pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/19/2012
Date of Incident: 05/24/2016
Date of Report to ChildLine: 05/24/2016
CWIS Referral ID: [redacted]

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

Fayette County Children and Youth Services

REPORT FINALIZED ON:
12/18/2016

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.

Fayette County has not convened a review team in accordance with the Child Protective Services Law related to this report. The county agency did not convene a review team due to unfounding the report within thirty days of receiving the referral.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/19/2012
* [redacted]	Mother	[redacted]1990
[redacted]	Father	1989
* [redacted]	Sibling (Twin Brother)	2012
* [redacted]	Sibling (Sister)	2010
* [redacted]	Paternal Grandmother	1969
	Paternal Grandfather	1950
	Family Friend	1985

*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 Family Services reviewed case records pertaining to the family. Follow-up interviews were conducted with the Fayette County Intake Caseworker.

Children and Youth Involvement prior to Incident:

Fayette County Children and Youth Services (CYS) had two previous referrals regarding the subject family.

On 11/30/2012, a report was received regarding concerns mother was not bonding with her twin sons. One of the twins was not gaining weight and the mother was not providing the [redacted] formula which was [redacted] The case was carried by the intake worker until it was closed 02/11/2013. The

closure was justified after follow up doctor visits were confirmed and contacts with medical professionals reported the child, who required the [redacted] formula, was developmentally on target and the parents were able to provide basic needs of the children.

On 04/24/2015, Fayette County CYS received a General Protective Services report with ongoing concerns of the father's mental health, [redacted] the father's continued marijuana use and his discontinuing parenting classes. An assessment was completed but no information was found documenting follow up contact regarding the father's [redacted] Mother reported that the father was actively caring for their children at times and she expressed no concerns regarding his caregiving abilities. The case was closed stating that the mother and father appeared to meet the needs of the children. The mother was the primary caregiver for the children at the time of closure.

The closing documentation also noted the father remained open with CYS regarding his youngest child, who had a different mother and was, at the time of the report, actively open with Fayette County CYS. The involvement regarding the father, his paramour and his youngest child (not subject child of this report) focused around a failure to thrive referral received on 06/26/2014. The allegations involved the child requiring additional feeding schedules as he was born premature [redacted] The investigation was indicated on the father and his paramour (the child's mother) due to evidence suggesting that the child was malnourished and dehydrated due to the missed feedings, [redacted] The child was placed in the custody of a relative. The father, his paramour and their newest child remain open with Fayette County CYS.

Circumstances of Child Near Fatality and Related Case Activity:

A referral was received on 05/24/2016 stating the victim child presented to the emergency department of Uniontown Hospital as a result of overdosing on [redacted] Mother stated she had been cleaning in another room while the children were playing in a different room. Mother said the children were being too quiet so she went to see what they were doing. Mother found the victim child had climbed up on the kitchen counter and had taken approximately six pills [redacted] Mother stated she contacted poison control, which was confirmed by CYS, and told to monitor the victim child. Mother stated the victim child laid down for a nap at his usual time. When victim child woke up he did not appear to be affected. Mother walked with her twin sons to a friend's house to pick up her daughter. Mother observed the victim child's pupils to be extremely dilated and that he was "falling over himself". Mother further explained the victim child was reaching for items that were not there and he was hallucinating.

Mother then contacted 911. Victim child was taken to Uniontown Hospital where his condition was determined to be life threatening. The victim child was then transported to Children's Hospital of Pittsburgh [redacted] A toxicology report confirmed the victim child had ingested [redacted]

[redacted] The victim child [redacted] to his mother's care on 05/25/2016.

On 06/21/2016, Fayette County CYS concluded the investigation with an unfounded determination of causing bodily injury to a child through a recent act. The investigation summary noted the incident was a result of an accident and was not caused intentionally or as a direct result of a lack of supervision. There was not enough evidence to support that child abuse had occurred in accordance to the Pennsylvania Child Protective Services Law.

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 County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

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

The County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

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 County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

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

The County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

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

The County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

Department Review of County Internal Report:

The County did not complete a report due to unfounding the ChildLine report within thirty days of receiving the referral.

