



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]
Date of Birth: 02/12/2015
Date of Incident: 11/06/2015
Date of Report to ChildLine: 11/06/2015
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Montgomery County Children & Youth

**REPORT FINALIZED ON:
July 1, 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 Children and Youth has not convened a review team in accordance with the Child Protective Services Law related to this report. The County had determined this report to be unfounded within thirty days of its receipt which negates the requirement of an ACT 33 Review Team Meeting.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Victim Child	02/12/2015
[REDACTED]	Cousin	[REDACTED] 1999
[REDACTED]	Cousin	[REDACTED] 2000
[REDACTED]	Cousin	[REDACTED] 2012
[REDACTED]	Cousin	[REDACTED] 2011
[REDACTED]	Paternal Aunt	[REDACTED] 1981
* [REDACTED]	Father	[REDACTED] 1992

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation case notes conducted by the MCCYS investigator and her supervisor. Follow-up interviews were also conducted with the quality assurance administrator and social services administrator regarding the county's internal procedures. Moreover, SERO did an extensive [REDACTED] review on the information received from St. Christopher's Hospital for Children [REDACTED]

Children and Youth Involvement prior to Incident:

MCCYS had no involvement with this family prior to November 06, 2015. However, the victim child's mother was known to the county between December 28, 2010 and January 10, 2011. The case was for General Protective Services, related to the child's maternal grandmother and mental health concerns and not caring for her children appropriately. MCCYS utilized [REDACTED] for the family until January 10, 2011 at which time the family's case was closed.

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

It was reported the mother and father brought the child into Pottstown Memorial Medical Center on 11/06/2015 at approximately 1:13 AM. They were concerned with strange noises the child was making such as coughing and/or choking sounds. The child was breathing slightly on her own, but was not very responsive. [REDACTED]

[REDACTED] The doctor then orders a urine drug screen (UDS) which came back positive for [REDACTED]. The parents denied any knowledge of knowing how the child could have gotten the medication. The mother indicated that she was not breastfeeding the child and she had no knowledge of anyone taking the medication in the household or how her child could have gotten the drug. However, the mother did recall taking the child with her to a party recently, but does not think anything happened to the child there. The father stated he was not with the child during this event and, as confirmed by the mother, only visits the child from time to time. The child was prepped to go to Children's Hospital of Philadelphia (CHOP) since they have a more extensive drug screening system that may provide more information. [REDACTED]

[REDACTED] However, the medical professional was reluctant to say that the critical condition of the child was due to neglect or abuse because they were unsure if the [REDACTED] in the child's system was the direct cause [REDACTED]. There were no other signs of abuse or neglect and the child appeared well nourished and clean when she was brought to the hospital.

The child was transported to CHOP later the same day and while under their care the medical team determined the mostly likely cause of [REDACTED] was [REDACTED] overdose. The medical professionals certified the child as a near fatality [REDACTED]. On November 11, 2015 the [REDACTED] was confirmed to be [REDACTED]. The child was receiving care from CHOP from November 06, 2015 until November 10, 2015 when she was [REDACTED] with the paternal aunt as the primary caregiver and responsible for ensuring the safety of the child.

The County established a safety plan with the family utilizing the paternal aunt as the person responsible to ensuring the safety of all the children in the home. The paternal aunt was the head of the household where the victim-child and her mother resided. The paternal aunt has five children of her own who also reside in the

home. The County did not find any safety concerns as it relates to assessing the safety of the aunt's home.

On 11/23/2015, the County reported as it relates to the allegation in this case that "The child accidentally ingested medicine. Unknown how the child gained access to the meds and the case will be opened for further monitoring." Also, the Child Protective Services Investigation (CPS) was rendered as Unfounded on this same date. MCCYS accepted this family for services on November 19, 2015. No criminal charges were filed by the [REDACTED] Detectives at this time. Currently the child is reported to be healthy and her needs are being met. MCCYS is continuing to monitor the family's case to ensure the proper care and supervision of the child continues.

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

- Strengths in compliance with statutes, regulations and services to children and families: None
- Deficiencies in compliance with statutes, regulations and services to children and families: None
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse: None
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: None
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: None

Department Review of County Internal Report:

No concerns

Department of Human Services Findings:

- County Strengths:
There was strong collaboration with multiple medical professionals as it relates to tracking the child's medical progress.
- County Weaknesses:
None found.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. MCCYS accepted the family for services on 11/19/2015. The Family Service Plan was completed and signed on 02/02/2016 which is more than 60 days from case acceptance.

Department of Human Services Recommendations:

It is recommended that the county collaborate with medical professionals and the pharmacist community to request they provide additional guidance and/or safety measures as it relates to the safe storage and/or discarding of narcotics and children's safety.