pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/14/09

Date of Incident: 11/10/2012

Date of Oral Report: 11/10/2012

FAMILY KNOWN TO:

Blair County Children, Youth and Family Services

REPORT FINALIZED ON: 05/23/13

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))

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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 Children, Youth, and Family Services convened a review team in accordance with Act 33 of 2008 related to this report on 12/06/2012.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	son (victim child)	09/14/09
[redacted]	Mother	[redacted]1986
[redacted]	Sibling – Sister	[redacted]2005
[redacted]	Sibling – Sister	[redacted]2008
* [redacted]	Father	[redacted]1985
* [redacted]	Grandmother – Paternal	[redacted]1965
* [redacted]	Uncle – Paternal	[redacted]1992

* not members of the household and/or did not live in the home at the time of the incident.

Notification of Child Near Fatality:

Blair County Children, Youth and Family Services (CYFS) received a report on the victim child's condition on 11/10/12. The agency received notification of the near death of [redacted], three (3) year old child, on 11/14/2012 when Dr. [redacted], physician with [redacted] Hospital certified the case as near death. The Department of Public Welfare, Office of Children, Youth and Families (DPW/OCYF) was notified on 11/14/13.

Summary of DPW Child Near Fatality Review Activities:

The Department of Public Welfare, Office of Children, Youth and Families Central Region obtained and reviewed all current and past case records pertaining to the [redacted] Family. Engagement and follow up interviews were conducted with the Intake Caseworker [redacted], Casework Supervisor [redacted] Caseworker [redacted], Senior Casework Supervisor [redacted], and Director [redacted]. Blair County CYFS conducted a Near Death Review Meeting on 12/06/13. DPW/OCYF personnel participated in the review.

Summary of Services to Family:

The victim child currently resides with foster family, [redacted] at [redacted] PA. The foster family is approved by the [redacted] agency. The child has completed [redacted] services through [redacted] program. The victim child also receives [redacted] services through [redacted] meets with the child on a weekly basis. Records indicate that the child is healthy and that his weight falls within normal range on growth chart.

The victim child's two (2) siblings reside with foster parent, [redacted] PA. [redacted] is an approved foster parent through [redacted]. The sisters also receive weekly [redacted] sessions via [redacted]. It is reported that the children are doing well in the foster home, but the sisters have displayed ineffective behaviors in relation to being defiant and being angry with the foster mother. The sisters are enrolled in the [redacted] School System and due to their [redacted] have been developed.

Blair County CYFS has arranged visitation with the children with their mother, [redacted]. The agency utilizes [redacted] to arrange and supervise the visits. The visits occur twice per week for three (3) hours. The first hour is with the victim child and his mother, the second hour allows the siblings to visit each other, and the third hour is with the daughters and the mother.

Children and Youth Involvement prior to Incident:

On 12/04/11, a child abuse report was received by Blair County CYFS which alleged the mother was beating the child, [redacted], which resulted in a black eye. During the CPS investigation, the mother stated that the child's "pack and play" was positioned by the television stand and that the child attempted to climb the stand. By the mother's account, the child fell, hitting the stand and striking the floor. The child had scratches that were stated to be inflicted by the family's pet cat. The report was unfounded and the case closed on 1/11/12.

On 07/04/12, an intake / referral report stated that the mother is not feeding the child and that the child is locked in a closet. The child is reported to have marks and bruises. The reporting source stated that the child is "so skinny that his skin hangs from his body". The agency referred the mother and child to [redacted], a pre-school program and to [redacted]. The health care facility reported that the child had gained 2 pounds during this family's current involvement with CYFS. It was reported that representatives of the health care facility and of the pre-school facility were directed to contact CYFS if the mother failed to make appointments. The case was closed on 9/ 21/12.

On 11/05/12, an anonymous call to Childline reported that the mother was starving the child [redacted] and that the child had bruises on his face and body. The reporting source stated that the mother was unable to give answers as to how the bruises occurred. The reporting source reported the child was skin and bones, and that the mother keeps the child in the camper to avoid

anybody seeing the condition the child is in. Blair County CYFS decided to screen out this report due to the fact that the case was just investigated and that there were no reports received from [redacted] or from [redacted]. There is no evidence that Blair County CYFS contacted the aforementioned providers to determine if the family was active with their respective services.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/10/12, the child's [redacted], contacted Blair County Children, Youth, and Family Services in regards to the health of the child, [redacted]. The reporting source stated that the mother does not feed the child and that the child is "so skinny, it is sickening". On the same date at 7:46pm, [redacted], Blair County CYFS caseworker, along with Police Officers [redacted] and [redacted] with the Altoona City Police Department visited a camper located at [redacted] Altoona, PA, where it was reported the family was staying. The caseworker described the child as "fragile, skin and bones, malnourished, and unable to speak." The child was transported by ambulance to [redacted] Hospital's Emergency Room. A [redacted] with the hospital reported the child was emaciated, malnourished, and in a skeletal state. The clinical progress note from the [redacted] Emergency Room Department stated that the child was given food and ate voraciously. Blair County CYFS dictation stated that [redacted] indicated that it looks like starvation and that the hospital has found no medical reason as to why the child is so underweight. The [redacted] review of the child indicates the chief complaint as malnutrition. The physical exam characterized the child as an ill-appearing male toddler and that that he has poor musculature throughout his extremities, core and trunk. The child's weight was recorded at 19.4 lbs. It was also noted that the child had multiple contusions on his back.

On 11/13/2012, the mother signed a voluntary placement agreement to move the two siblings to a formal foster home after the agency received reported concerns that the paternal grandmother was allegedly abusing [redacted] that was not prescribed to her. It was also reported that one of the children residing in the paternal grandmother's home had previously exhibited sexual acting out behaviors.

