REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/09/2012
Date of Incident: 04/14/2016
Date of Report to ChildLine: 04/14/2016
CWIS Referral ID: [redacted]

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

Greene County Children and Youth Services

REPORT FINALIZED ON:
September 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))

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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.

Greene County Children and Youth Services (GCCYS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/13/16.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	06/09/12
[redacted]	Father	[redacted]/92
[redacted]	Father's paramour	[redacted]/97
* [redacted]	Paternal Grandfather	unknown
* [redacted]	Paternal Grandmother	[redacted]/71
* [redacted]	Mother	[redacted]/94

* 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 (WRO) obtained and reviewed all records pertaining to the family, including past history. WRO attended the Review Team Meeting on 05/13/2016. WRO interviewed the caseworker, supervisor and agency director, reviewed the entire file, including all medical documentation and collateral contacts. WRO also spoke with the victim child's pediatrician as well as the physician from Children's Hospital of Pittsburgh (CHP) who treated the victim child.

Children and Youth Involvement prior to Incident:

GCCYS had extensive history on this family dating back to 2012 when the victim child was born. On 06/11/2012, GCCYS received a referral [redacted] that the victim child who was born on 06/09/2012 was born positive for [redacted] GCCYS investigated the allegations and found that the mother had [redacted] [redacted] A home visit was conducted and the case was closed.

On 07/22/2013, GCCYS received a General Protective Services (GPS) referral alleging the mother was using drugs and the home was unfit. The mother and the victim child were living with the maternal grandmother. GCCYS immediately made a home visit and ensured safety of the victim child. The mother refused to take a drug test at this time. On 08/04/2013, the mother tested positive for cocaine and ███ The agency spoke to the father who agreed to care for the victim child if he needed too. At this time, the father was ███ On 08/10/2013 the agency received a ███ that the victim child had a burn on her hand. At the time the child sustained the burn she was living with her mother and maternal grandmother. She was taken to a community hospital for medical care. Along with the burn, the victim child was found to have ███ The victim child ███ to her father's care. The initial referral on 08/10/2013 was a GPS referral, however on 09/12/2013 the report was called in as a CPS as the medical documentation concluded that the wound was indeed a burn and there was no reasonable explanation for the injury. The GPS case from 07/22/2013 was opened for services on this day as well 09/12/2013. A Child Protective Service (CPS) investigation was conducted. The mother was indicated along with the maternal grandmother for the untreated burn on 10/25/2013 and the case was remained open for general protective services.

The father began testing positive for various drugs during this time and the victim child was removed from his home and placed into foster care on 10/18/2013. On 10/25/2013, the victim child ███ placed into kinship care with her paternal grandparents. On 11/08/2013, the grandparents informed GCCYS that they could no longer care for the victim child and she was placed into regular foster care. The parents were in and out of jail most of the time that the child was placed.

In February of 2014, the victim child ███ She was receiving medical care from CHP. The foster parents received training on the precautions they needed to take in their home, which they did.

The victim child received ███ while in foster care ███ As her stay in foster care continued the foster mother reported that the child was having temper tantrums and was hyper at times. ███

The father was released from jail in February of 2015 and began visiting with the victim child. ███ The father told the agency he wanted to have his daughter returned to him. With assistance from his parents he was able to complete services. On 08/28/2015, the child was returned to his care.

After the victim child was returned to the father's care, they moved out of his parents' house to their own home. The father continued to cooperate with the agency. and the agency case was closed on 02/12/2016 with the child living with her father.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/14/2016, GCCYS received a referral that the victim child was at Washington Health System Greene and was brought in by her father for a suspected Tylenol and Motrin overdose. The allegations were that the incident happened around 8:00 AM and the father waited until 6:00 PM to bring the victim child to the Emergency Department. The victim child's and she was transferred to CHP by ambulance. She was certified to be in critical condition and was at CHP. On 04/15/2016, the victim child was still hospitalized at CHP

The father reported to GCCYS that on 04/14/2016, he and his paramour were asleep and heard the victim child rummaging through the kitchen around 8:00 AM and the father heard the child retrieve a bottle of pop. Around 8:45 AM, the father got out of bed and went into the bathroom and saw the empty Tylenol bottle in the trash, and an empty Motrin bottle on the sink; however, the father's story was not consistent and there have been conflicting stories as to whether the bottles were found in the trash, on the counter or on a shelf. The Tylenol bottle was not empty the night before. The father stated he was going to bring the victim child to the hospital, but then the victim child appeared "ok" and his truck was not working. He had no cell phone and no working home phone. The father proceeded to work on his truck for approximately four hours. The father and his paramour continued to check on the victim child and she was reportedly fine. Eventually the father got his truck started and they left the home to go to the paternal grandparents. Allegedly the father called the local hospital and told them what happened and they allegedly told him to use his best judgment on whether to bring the child into the hospital. The father, the victim child and the father's paramour then left the paternal grandparents home and went to the paramour's parent's home.

