, 2013 included an allegation that the mother's new paramour had an extensive criminal history in Florida that involved sexual abuse of a minor. The caseworker assigned to the referral made a home visit with the mother on May 3; however the criminal history was never discussed. The caseworker never went back to address the concerns until May 20. At this time, the mother was interviewed, however no documentation exists in the case record that the paramour was ever interviewed regarding his history.
- The case record does not include documentation about concerns surrounding the subject child's [redacted] The child (and her sister) was the subject of sexual abuse in 2006. Several years later there is no indication in the record of an assessment related to determining if the child's self-sabotaging behavior was related to the trauma of that past abuse or whether the child was dealing with a separate [redacted]. The child was determined by the neighboring county to have [redacted] and referred for services, however besides forwarding the referral; the agency did not appear to follow through with any monitoring of the child's compliance. The child failed to receive any significant [redacted] services over the course of the agency's involvement.

Department of Public Welfare Recommendations:

The Department noted that during each of the six intervals of agency intervention the assigned caseworkers documented the child was [redacted] however, there was very little documentation detailing the child's [redacted] or reflecting an understanding of why the child so poorly manages her [redacted] The Department recommends the agency obtain better medical assessments and recommendations pertaining to known chronic medical conditions with children. This would include review of medical records, documentation of any required monitoring for the child by the child and/or caregiver(s) and referrals to any support programs that would assist the family in managing the condition. The Department also recommends that the significance of the potential impact of previous traumatic events that children have endured be included in the agency's assessment of their current functioning.

With the exception of June 2013, the Department recognizes that the agency was mindful and compliant in seeing all of the children in the family when completing monthly visits. Although the agency responded to the home on two different occasions in June 2013 the caseworker did not see the subject child. Even though the subject child of the near fatality was not the child on the truancy referral, the case had been accepted for services as of April and required all children be seen. In this case, the subject child was dealing with a well known medical condition and was not assessed during that month.

The Department also recommends the agency better document the criminal/abuse history of any household member involved in an active case. It was reported that the mother's paramour had a criminal record in another state for sexual assault of a minor; however, the caseworker never

interviewed the paramour and never documented in the case notes follow up contact with the alternate state authorities.

Additionally the Department recommends better global assessments of families open to the agency. Although it was noted on multiple occasions that the subject child had a chronic and very unstable medical condition, there was no documentation in the case record of efforts to obtain a comprehensive assessment related to why the child was self-sabotaging her condition. Instead agency staff attributed the child's behavior to defiance, rather than seeking a better understanding as to why the child felt the need to disrupt her treatment.