pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/25/2013
Date of Incident: 02/14/2016
Date of Report to ChildLine: 02/15/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Erie County Office of Children and Youth

REPORT FINALIZED ON:
07/02/2016

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.

Erie County has not convened a review team in accordance with the Child Protective Services Law related to this report as the report was Unfounded on 03/01/2016, within 30 days of the date of the report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	12/25/2013
[redacted]	Biological mother	[redacted]1985
* [redacted]	Biological father	[redacted]1980
[redacted]	Half-sibling maternal	[redacted]2011
* [redacted]	Half-sibling's father	[redacted]1984

* 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 Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the caseworker and the supervisor on 03/01/2016. The agency unfounded the report within 30 days therefore no team meeting related to this case was conducted.

Children and Youth Involvement prior to Incident:

General Protective Services report (GPS) 08/31/2012-10/18/2012:

- Report involved allegations that the half-sibling had a burn from the stove as well as diaper rash. The agency investigated the allegations and learned that there was a custody dispute between the parents at this time. The half-sibling was receiving [redacted] and the pediatrician did not

have any concerns. The allegations were not substantiated and the case was closed.

GPS report 11/20/2012-01/14/2013:

- Report related to the half-sibling who allegedly had another bad diaper rash and concerns that his medical needs were not being met. The agency accepted the GPS assessment and met with all parties. A collateral contact was made with the pediatrician and no concerns were noted; the case was closed at the intake level.

GPS report 01/20/2015-02/23/2015:

- Report alleged that the mother was using illegal substances. The mother admitted to [redacted] heroin [redacted] The agency learned that the mother [redacted] She had support of her parents at the time. [redacted] There were no safety factors identified for the children, therefore the case was closed.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/15/2016, Erie County Office of Children and Youth (ECOCY) received a report regarding the victim child. The victim child had arrived at the local emergency room via ambulance after the mother called emergency services. The mother reported placing [redacted] on the kitchen table. When she turned around from getting a glass of water, the pill was gone and only the victim child was close enough to have taken it. Toxicology testing was completed and the results were still pending at the time of the report. ECOCY responded to the Child Protective Services (CPS) report by going to the local hospital to see the victim child and to interview the mother. The caseworker spoke to [redacted] who reported that the victim child was doing fine and his vitals were normal at that time. The mother reported previous drug use, but stated currently she was [redacted] The hospital conducted a blood test on the victim child and it was explained that this drug can cause lethargy and respiratory depression, both of which the victim child had exhibited when first arriving at the hospital.

The mother reported to the caseworker that she was at the maternal grandfather's residence watching her five half-siblings as well as her own two children. She stated that she only had one [redacted] pill with her at the time because she does not like to carry around [redacted] bottle. She described that she was passing out snacks for the children and she remembered sitting her medication out in front of her on the table, and then she could not find it. She stated she looked for the pill for 5-10 minutes and the victim child was the only one around the table where she had put the pill. She stated that she contacted 911 to report this as she wanted to be safe. The mother reported that the victim child's half-sibling was with his biological father at the time of the incident.

The caseworker did contact the half-sibling's biological father who confirmed that his son was with him. He agreed for the caseworker to come to his home to see the half-sibling and to assure safety.

On 02/16/2016, the agency learned that the victim child's [redacted] results were negative for any substance and the hospital [redacted] victim child to his mother's care [redacted] to follow-up with the pediatrician. The caseworker attempted a home visit at the mother's residence to see the victim child, but no one answered the door. No one was home, so the caseworker attempted to call the mother and left a message for her to call as soon as possible.

There were several messages between the mother and the caseworker, and the caseworker and the half-sibling's father between 02/16/2016 and 02/18/2016. The mother contacted the caseworker and a home visit was scheduled for 02/23/2016 for the mother, the victim child, the half-sibling and the half-sibling's biological father.

On 02/19/2016, the caseworker contacted [redacted], to discuss the fact that the case was assigned as an Act 33 review. The caseworker explained that [redacted] was listed as the certifying physician. [redacted] became upset and expressed "that this case is not a near fatality" and stated "the [redacted] should have not made those statements". The worker asked [redacted] to put this statement in writing but [redacted] did not follow through with the request.

On 02/23/2016, the caseworker made an announced home visit to the mother's home. The mother provided her with the same details she provided the hospital staff. She stated that she panicked when she saw the pill was missing and after looking for a few minutes she contacted 911. The mother reported that the victim child was not lethargic the next day, but exhausted from screaming and crying when the hospital staff were poking and probing him. She stated she had to hold him down as he was fighting the nurses [redacted] The home was observed to be clean and appropriate with no hazards to the children. The caseworker observed the victim child was up running around and playing; and, he appeared to be healthy and bonded to his mother.

The caseworker then visited the half-sibling at his father's home. The half-sibling was described as being active and showing the caseworker his toys and what he recently got for his birthday. The home was clean and deemed appropriate. The half-sibling's parents share 50/50 custody. The caseworker made efforts to contact the child's biological father and left several messages for him to call.

On 03/01/2016, ECOCY submitted the investigation summary with an unfounded determination based on the fact that the victim child's [redacted] tests were negative for [redacted] or any other substance; the mother (alleged perpetrator) remained consistent in her story as to what happened; and, the fact that there is no medical evidence to support that the child ingested the medication, therefore, he was not in immediate danger. The agency closed the case after a final home visit on

03/10/2016 in which the mother, the victim child and his half-sibling attended. There were no identified safety threats or risk to the children.

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

The investigation summary was submitted with an unfounded determination on 03/01/2016, within 30 days of the date of report. The agency did not have a formal team meeting; therefore, there were no strengths, deficiencies or recommendations made regarding this situation.

- Strengths in compliance with statutes, regulations and services to children and families: Not applicable
- Deficiencies in compliance with statutes, regulations and services to children and families: Not applicable
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse: Not applicable
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies: Not applicable
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse: Not applicable

Department Review of County Internal Report:

There was no internal report submitted by the county as explained above.

Department of Human Services Findings:

County Strengths:

- The agency responded the day of the report by seeing the victim child and his mother at the hospital. The agency interviewed the mother and obtained collateral information from the nurse and social worker regarding statements made by the mother.
- The agency contacted [redacted] related to the fact that the report stated the physician deemed this to be a near fatality. When [redacted] stated that he did not agree with this, the agency attempted to get a written statement from the physician which was never received.

County Weaknesses:

The county made a request for [redacted] physician to write a letter stating this incident should not have been certified as a near fatality; however,

additional follow-up was not conducted by the county to obtain the letter when it was not received.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.
There were no statutory or regulatory areas of non-compliance identified.

Department of Human Services Recommendations:

It is recommended that the hospital review their protocol regarding the requirement that near fatality reports are to be certified by a physician. In this case, [redacted] used the physician's name in making the certified near fatality report. When the agency followed up with the physician, it was stated that [redacted] had made a mistake and the physician had never certified this to be a near fatality. The agency requested that the physician put the non-certification statement in writing, which never occurred. Changes to the hospital fatality/near fatality certification protocol could eliminate reports being deemed Act 33 cases when the physician is not making this statement.

It is further recommended that the Department of Human Services perform outreach training to further clarify immunity from liability, mandated reporting and certification of fatality/near fatality referrals.