pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/15/1999
Date of Incident: 04/28/2016
Date of Report to ChildLine: 04/29/2016
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
02/07/2017

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.

Bucks 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 05/24/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	12/15/1999
[redacted]	Biological mother	[redacted] 1978
* [redacted]	Biological father	[redacted] 1978
[redacted]	Maternal half sibling	[redacted] 2003
[redacted]	Maternal half sibling	[redacted] 2005

* 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 and historical investigations and case notes conducted by the Bucks County Children and Youth Social Services Agency. Follow up interviews were conducted with the county's administrator and investigative case worker. SERO reviewed all police reports and attended the Act 33 meeting. SERO also attended a meeting at [redacted] on 05/03/2016. The purpose of this meeting was to discuss the circumstances of the near fatality. In attendance at the meeting were the following individuals: [redacted] director, the director of risk management and the director of quality assurance. Also in attendance were representatives from the Bureau of Human Service Licensing and Bucks County Children and Youth. After the meeting SERO reviewed the medical chart, viewed the video camera of the incident and performed a walk-through of the unit where the incident took place.

Children and Youth Involvement prior to Incident:

At the time of this report the family did not have an open case with Bucks County Children and Youth. It should be noted that the victim child's family resides in

Delaware County. The victim child was residing at [redacted] in Bucks County at the time of the incident.

The family has a history with Delaware County Children and Youth. Delaware County Children and Youth had been involved with the family from November 2012 to January 2013. The county was involved in response to the victim child of this near-fatality reporting that she molested her sisters. She also reported that she was a victim as well as a perpetrator of sexual abuse. She and her siblings were forensically interviewed and no disclosures were made. All of the child protective services (CPS) investigations were unfounded. The family was provided with [redacted] services for the victim child's attempts of suicide, self-harm and fire setting. [redacted]

Circumstances of Child Near Fatality and Related Case Activity:

On 12/07/2015, [redacted] was admitted [redacted] in response to running in front of a moving car with the intent to kill herself. She was hit by the car. [redacted]

On 05/02/2016, Bucks County Children and Youth received a report of the near fatality of [redacted] It was reported that victim child had ingested and overdosed on [redacted] The child was transported to Doylestown hospital via [redacted] staff. The child was not transported to the hospital via ambulance as [redacted] reported that she was not in medical distress. [redacted] was [redacted] at Doylestown Hospital at the request of Children's Hospital of Philadelphia (CHOP) for the transport [redacted] She was then transported via ambulance to Children's Hospital of Philadelphia. Upon her arrival to CHOP it was reported that the child was [redacted] and in critical condition and certified as a near fatality.

On 04/28/2016 the incident took place while the victim child was in [redacted] the unit in which the child resided. The child had resided at [redacted] since 12/07/2015.

On 04/28/2016, [redacted] delivered all of the medications [redacted] to the [redacted] medication room around 3:00pm. The medication room [redacted] is the medication room for the residential treatment facilities [redacted] There are some units that have medication carts located on the units without a designated medication room. All of the [redacted] are kept in a lock box in the medication cart [redacted]. This is the unit in which the victim child resided. Medications are delivered from [redacted] three times a day [redacted] This is where the nursing station is located. [redacted] was verifying the medications around

4:00pm and noticed one child's medications were wrong and placed the medication on the counter to be sent back to at the next delivery. Around 5:00pm left to distribute the medications to the other units. There was a on to distribute the medication to the children on

At the time of the incident, the victim child was on the with three staff that included and It was observed through the video that a staff was in the kitchen serving food for dinner and a staff was in the dining room with the children while they were eating. The third staff, was called to escort another child to the administration building for a family visit.

When left the unit, she left the top half of the medication room door open and the medications that were going to be returned were left on the counter. It was observed through the video that the victim child went to the common area and was walking around in front of the medication room. She then goes into the medication room that is unattended and the door was open. The door was a barn door that separated in the middle. She does not initially go into the medication room. She is observed pacing back in forth in front of the medication room. Then she eventually enters the medication room and she takes several packs of medications that had been left on the counter. According to the children on do not need to be within eyesight at all times unless ordered by a doctor. The children are permitted to be in the common area without staff supervision. However, the children's bedroom doors are supposed to be locked when the children are not in their bedrooms.