Department of Human Services Findings:

County Strengths:

Fayette County CYS immediately responded to the report. The caseworker met with the father and the other children while the mother and victim child were at Children's Hospital of Pittsburgh. Fayette County CYS provided the mother with in-home services, linked her to [redacted] and referred the family to [redacted] The caseworker completed clearances of multiple supports who the mother reported were in the home to assist with caring for the children while she was at work.

County Weaknesses:

Fayette County completed an assessment of the children the night the referral was received, and although none of the below concerns prohibited the children from staying with their father, the case documentation regarding the concerns vaguely detailed why this was the most appropriate plan for the children. The following concerns were noted:

> Upon arriving at the father's home concerns were noted regarding overcrowding and the father having been indicated previously for physical neglect (medical), along with his paramour, on their son. The decision was made to have the siblings remain in the care of their father.
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> Both the father and paternal grandfather were asked to complete a urine screen. They complied; however, no other household member was asked to complete a urine screen.
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> Clearances and CYS background checks were completed on all household members. Information noted two of the household members had an active CYS case (child positive at birth), one criminal background check included domestic violence and DUI's. It was further noted that the father and his paramour were not compliant with the previous involvement and did not complete their Family Service Plan Goals, yet the case was closed.
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> It was made known to CYS the children were at the father's residence (paternal grandparents' home) often. Previous reports of concerns regarding father's mental health were noted but documented no assessment or services offered during the previous investigation. It was noted in the past investigation, during a home visit at mother's residence, that the father was verbally combative with the caseworker. Additionally, the previous report noted that the caseworker observed the father "snatch the child up" and yell and swear at the child about touching the air conditioner. [redacted] also reported the father's inappropriate yelling at the children.

During the investigation it was noted that attempts were made to interview the victim child and his twin brother; however, when unsuccessful, no other follow up attempts were conducted. While the children are 3 ½ years old, another attempt may have provided information. The victim child's sister, during two separate interviews, stated her mother was sleeping when her brother found the medication in the bathroom. She was able to provide detail regarding the bag the medication was kept in. There was no documentation regarding any follow up.

Documentation indicated mother never obtained a lock-box for her medications as recommended by Fayette County CYS and the in-home provider. Multiple reasons were provided by the mother for not following through. Fayette County CYS was informed by the mother and the in-home provider that mother was keeping her bedroom door locked as a solution for the time being. During a home visit, the caseworker witnessed the victim child climbing up on the counter top unassisted.

A referral was screened out on 08/06/2016 with the reporting source noting "the children are unsupervised in the street all day, allegedly twelve people in a two bedroom apartment, the house allegedly smells of marijuana and that the father smacks the kids in the head, face, arms 'everywhere but their butts' for no reason". There is a note on the referral screen stating, "Agency recently closed with these children. Agency is currently open". It is the assumption that these allegations were addressed with the father in regards to his household; however, it is not documented in either case. It is concerning given the history of non-compliance with the County, an indicated report, unaddressed mental health that there was no investigation or noted follow up with the parents regarding these allegations.

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

No findings of statutory or regulatory non-compliance.

Department of Human Services Recommendations:

Recommendations are to complete a full assessment of all family members. Attempts were made to interview the victim child and his twin brother; however, they were unsuccessful. There were no further attempts. It is understandable given their young age they may not have been able to provide a clear disclosure but with no further attempts it cannot be determined if any information would have corroborated their sister's two consistent disclosures.

Only certain household members within the father's home were requested to complete a urine screen, yet with concerns of leaving the children in the care of indicated perpetrators, it would be worth inquiring if urine screens should be considered on all current household members.

The father's history of non-compliance and mental health concerns suggest a recommendation for father to complete [redacted] Engagement with father was minimal. There were previous concerns that were never documented as being completed or addressed. Without a formal review of the father's active case with his other children, it is unclear if this has been addressed.

The Department would recommend follow through on mother obtaining a lock-box. Both Fayette County CYS and the in-home provider expressed concerns for the need; [redacted] Ultimately, the lack of a lock-box resulted in the reason for the incident taking place.