pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/05/2010
Date of Incident: 06/20/2013
Date of Oral Report: 06/20/2013

FAMILY KNOWN TO:

Blair County Children, Youth and Families

REPORT FINALIZED ON:

January 12, 2015

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))

Department of Public Welfare/Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dpw.state.pa.us

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. Blair County convened a review team in accordance with Act 33 of 2008 related to this report on July 15, 2013.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim child	[redacted]2010
	Mother	1994
	Sibling	[redacted]2011
	Father	1993
	Mother's Paramour	1990
	Half-Sibling	[redacted]2012
	Household Member	1994
	Household member	1994

*The child's father is not a member of the victim child's household.
**Member of the Household where the incident occurred.

Notification of Child Near Fatality:

On June 20, 2013, Blair County Children, Youth and Families (BCCYF) received a report from [redacted] indicating that the child and his sibling were brought to the hospital on June 20, 2013, at 4:00 pm. [redacted] stated that the children's mother reported the children had ingested another child's medication. [redacted] stated that the details of the mother's story were questionable. Additionally, [redacted] stated that the incident occurred earlier in the day and the children were not brought to the hospital until 4:00 pm. [redacted] states the children were [redacted] upon arrival and flown to Children's Hospital of Pittsburgh (CHOP). Because the children did not arrive at the Altoona Regional Hospital until 4:00 pm and the mother's story was noted as questionable, the report was registered for "Lack of Supervision Resulting in a Physical Condition". The attending physician also classified the child as near-death.

Summary of DPW Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the entire case record from Blair County Children, Youth and Families; including the Child Protective Service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed Blair County Supervisor [redacted] and Caseworker [redacted] who conducted the agency investigation. The CROCYF also attended the Act 33 Child Near-Fatality Review Team meeting on July 15, 2013.

Children and Youth Involvement prior to Incident:

Blair County Children, Youth and Families was previously involved with the family prior to receiving the Child Protective Services Report on 06/20/2013.

06/29/2010 – 06/29/2010: Blair County Children, Youth and Families, (BCCYF), received a referral regarding concerns with home conditions that was screened out. There was no documentation of the agency's actions in determining how/why this was screened out. The agency caseworker who completed the screen out is no longer employed at the agency and the agency supervisor could not provide any further information.

07/10/2010 - 07/10/2010: Domestic violence was reported in the home between the mother and maternal grandmother. The police responded to the report. The referral was screened out by BCCYF. The agency documented that the police had handled the situation and there was no further need for agency intervention.

8/9/2010 – 01/30/2012: Concerns of the child being ill, needing medical treatment and the mother not taking the child to the doctor was reported to BCCYF. It was also reported that the mother was drinking, smoking marijuana and leaving the children with any individual, that the home conditions were unsanitary and that the child's crib was broken. This report was accepted for ongoing services on 10/15/2010 and remained open until the family moved out of state to California on 12/01/2011. A referral was made to [redacted] County CYF in California and the case was closed with BCCYF.

6/18/2012 – 07/02/2012: The family returned to the area. Concerns were reported regarding living conditions, yelling and inappropriate discipline, that the children were not cared for and living in unstable living conditions. The agency conducted several visits and the home where the mother was staying with the children proved to be appropriate. [redacted] The referral was then closed.

11/12/2012 – 11/14/2012: It was reported that there is domestic violence in the home, that the mother's paramour yells and is rough with the children. It was alleged that the mother's

paramour uses drugs and is very controlling. The report was screened out on 11/14/2012 after it was determined that mother was no longer residing with paramour.

12/27/2012 - 01/28/2013: It was reported that the mother delivered a son on 12/24/12 and that she left the hospital with the child without meeting with social services on 12/25/12. The mother had tested positive for marijuana at the hospital. A BCCYF Caseworker conducted several visits with the mother and the family. The caseworker also talked with service providers and obtained medical records. With no concerns being noted, the case was closed.

2/27/2013 – 03/15/2013: It was reported that the mother and her paramour were living on the third floor with their three children. They reportedly stay upstairs until 5:00 pm or later and lock the door so the children can't get out. The children are in bed until they come downstairs. The RS heard that the mother will be moving but does not know where. The parents are reported to sleep all day and not take care of the children. The oldest child is not in school but the mother mom is supposed to go to a meeting to see about getting him into [redacted] The caseworker conducted home visits and learned that the family was seeking other housing. They denied the other allegations. The caseworker noted that the children appeared healthy and happy with their needs met. The caseworker made a referral for [redacted] and the case was closed.

3/18/2013 – 04/26/2013: Neglect issues were reported stating that the mother and paramour sleep all day, don't feed or bathe the children regularly, that the oldest child choked on a penny and the parent's bedroom door was locked, that the parents yell at the children and use inappropriate discipline. No injuries were reported. The agency caseworker conducted a HV and kept in touch via telephone. [redacted] was still working with the family [redacted] The case was closed on 04/26/2013 following assessment services.