In the video, the victim child then leaves the medication room and she goes into her bedroom that is directly next door to the medication room and she closes her bedroom door. It was reported that she comes out of her bedroom and asks one of the residential advisors for a glass of water. She then goes back into her bedroom and closes the door. She then comes out into the common room and for 45 minutes she talks to staff. During this time she informs staff to call the campus coordinator because she wants to talk to them. She did not inform that she had taken the medication. A campus coordinator comes to the unit around 6:08pm and speaks to the victim child. She reports to the campus coordinator that she entered the medication room, had taken medications and ingested the medications. The campus coordinator notifies and then goes to the child's bedroom to see the empty packets of pills. contacts the who instructs staff to take the child to Doylestown Hospital. The child was taken to Doylestown Hospital transported by staff and then transferred to CHOP. She prior to leaving Doylestown Hospital as directed by CHOP

On 05/02/2016 the victim child was medically cleared from CHOP and she was placed where she remains to date.

To ensure the safety of all of the children in the facility, [redacted] changed the structure of the medication room door. The medication room door is no longer structured as a barn door. The medication room door is no longer able to open separately. Once the door closes it locks immediately. The door is secured together and cannot be left open. The locks were changed on the medication cabinets as some of the locks were loose. Also the medication cart will be locked and when not in use it will be locked inside the medication room. In addition the facility instituted locked medication boxes. [redacted] retrained the staff in safety of medication administration and ensuring that medication is properly secured. [redacted] did submit a plan of correction regarding the safety issues that allowed the child to have access to the medication.

On 05/31/2016, Bucks County Children and Youth filed an indicated report of physical abuse [redacted] that were involved in this incident. There was also a police investigation, with no arrest being made at the time of the writing of this report. The county interviewed all of the subjects of the report that included the child the child's parents and the perpetrators. The county held several meetings with the facility regarding the incident. SERO participated in the meeting held at the facility on 5/3/2016. The county collaborated with the PA Department of Human Services, Bureau of Human Service Licensing. The Bureau of Human Services Licensing issued a citation to the facility. In addition the county collaborated with Delaware County Children and Youth as that is the county of origin for the subject child. In addition the county met with hospital staff. The hospital staff provided the medical reports and status of the child. After the child was medically cleared and [redacted] she did not return to the facility. She was placed [redacted] to ensure the child's well- being.

There is currently an open child abuse (CPS) case with the victim child. The date of oral report is September 15, 2016. The child is currently at [redacted] The allegation is sexual abuse while she was placed at [redacted] Bucks County Children and Youth are investigating the allegation as they do not have a contract with [redacted]

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;
    - Relationship between [redacted] staff and [redacted]-specifically in [redacted] seeking out a staff member to talk to.
    - Cooperation amongst [redacted] staff, Children and Youth, and [redacted] Police Department.
    - [redacted] immediately fixing medication room door, as well as their immediate reaction to make changes in locking the medication room door and locking medications.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - In relation to 3800 regulations, clarification is needed as to whether a barn/half door can be used for a medication room.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - Suggestion made to have an "outsider" review potential problematic areas of a facility to determine if increased safety members should be implemented.
    - Consider alteration of child abuse law specific to naming staff as perpetrators as opposed to name a facility.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  Not applicable

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - All agreed that collaboration amongst Children and Youth, law enforcement and [REDACTED] was integral in reviewing this incident.

Department Review of County Internal Report:
The county report provided the necessary information regarding the near fatality of the child. The county report was received on 7/25/2016.

Department of Human Services Findings:

- County Strengths:
  The collaboration with the police, [REDACTED] and Delaware County Children and Youth. Delaware County attended the Act 33 meeting on 05/24/2016.

- County Weaknesses:
  There are no weaknesses identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  There are no areas of noncompliance.

Department of Human Services Recommendations:

- All 3800 facilities need to ensure that the medication is safely secured. The medication rooms made need to be housed in a separate location and not in the units where the children reside.
- In 3800 facilities, the residents with history of suicide attempts their bedrooms should not be next door to the medication room.