



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 04/18/2016
Date of Incident: 05/13/16
Date of Report to ChildLine: 05/13/16
CWIS Referral ID: [REDACTED]

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

Lycoming County Children and Youth Services

REPORT FINALIZED ON:
11/01/2016

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.

Lycoming 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 06/03/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim child	04/18/2016
[REDACTED]	Mother	[REDACTED] 1984
* [REDACTED]	Father of [REDACTED]	[REDACTED] 1980
[REDACTED]	Half-sibling	[REDACTED] 2006
[REDACTED]	Half-sibling	[REDACTED] 2010
[REDACTED]	Sibling	[REDACTED] 2011

* 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 Central Region Office of Children, Youth and Families (CROCYP) obtained and reviewed all medical records and case records pertaining to the family. The CROCYP had ongoing contact with Lycoming County Children and Youth Services (LCCYS) Caseworker and Supervisor. The CROCYP ensured the Child Fatality Data Collection Form was sent to ChildLine within 60 days of the report. CROCYP also confirmed ChildLine received the CY-48 within 60 days and confirmed that the investigation was indicated.

CROCYP attended the county review team meeting which was held on 06/03/2016.

Children and Youth Involvement prior to Incident:

The family was known to LCCYS. The history is as follows:

On 05/18/2009, LCCYS received a General Protective Services (GPS) report with concerns regarding parenting and supervision. It was reported that the now 10-

year-old half-sibling was outside unsupervised. Mother denied the allegations and LCCYS was unable to substantiate. The case was closed on 06/03/2009.

On 07/21/2011, a GPS report was received by LCCYS regarding the now 10-year-old half-sibling's behavior (aggression and making sexual comments) and mother's drug and alcohol use. Mother acknowledged that the half-sibling had made inappropriate sexual comments; mother disconnected the half-sibling's cable television, which mother alleged to be the source of the behavior of the half-sibling. LCCYS did address mother's drug and alcohol issues however she denied using drugs or alcohol. Mother declined services and on 08/05/2011, the case was closed.

On 11/28/2011, a GPS report was received by LCCYS with concerns about mother's drug use. Mother had recently given birth and had been [REDACTED] throughout her pregnancy. Mother was reportedly abusing [REDACTED], which she was [REDACTED]. An assessment was completed with no immediate safety threats identified. Mother was meeting the children's basic needs [REDACTED] was involved, and mother was being drug screened. On 01/17/2012, the case was closed.

On 02/18/2012, a GPS report was received by LCCYS with concerns related to mother's drug use. Mother was reportedly using drugs even though she was [REDACTED]. It was alleged that she abused alcohol, drove drunk with the children, and missed some medical appointments for her children. Mother also missed some [REDACTED] appointments. Mother's drug use and parenting concerns were substantiated and mother agreed to accept voluntary services. From 03/14/2012 until 08/16/2013, the family received [REDACTED] services. During this time, the paternal grandmother petitioned for custody of the now 10-year-old half-sibling, but lost. The father obtained custody of the now 6-year-old half-sibling. [REDACTED]

[REDACTED] In April 2013 the mother [REDACTED] she successfully petitioned for custody of the 6-year-old half-sibling. [REDACTED]

[REDACTED] She had [REDACTED] and the children's needs were met. On 08/16/2013, the case was closed.

On 04/19/2014, a GPS report was received by LCCYS due to the poor school attendance of the now 10-year-old half-sibling. No safety concerns were identified. LCCYS conducted several unannounced home visits. Mother never appeared under the influence, the home was clean, and the children were supervised, clean and dressed appropriately. The half-sibling's school attendance improved greatly and the assessment was closed on 05/30/2014.

On 03/24/2016, a GPS report was received by LCCYS regarding mother's drug use, parenting, and home conditions. [REDACTED] The victim child was born [REDACTED]. Concerns were substantiated and the mother agreed to voluntary services for all four children. On 05/04/2016, the family was accepted for services. The family was open for services when this near fatality occurred on 05/13/2016.

