



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 08/06/2013
Date of Incident: 03/27/2016
Date of Report to ChildLine: 03/27/2016
CWIS Referral ID: [REDACTED]

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

York County Office of Children, Youth and Families

REPORT FINALIZED ON:
09/08/2016

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.

York County Office of Children, Youth and Families (YCCYF) convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 04/19/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	08/06/2013
[REDACTED]	Biological Mother	[REDACTED] 1987
[REDACTED]	Biological Father	[REDACTED] 1990
[REDACTED]	Full Sibling - brother	[REDACTED] 2015
[REDACTED]	Full Sibling - brother	[REDACTED] 2012
[REDACTED]	Paternal Grandmother	[REDACTED] 1965
[REDACTED]	Paramour of PGM	[REDACTED] 1965
[REDACTED]*	Uncle	[REDACTED] 1994
[REDACTED]*	Uncle	Unknown
[REDACTED]*	Paramour of Uncle	[REDACTED] 1993

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

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a preliminary meeting with the MDT/Act 33 Review board on 04/19/2016 to review and discuss case information. Additional discussions were conducted with the York County Office of Children, Youth and Families (YCCYF) Quality Assurance Specialist on 03/31/2016 and through ongoing email correspondence.

Children and Youth Involvement prior to Incident:

YCCYF received two general protective service (GPS) reports prior to their current involvement with the family. Both reports were screened out as there were no allegations of abuse or neglect.

On 10/02/2015 the YCCYF received a GPS referral regarding the victim child and her sibling alleging lack of supervision by the mother and father. There were concerns that the children would be left without proper parental supervision if mother remained [REDACTED] and if father would be picked up on warrants. The family later identified a plan of supervision for the children, if the father was arrested on outstanding warrants. This referral was screened out on 10/07/2015 citing no abuse or neglect alleged.

On 10/06/2015, YCCYF received a GPS referral concerning behavior problems exhibited by the victim child's oldest sibling. According to the reporting source, the mother was 33 weeks pregnant and went to the hospital due to medical concerns [REDACTED]. The hospital wanted her to stay until delivery. However the father wanted to sign her out against medical advice (AMA), because he was unable to continue to provide care to the children at home. The oldest sibling was to receive case management due [REDACTED]. The father had an arrest warrant and did not have resources to pay the associated fines. The mother left the hospital AMA on 10/03/2015. The family also reportedly did not have supplies for the new baby and were resistant to any services for the children. This referral was screened out on 10/07/2015 citing no abuse or neglect alleged.

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

On 03/27/2016, YCCYF received a Child Protective Services (CPS) near fatality referral concerning the victim child (VC) from [REDACTED]. The victim child's urine toxicology tested positive for [REDACTED], possibly from her father's [REDACTED]. The VC was noted as dirty in appearance and also had ingested a metal button or foreign object [REDACTED]. On 03/27/2016, the agency received a GPS referral regarding the victim child's two siblings due to risk associated with the parent's actions in the near fatality report. Both parents were identified as responsible parties.

An interview with [REDACTED] revealed that the VC had been brought to the hospital by the mother, as she was "having spells of not breathing" and then would breathe on her own. [REDACTED] asked the mother if the VC had ingested anything and she responded no. The mother initially stated that no medications were available in the house except for the grandmother's medications which were locked up. Later, she disclosed that the father [REDACTED] with one pill that he had in a bedside drawer that was missing. A skeletal survey was completed [REDACTED].

[REDACTED] A language barrier was also identified as the mother spoke limited

English. [REDACTED]

The child [REDACTED] later in the day on 03/27/2016 after a period of observation and was allowed to resume age appropriate and usual activities as tolerated. A follow up appointment was scheduled for 03/31/2016 with her primary care physician.

