



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON FATALITY OF

Londyn McCall

Date of Birth: 10/1/2013

Date of Incident: 11/16/2015

Date of Report to ChildLine: 11/17/2015

CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE:
MONTGOMERY COUNTY OFFICE OF CHILDREN & YOUTH

REPORT FINALIZED ON:

07/01/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Montgomery County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/16/2015.

Family Constellation:

<u>First and Last Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Londyn McCall	Victim Child	10/01/2013
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1976
[REDACTED]	Maternal Grandmother	[REDACTED] 1967
[REDACTED]	Sibling	[REDACTED] 2010

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documentation, and documents pertaining to the [REDACTED] Family. Contact was made with the county caseworker to obtain the structured case notes, safety and risk assessments and the child's medical reports. In addition, the county, [REDACTED] reports were reviewed.

Children and Youth Involvement Prior to Incident:

Montgomery County Office of Children and Youth (MCOCY) received a previous referral on 07/29/2015 due to inconsistent and inadequate health care for the victim child. MCOCY was involved through 09/10/2015 with the mother and maternal grandmother to assess why medical appointments were missed and to assure that medical care was being provided as needed. It appeared that the biological mother had unstable housing and allegations of cocaine use. At the time of the assessment the maternal grandmother was the primary caregiver. The biological mother made some effort to get involved with getting the victim child and sibling to medical appointments along with the maternal grandmother. The county completed their assessment of the family's needs and the case remained opened for

ongoing services [REDACTED], if needed.

Circumstances of Child Fatality and Related Case Activity

On 11/17/2015, MCOCY received a [REDACTED] report [REDACTED] and then upgraded to a fatality. The incident occurred on 11/16/2015, and the alleged perpetrator is unknown at this time. The report indicated that the biological mother put the toddler down for a nap in her bed, after the child had fallen asleep with the mother on the couch. When the mother attempted to awaken the toddler by tickling her arm, she realized something was wrong. She picked up the victim child and the toddler's head flopped. The mother called 911, and informed the dispatcher that she was performing cardiopulmonary resuscitation (CPR) on the victim child. The call to the paramedics was for an unresponsive 2-year-old child, they were informed that the biological mother was performing CPR. The paramedics arrived at the home within five minutes of receiving the 911 call, and found the biological mother and victim child in the bedroom, the victim child was not breathing and the biological mother was screaming. The paramedics moved the victim child into the ambulance; they continued to perform CPR on the victim child [REDACTED]

[REDACTED] It remains unclear how long the victim child was without oxygen. The victim child was then transferred to Children's Hospital of Philadelphia (CHOP) via medical helicopter [REDACTED] Initially there were concerns as to whether the victim child had taken medication that were in the home [REDACTED] the maternal grandmother. A urine test was taken and the results were negative. The physicians agreed not to do a skeletal survey on the victim child because she was not physically stable. The victim child had a cold at the time she was admitted to the hospital, [REDACTED] [REDACTED] The examinations were put on hold until the victim child was stable, and not to cause additional distress. The victim child was declared brain dead on 11/21/2015.

The investigation was [REDACTED] on 12/21/2015 due to insufficient information. Toxicology tests and an autopsy have been completed. Once the results/findings are returned to the county there may be new information; [REDACTED]

The maternal grandmother had custody of the 2-year-old-female victim child, there was also a 10-year-old-male sibling in the home; he has been removed from the home where the incident occurred.

[REDACTED] reported that during her initial contact with the mother, she appeared very unstable, and stated that she was in the process of moving, but had been living with her grandmother. [REDACTED] [REDACTED] After giving her statement she was taken to the hospital to be with the victim child.

██████████ found a small amount of marijuana at the maternal grandmother's home; however the maternal grandmother was not at home at the time of the incident. The maternal grandmother stated the marijuana did not belong to her, and gave the name of the person who left the marijuana at her home, according to her she was not aware that the marijuana was in her home. No other information was provided around the marijuana being found in the home ██████████. The police are not pursuing criminal charges as well as no drug charges. The police also stated that the maternal grandmother tried to commit suicide in July 2015 by drinking antifreeze.

The county case manager made the 24 hour contact/ visit with the victim child at CHOP. The caseworker met with ██████████ to obtain information received from the maternal grandmother; she provided the team with her ██████████. According to the physician, the combination of medications that the maternal grandmother ██████████ was not unusual.

Current Case Status:

The male sibling has been placed in kinship care as of 03/4/2016 due to substance abuse issues in maternal grandmother's home. He resided in a resource foster home until 03/18/2016 until the kinship home of the Maternal Aunt was approved as a MCOCY foster/kinship home. He has supervised visits with his mother weekly for three hours.

The mother is working on her family service plan goals ██████████. Mother needs to maintain housing, employment and ██████████. The mother will need to follow through ██████████ and be consistent with ██████████.

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

The multi-Disciplinary Investigative Team worked collaboratively to complete the investigation.

Montgomery County Children and Youth was in compliance with all state regulations and statutes and worked in collaboration with the local police and county detective during the investigation.

Montgomery County Children and Youth interviewed family members in connection with the police.

The review team has recommended that the family be monitored for compliance to services and to support the maternal grandmother and mother toward ██████████.

A recommendation has been made to always assure that families are adequately locking all medication out of the access to children.

Public education was recommended via collaboration between public health, behavioral health and, MCOCY regarding awareness of impact of second hand smoke on children and on safe storage of medications.

Department Review of County Internal Report:

The county submitted the report on 02/11/2016 in a timely manner. SERO concurs with the County Report on 03/11/2016 without further recommendations.

Department of Human Services Findings:

County Strengths: The county investigation was complete and conducted in a timely manner.

County Weaknesses: None identified.

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

There were no areas regulatory non-compliance.

Department of Human Services Recommendations:

The Department of Human Services Recommends that the County document a detailed plan of safety. The report should reflect the family's stability, medical updates, and school visits, along with the progress that the family has made before the case is closed; with a recommendation stating whether or not the family could benefit from additional services.