Circumstances of Child Near Fatality and Related Case Activity:

On 05/13/2016 the victim child was taken to Williamsport Hospital by the mother and maternal grandmother. The mother reported the victim child's 4-year-old sibling picked him up and dropped him, accidentally. On 05/13/2016, LCCYS received a Child Protective Service (CPS) report regarding the victim child, naming [REDACTED] as the alleged perpetrator. While at Williamsport Hospital, [REDACTED] noted that mother was falling asleep while holding the victim child and mother appeared to be under the influence of something. Mother was slurring her words and not making eye contact. [REDACTED] reported that mother was on drugs. Mother has a history of heroin and [REDACTED] abuse. [REDACTED]

LCCYS interviewed the mother and she stated that the victim child was sleeping on a chaise lounge, and the 4-year-old sibling was sleeping on the couch. Mother stated she fell asleep and was woken when she heard the victim child crying. The 4-year-old sibling was standing near the victim child who was on the floor. Mother asked the 4-year-old sibling what happened. The 4-year-old sibling initially stated the victim child rolled over; but later he said he picked the victim child up and tried to put the victim child in his pack 'n play, but dropped him. Of additional concern was the mother's decision to allow the victim child to sleep on the chaise and not in a "safe sleep" situation, along with her failure to appropriately supervise the children. Safe sleep had been discussed with mother prior to the incident, as the case was open for services on 05/04/2016. Mother had indicated that she was aware of the importance of safe sleep practices, as her sister's child had died in December 2015, due to unsafe sleep practices.

[REDACTED] and he had a quarter-sized bruise on the upper right side of his head, above his temple. There were two areas on the victim child's right flank that were bruised as well. Additionally, the child had a bad diaper rash. The victim child had also lost weight since birth. At birth the victim child weighed 4 pounds and 8 ounces. On 05/13/2016, the victim child weighed 3 pounds and 3 ounces. On 05/13/2016, the victim child [REDACTED] to Geisinger Medical Center in [REDACTED] Pennsylvania; [REDACTED]

On 05/15/2016, the victim child [REDACTED] Geisinger Medical Center. Due to drug abuse, lack of supervision and parenting concerns, the four children were determined to be unsafe and a formal safety plan was put into place. The maternal grandmother and maternal aunt agreed to supervise contact between the mother and the children. The plan was put into place on 05/15/2016, and signed by all parties.

On 05/16/2016, caseworkers from LCCYS found mother unsupervised with the victim child and the 4-year-old sibling. [REDACTED]

caregivers and on 05/16/2016, the victim child and his 4-year-old sibling were placed with their father who resides in Lycoming County. The 10-year-old half-sibling and the 6-year-old half-sibling were placed with the 10-year-old's paternal grandmother in Lycoming County. LCCYS located the father of the 6-year-old half-sibling in the state of Indiana and they made a referral in accordance with the Interstate Compact on the placement of the children. The father's home study was determined to be appropriate. [REDACTED] the 6-year-old half-sibling went to live with her father in the state of Indiana. [REDACTED] A private custody hearing has been scheduled for August 2016.

LCCYS currently has an ongoing open case on mother; they are providing [REDACTED] Services for mother. Mother has also agreed to accept Family Group Decision Making and Parenting/Outreach Services. [REDACTED]

On 06/17/2016, LCCYS indicated [REDACTED] as the perpetrator of the abuse, due to her failure to supervise her children.

[REDACTED] Police Department has completed their investigation they have determined the incident to be accidental and no charges were filed.

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;

LCCYS was viewed as compliant with statutes, regulations, and service provision. There is an active Multi-Disciplinary Investigative Team and an established child abuse protocol for the mutual investigation of abuse cases.

- Deficiencies in compliance with statutes, regulations and services to children and families;

No areas of deficiencies were identified during this investigation.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The Act 33 team recommended that confirmatory lab testing be used to validate drug test results. Blood testing was also recommended instead of urine testing. Additionally, communication with [REDACTED] is often very difficult and inconsistent. [REDACTED]

██████████ and professionals are often unable to reach ██████████. In an effort to address this problem, an interdisciplinary meeting will be coordinated by Susquehanna Health to bring service providers (including LCCYS and ██████████) together to discuss practices and concerns, as well as to problem-solve strategies for working with adult caregivers who are involved ██████████.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

None at this time.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None at this time.

Department Review of County Internal Report:

CROCYP agrees with the strengths and recommendations identified by the Act 33 team.

Department of Human Services Findings:

- County Strengths:

CROCYP determined that LCCYS conducted a thorough and comprehensive investigation of this case. The case file was well documented. They had obtained medical records from Williamsport Hospital and Geisinger Medical Center.

CROCYP determined that LCCYS was in full compliance with all applicable regulations.

There was also collaboration between law enforcement and LCCYS during this investigation of suspected child abuse.

- County Weaknesses:

No areas were identified.

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

No areas were identified.

Department of Human Services Recommendations:

CROCYP recognized the quality and procedural mechanisms currently in place within LCCYS as they relate to the assessment and investigation of CPS cases and recommends their continuation.

CROCYP also commends LCCYS in its collaborative relationship with CROCYP in compiling case specific data and evaluating the overall process of the Fatality/Near Fatality in an effort to promote consistent, quality services to children, youth and families.