The mother was interviewed at the hospital on 03/27/2016, with the assistance of Interpretalk due to the language barrier. The mother reported that at the time of incident, she was in the bathroom and the father was downstairs in the home. The VC ran upstairs and the father followed her up to find her holding his empty [REDACTED] bottle. [REDACTED]

The mother did not know how long the VC was alone upstairs without supervision. The VC was [REDACTED] and always putting things in her mouth. The mother planned on buying a lockbox to secure all medications.

The father and two other children were seen in the family home on 03/27/2016 along with the paternal grandmother. Interpretalk was again used due to the father's limited English. The father reported having [REDACTED]

[REDACTED] He stated that he threw the bottle away as the bottle was now empty. [REDACTED]

[REDACTED] At the time of the incident, the father was downstairs dealing with the behaviors of the VC's sibling. He then went up to find the VC and discovered she had swallowed [REDACTED] The bottle had been uncapped as the lid was missing. No other concerns were noted in the home environment.

The assigned caseworker, along with a bilingual caseworker to aide with interpretation, conducted an unscheduled home visit to the home on 03/28/2016. The VC was [REDACTED] and all immediate family members were present. The parents' story had changed slightly from the day before in that the father now said he was planning to take his medication and left the [REDACTED] tablet on the dresser when he went down stairs to address his other child's behavior. The mother observed the VC to be chewing something when they were all downstairs in the home. It was later that the father went back upstairs to take his medication and noticed it was missing. By this time, the VC had started to act "out of it" and falling in and out of sleep. The VC was then taken to the hospital ER. The Agency developed a safety plan that all contact between the parents and the children must be supervised. The safety threat identified was: caregivers in the home were not performing duties and responsibilities that assure child safety, as the medication was left unsecured in a location the VC, who has a history of putting things in her mouth, could reach. The protective capacities of other household members were assessed. Alternate caregivers [REDACTED] [REDACTED] were approved to supervise all contact between the minor children and their parents. [REDACTED]

The parents were

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
 - No deficiencies were identified.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
 - Medical professional recommended that the YCCYA assure that the primary care physician is involved in the children’s treatment team as well as assuring an enduring plan of supervision is in place for the children.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - It was recommended that medical professionals receive education about the Act 33 process as related to the definition of serious vs critical in relation to the Act 33 process to ensure thorough understanding in regard to reporting of a near fatality.

Department Review of County Internal Report:

The York County Internal Fatality/Near Fatality Review Team held an Act 33 meeting on 04/19/2016 where medical information and case history were presented. The County report was received by the Region on 07/19/2016. On 07/29/2015, CROCYF notified [REDACTED] YCCYS Administrator, via letter that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
 - YCCYS worked in collaboration with the law enforcement and attending medical providers during the investigation.
 - YCCYS utilized appropriate resources to address the language barrier with the family during the crisis and ongoing service activity.
- County Weaknesses: and
 - YCCYS enacted a safety plan on 03/28/2016 upon a visit to the home due to a high level of concern for the safety of the child. A subsequent home visit did not occur until 04/25/2016. The Agency should consider having more frequent contact to assess the home situation during the initial phase of an investigation where the concerns in the home warrant a safety plan, and to monitor the safety plan.
 - The parents reported that they would be purchasing a lock box to secure the medication to prevent future incidents of accidental access or ingestion. The Agency did not document verification of the

placement of medication in a locked location until the subsequent home visit on 05/25/2016.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - No areas of regulatory non-compliance were noted.

Department of Human Services Recommendations:

DHS offered the following practice recommendations as a result of the finding in this review:

- The Agency should evaluate the process to determine monitoring timeframes for cases in which a safety plan is in place. Risk and associated frequency of home visits required for the family under a safety plan should be considered based upon knowledge of the home environment and individuals involved.
- In situations of accidental ingestion of medications or other hazardous substances, the Agency should verify and document the efforts of family to secure medications and prevent future access to the medications by the children.
- The family should be referred to English as second language classes, to strengthen their ability to communicate with community resources and medical professionals.
- The Agency should evaluate the potential need for additional bi-lingual caseworkers.