At this point it was around 6:00 PM and the paramour's father suggested they take the victim child to the local hospital. While at Washington Hospital-Greene, the father failed to give the hospital vital information about the victim child's medical history which could have impacted her health greatly. The victim child was transported via ambulance to CHP for further evaluation. While at CHP, the father reported that at around 3:30 PM the victim child vomited which contained orange coloring similar to the medication she ingested. The victim child then appeared sleepy. This was

information that he never told GCCYS, or Washington Hospital-Greene. The father also reported to CHP that around the same time the victim child vomited she began to become sleepy and acted confused.

The victim child was expected to fully recover and have no long lasting effects.

On 04/15/2016, the victim child to the kinship home of her paternal grandparents

GCCYS initiated services through Parent as Teacher's and verified that the father made necessary safety changes to the home to ensure that all medications are locked and out of the reach of the victim child. The father also obtained a cell phone in case of an emergency.

On 05/20/2016, GCCYS submitted the Child Protective Service Investigation report to ChildLine report with the status of "Indicated". The case was substantiated for lack of medical care against the father. GCCYS found substantial evidence that the father waited approximately eight to ten hours to take the victim child for medical attention after she ingested the medication and the case was indicated for failure to provide medical treatment/care. GCCYS is currently servicing an ongoing case with the father. The victim child has fully recovered from the near fatality incident. The victim child remains in the care of her father and GCCYS remains involved providing ongoing services.

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;
  The prompt attention by the Agency and their communication with WRO and the agency's Solicitor is a strength, along with the strong collaboration among the agencies involved.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  The Agency must understand that when a CPS report is received, the safety of the children has to be assured immediately, not within 24 hours. If the safety of the children can be assured immediately, then the first face to face contact can be made within the 24 hour time-frame.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  Given the drug epidemic not only in Greene County but the entire state, there needs to be a strong concentration on how drug abuse directly correlates to child abuse. There perhaps needs to be mandatory parenting classes offered within all of the clinics. There needs to be

more funding available for people to afford inpatient drug and alcohol treatment if their insurance does not cover it, or if they are not insured at all. Parents dealing with severe mental health issues should also be receiving mandatory parenting classes focused on their specific mental health diagnosis and how to handle that diagnosis while also safety parenting children.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  The County/State needs to provide education on poison control now that the Mr. Yuk campaign appears to be a thing of the past. The County/State needs to provide education to families who may have children with serious medical conditions on the harm of over the counter medications.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Mandated reporter training for all community agencies. CPSL 101 trainings for all mandated reporters.

Department Review of County Internal Report:

The Department has reviewed the County Internal Report and agrees with the County Internal Reports recommendations. The report was received and reviewed in the requirements of Act 33.

Department of Human Services Findings:

County Strengths:

- GCCYS made immediate contact with the child and the medical providers. GCCYS kept the child with family when she was placed into care and immediately contacted service providers to begin working with the family.

County Weaknesses:

- In reviewing the file, the Department found several regulatory concerns in the previous history with this family. The victim child came into care on 10/18/2013 and was released to the custody of her father on 08/28/2015. However, the case dictation has the last contact with the family being on 08/11/2015 at a supervised visit between the child and the father and then the there is no further contacts until 11/09/2015. On 11/09/2015, the caseworker did an unannounced home visit and then the next home visit with the family was not until 02/08/2016.
- GCCYS failed to make monthly in home contacts with the victim child and her father after she was returned to his care on 08/28/2015. There were only two visits to the home during the time period of 08/28/2015 and 02/08/2016. No home visit was done to the home after the child's return until 11/09/2015.

- While conducting the file review WRO could not find documentation in the file that the father was informed of the victim child's [redacted] when the victim child was returned to his care. It does not appear that the father was made aware of the ongoing need for the victim child to be seen at CHP for continuing follow up care yearly due to this diagnosis or given the name and contact information of the victim child's [redacted] There was no documentation that the father received instructions on what precautions he and other household members need to take.

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

3490.235 (g) (i) Face to Face contact with the parent and child(needed weekly if high risk, 1x/month for 6 months or case closure when not high risk) Face to face contacts with the parents and the child must occur as often as necessary for the protection of the child but no less often than:
(2) Once a month for 6 months or case closure when the child is either: (i) Placed out of the home or in the setting in which the abuse occurred. (ii) not a high risk of abuse/neglect.

3490.321 (i) The agency shall assess risk as often as necessary to assure the child's safety and (j) The agency shall assess safety and risk of the child when circumstances change in the child's environment at times other than required in this section.

Department of Human Services Recommendations:

- The Department agrees with the recommendation that campaigns like the Mr. Yuk program should be promoted again to gain more awareness for young children who are around medications both over the counter and prescribed. Literature should be distributed at Pediatrician's offices around safe ways to keep medications away from young children.
- As far as recommendations for GCCYS, the Department after reviewing the entire file found it difficult to establish what services the father was being provided and what services he completed before the return of the child to his care on 08/25/2015. It was not well documented that the father had completed the services he needed to in order to regain custody of the victim child. In the future, GCCYS documentation needs to clearer as to the services the parents were offered and their completion of services.
- GCCYS needs to develop a policy/procedure that parents are fully made aware of a child's medical condition. It should be documented in the case file if a child is diagnosed with a condition while in care and how the Agency will assist the parents in obtaining the necessary training and information on how to care for the child.