Circumstances of Child Fatality and Related Case Activity:

The mother, the victim child and his sibling, a half-sibling and the father of the half-sibling, who is also the mother's paramour, all stayed at a friend's home on 06/19/2013.. The friends who own the home babysit two children in their home. They have no children of their own. The next morning, 6/20/2013, the mother's paramour left the friend's home for work at 8:40 am. He reported that the mother and all of the children were sleeping and everything was fine when he left the home. The mother reports that she and her youngest child were sleeping on the couch together in one room and the victim child and his sibling were sleeping in a bedroom. The mother reported the child got up at 7:00 am and she gave him some water and he went back to bed. The mother reported she went back to sleep as well. The mother stated she thinks that the child's sibling may have been up at 11:00 am but she was not sure. The mother states she woke up at 1:00 pm because her youngest child was screaming from being hungry.

When the incident occurred, the two other household members listed above were asleep in their bedroom along with the two children they babysit, a girl age 5 and a boy age 8. The boy takes the medications [redacted] The medications were stored in a baby wipe container and was on the kitchen counter. These two children were not involved in the incident.

BCCYF and the parents of those two children developed a safety plan together that the children would no longer be babysat by the two household members. BCCYF monitored the family's compliance with the safety plan.

While the mother was sleeping, the child and his sibling got into the container and ingested the medication. When the mother awoke at 1:00 pm she found the victim child and his sibling lying down and unresponsive. The pill bottles were empty and pills were lying around the children. The mother stated that a friend told her to put the children in the bathtub and bathe them to try to awaken them. The mother states she did not seek immediate medical treatment due to fear of Children and Youth Involvement. The mother states that at approximately 4:00 pm, she put the children in the car and began to take them to the hospital while at the same time she was calling Poison Control. The mother states that Poison Control instructed her to pull the car over and call 911. An ambulance then arrived and transported the children to Altoona Regional Hospital. Once in the hospital, Dr. [redacted] examined the children and ordered that they be life-flighted to Children's Hospital of Pittsburgh. Dr. [redacted] stated that both children were in serious and critical condition due to suspicion of child abuse or neglect. He also classified the children as near-death.

The father of the victim child and his sibling was notified of the report and he arrived at the Altoona Regional Hospital to check on the condition of his children. The father has a long history with BCCYF as a child. He was in placement services, had several incidences of runaway and violent behavior and was very provocative. He was not found to be a stable resource at that time to care for the children. Initially, both parents of the victim child and his sibling agreed [redacted] At approximately 1:30 am of 6/22/13, the [redacted] and wanted to take both children from CHOP against medical advice. The hospital police were called to the floor due to the situation. [redacted] The child [redacted] and placed in foster care on 06/22/2013. The child's sibling remained at CHOP [redacted] she was in need of additional care. She [redacted] the same foster home as her older sibling on 06/24/2013. She received and completed follow up medical care [redacted]

Blair County Children, Youth and Families indicated their case and submitted the CY 48 on 07/02/2013. The mother, her paramour, and the two household members were indicated for lack of supervision and medical neglect.

Current Case Status:

Following the children's placement into foster care [redacted] until 12/11/2013 when they returned to their mother's care following her and her paramour's successful completion of supportive services. Those services included [redacted]

[redacted] The child's father did not cooperate with supportive services and also failed to attend visitations.

The safety plan for the half-sibling of the victim child immediately following the incident was that he would reside with his biological father. The father agreed to supervise all contact with the mother. Additionally the mother left the family residence and stayed with one of the father's relatives, which was verified by BCCYF through monitoring and contacts. The mother was reunited with her youngest child and her paramour on 09/17/2013 following their completion of identified services (described above).

Law enforcement concluded their investigation in August 2013 and decided not to pursue criminal charges.

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

A Child Death Review Team Meeting was held on 07/15/2013.

Deficiencies Identified:

- No deficiencies were identified.

Strengths:

- It was noted as a strength that the mother and her paramour came to BCCYF and requested assistance from the agency on a prior referral. The team felt this was a strength that the family willingly requested assistance from the agency.

- The coordination of resource services to assist the family was done timely. BCCYF carefully monitored case progress and maintained contact with the service providers.

Recommendations for Change at the Local Level:

- There were no recommendations for change at the local level.

Recommendations for Change at the State Level:

- There were no recommendations for change at the state level.

Department Review of County Internal Report:

The report from BCCYF was received by the Regional Office on January 31, 2014. The report details the topics that were discussed during the Death Review meeting held on July 15, 2013. There were no deficiencies noted.

Department of Public Welfare Findings:

- County Strengths:
  The investigation was conducted timely and in close collaboration with law enforcement. Case documentation was comprehensive including medical reports, interviews, risk and safety assessments, criminal complaint documents and case dictation.

- County Weaknesses:
  There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of non-compliance noted.

Department of Public Welfare Recommendations:

Blair County Children, Youth and Families should continue to conduct thorough and timely investigations in coordination with law enforcement officials. The agency may want to consider a thorough case review process when they receive repeated referrals to assess the need for intervention services with families.