pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: March 27, 2011
Date of Incident: March 21, 2013
Date of Oral Report: March 22, 2013

FAMILY KNOWN TO:

Jefferson Co. CYS

REPORT FINALIZED ON: October 9, 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. Jefferson County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/27/2011
[redacted]	Mother/AP	[redacted]1993
[redacted] *	Father	[redacted]1986

*indicates that this individual lived in a different household.

Notification of Child (Near) Fatality:

On March 20, 2013, the child was transported via ambulance to the Dubois Regional Medical Center's Emergency Room. The emergency room physician made the determination that the child needed to be transported to Children's Hospital in Pittsburgh due to not being able to stop the [redacted]. The child was transferred via life-flight to Children's Hospital of Pittsburgh. Upon arrival at the hospital he was admitted to the [redacted] had been diagnosed with [redacted] at birth, a lifelong condition that can be fatal if medication is not given as directed. The preliminary statement from [redacted] described the condition of child to be in serious critical condition. Jefferson County Children and Youth Services received a Child Protective Services referral on March 22, 2013.

Summary of DPW 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. The regional office also participated in the County Internal Fatality Review Team meeting on April 26, 2013.

Children and Youth Involvement prior to Incident:

Jefferson County CYS had one prior referral dated March 27, 2011 due to concerns [redacted] was born prematurely, [redacted] had contacted the agency due to stressors which involved a young teenage mother. The mother refused intervention at that time and there did not appear to be any issues of abuse or neglect. The case was closed at intake on April 19, 2011.

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

On March 18, 2013 the mother had contacted Dubois Regional Medical Center's Emergency Room to report that she had ran out of [redacted] medication. The hospital staff sent [redacted] to [redacted] Pharmacy on March 18, 2013.

On March 19, 2013, the mother took [redacted] to the [redacted] Emergency Room to receive a dosage of the [redacted] medication. The mother had reported to hospital personnel that she had [redacted] and was unable to pick-up [redacted] medications at the pharmacy. [redacted] The hospital [redacted].

Approximately around 4:30 a.m. on March 20, 2013, [redacted] began to vomit and stumble and began to [redacted] The mother called 911 and it took approximately 20 minutes for the ambulance to arrive at the mother's residence. [redacted] was taken to Dubois Regional Medical Center where he continued to experience [redacted] It was determined by the physicians in the emergency room to life-flight him to Children's Hospital in Pittsburgh.

Upon arrival at Children's Hospital he was admitted to the [redacted] due to experiencing [redacted] Jefferson County Children and Youth Services obtained an emergency court order and a hearing was held on March 25, 2013, which resulted in the child being placed into the custody of Jefferson County Children and Youth Services. [redacted] on March 26, 2013 to the care of his paternal grandmother. The father at time of incident was incarcerated at SCI [redacted] on drug related charges.

During the course of the investigation, Jefferson County Children and Youth Services Caseworker learned that the mother had obtained both of the child's medications on February 25, 2013 and was given at that time a 40 day prescription. The child's pediatrician had stated that the mother should have still had some of the child's medication on March 20, 2013. During the course of the investigation, it was unable to be determined what happened to the medication.

Jefferson County CYS filed an Indicated report on the mother as the alleged perpetrator of medical neglect on May 13, 2013.

On March 22, 2013, Jefferson County CYS conducted a Family Group Decision Making Conference, to assist the mother in regaining her support system. A referral was made to [redacted]. The agency contracted with Family Preservation Program to

assist the mother with stabilizing her [redacted] and to increase her parenting skills. Jefferson County Children and Youth sought dependency of child on April 24th, 2013.

Current Case Status:

The child remains on his medication regime of [redacted] prior to the incident on March 20, 2013. On September 26, 2013, the paternal grandmother received permanent legal custodianship of [redacted].

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

Strengths:

- Caseworker was diligent in obtaining and reviewing medical records.
- Open communication between hospital staff and Jefferson County Children and Youth.
- Hospital staff was supportive and attempted to assist mother in receiving necessary medication for child the day prior to the incident.
- Collaboration between local police, District Attorney, Children and Youth and medical personnel.

Deficiencies: No deficiencies were indicated by the County

Recommendations for Change at the Local Level: No recommendations were offered.

Recommendations for Change at the State Level: No recommendations were offered.

Department Review of County Internal Report:

The Department reviewed the report and is in agreement with their findings.

Department of Public Welfare Findings:

County Strengths:

The County completed the meeting in a timely manner and had all the required people present. The County completed its report in a timely manner and submitted to the Department. The County also has ensured safety of the child.

County Weaknesses:

None were identified

Statutory and Regulatory Areas of Non-Compliance:

No areas of non-compliance were determined.

Department of Public Welfare Recommendations:

The Department has no recommendations for this report.