On 11/14/2012, Dr. [redacted] certified the case as near death. The child was [redacted] Hospital on 11/15/12. The child [redacted] to the same foster family that his siblings were already residing in. The [redacted] instructions recommended that the child be followed up with at [redacted] and the child was to be offered a regular food diet. The [redacted] instruction offered no other restrictions or medications. The [redacted] summary indicated that the primary diagnosis for the child was failure to thrive.

On 11/27/2012, [redacted]. The agency's rationale is founded on the child not receiving proper care. The [redacted] outlined the family's involvement with the agency including the child's need to be hospitalized for five (5) days due to being malnourished. The agency's [redacted] paralleled the [redacted] Hospital's diagnosis of the child as failure to thrive.

[redacted]. The foster parent began reporting concerns regarding how the siblings were treating the victim child. They would ignore him, not want him to be given food and snacks, and became physically aggressive with him. Concerns also began to arise regarding the ability of the foster mother to handle the needs and behaviors of the children. [redacted]. It was decided that it was in the victim child's best interest to be placed in a foster home away from his siblings due to their behaviors and the detrimental effect that it was having on him.

Current Case Status:

The mother, [redacted], is residing with the children's [redacted] uncle, [redacted] at [redacted] PA. Blair County CYFS did report that Ms. [redacted] and the Uncle also stay with the [redacted] Grandmother, [redacted], in Altoona, PA. The children's father, [redacted] whereabouts are unknown at the time of this report. It was verified that he was released from the [redacted] Prison, but authorities are unable to locate him. It was reported that his involvement with his children has been infrequent and sporadic. His last contact with the children was on October 25, 2012, the night the city of [redacted] observed Trick or Treat.

The permanency goal for the children continues to be reunification with the mother but Blair County CYFS is reviewing the progress of each family member and the family as a whole is making.

A report was filed with the Pennsylvania State Police on 11/13/12. At the time of this report, criminal charges against [redacted] have not occurred. It was also reported that [redacted] has yet to be contacted by the law enforcement officials.

On 01/04/13, the victim child's siblings were transported to the [redacted] Center in [redacted], PA to participate in forensic interviews. Neither child disclosed any information regarding the mother's behaviors toward their brother, [redacted]. The sister did not disclose any concerns regarding their mother or the other APs. On 01/08/13, the Blair County CYFS indicated [redacted], and [redacted] for medical neglect on [redacted]. All four (4) individuals had access to [redacted] and observed his condition.

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

- Strengths:
  - Caseworker was detailed in her review of the case
  - The agency effectively collaborated with law enforcement from the City of Altoona

- Deficiencies:
  - None noted in report

- Recommendations for Change at the Local Level:
  - [redacted] representatives recommended that the children and youth agency notify them prior to sending a request for information thus allowing communication to occur between agencies to specify what information is being requested
- Recommendations for Change at the State Level:
  - A universal "release of information" form would benefit the child welfare agencies in obtaining information more efficiently during an investigation

Department Review of County Internal Report:

The report from Blair County CYFS was received by the Regional Office on 01/18/2013. The report details the topics that were discussed during the Near Death Review meeting held on 12/06/12. The CYFS agency conducted the investigation in collaboration with City of [redacted] Police Department and the [redacted] State Police. There were no deficiencies identified, but it is noted that communication between the agency and the Trooper assigned to the case has been minimal.

Department of Public Welfare Findings:

- County Strengths:
  - The agency was also expedient to ensure the safety of the other children in the home.
  - The agency has compiled an effective MDT community team; members of which represent a wide array of community services and supports.

- County Weaknesses:
  - In regards to the near fatality investigation, there were no concerns regarding how the agency conducted the investigation or the services that were provided to the family. Weaknesses were identified regarding services the agency extended to the family prior to the receipt of the near fatality report; please refer to the areas of non-compliance listed below.

- Statutory and Regulatory Areas of Non-Compliance:
  - A Licensing Inspection Summary was issued to Blair County Children, Youth and Families on 05/23/2013 due to concerns identified during the record review of this family's case history. None of the citations issued derived from the Near Fatality Report that the agency received on 11/10/2012. Citations included:
    - 3130.21(b): The citation was due to the county agency not conforming to the Safety Assessment Manual. A Preliminary Safety Assessment Worksheet did not include all of the children residing in the home.
    - 3490.55(c): This citation was a result of the agency caseworker seeing the victim child as required for a CPS investigation but failing to see the other children in the home until 3 days after the required timeframe.

- 3490.55(g): The agency determined that the child was examined by a pediatrician regarding an allegation of abuse but did not request or receive the pediatric records for this visit.
- 3490.61: The agency failed to facilitate 10 day supervisory reviews during a CPS investigation.
- 3490.32(e): The agency failed to complete a CPS investigation within 30 calendar days of when the report was received and did not provide documentation in the record as to the circumstances of why the investigation extended beyond that timeframe as required.
- 3490.232(e): The agency received a GPS report and failed to make a status determination of whether to accept the case for ongoing services or close it within the required 60 day timeframe.
- 3490.232(i) and 3490.236(a)(5): The agency received a GPS report regarding allegations of neglect that had been previously been substantiated by the agency but the case was closed due to services being provided to the family that would alleviate the concerns. The agency received a similar GPS report less than 2 months from when the substantiated report was closed for services. The agency screened the report out without investigation. No contact was made with the child, family or service providers to ensure the welfare of the child (The near fatality report was received 5 days later).

Department of Public Welfare Recommendations:

The Regional Office is committed to working with Blair County Children and Youth Services as they prepare their respective plans for corrections for the aforementioned citations. It recommended that supervisors and caseworkers of the agency have the opportunity to review the citations and rationale behind them. Their respective input in preparing the plans of corrections would benefit the agency.