pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/18/2015
Date of Incident: 07/28/2016
Date of Report to ChildLine: 07/28/2016
CWIS Referral ID: [redacted]

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

Lancaster County

REPORT FINALIZED ON:
12/29/2016

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.

Lancaster County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/24/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/18/2015
	Father	[redacted]1991
	Mother	1994

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 meeting with the MDT/Act 33 Review board on 08/24/2016 to review and discuss case information. Additional discussions were conducted with the Lancaster County Office of Children, Youth and Families (LCCYF) caseworker on 08/18/2016, 10/04/2016, and through ongoing email correspondence.

Children and Youth Involvement prior to Incident:

There is no prior history with this family.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/28/2016, a report was received [redacted] The 17-month-old child came to the emergency room via EMS services for exposure to insecticide. Per the mother, the victim child (VC) was alone in the garage and somehow got a hold of a glass jar of lannate insecticide, broke it on the floor, and got it on his skin. The mother stated she was unsure how long VC was exposed or if he ingested any. The mother reports she immediately washed child's body with soap and water, then administered activated charcoal. The child vomited once prior to the charcoal, and 3 times after. On arrival at the hospital the VC was

listless, staring off, and his eyes were glassy. While sitting on his father's lap, the child was drooling and slumped over. [redacted] the child also presents as malnourished, anemic, and underweight. The parents reported to the hospital that child was in the garage alone and were unable to estimate length of time. A toxin screen done was done at the ER and one of the toxins was at a level 10. The child had to be given an antidote as that specific toxin would metabolize into alcohol. The child was transferred to Children's Hospital of Philadelphia [redacted] and [redacted] on 07/29/2016.

The LCCYF Caseworker responded to Lancaster General Hospital to see the child, and to meet with his parents on the date of the report. The mother reported that she was making lunch, while her son was playing in garage. The mother reported that she heard her son crying outside, and when she went outside she noticed an odor on him. At that point she bathed him in different oils and administered charcoal. When the mother could not get a hold of the child's primary care physician (PCP), she went to her neighbor's home who called 911. There are no other children in the home.

A visit to the family home was conducted on 08/02/2016. Photographs of the jar and the cabinet where it was stored were taken. During this visit, the mother reported that her son was outside playing and she that was inside making lunch. She had asked the VC to bring in the berry containers, at which point she heard him crying. The mother said she went to garage and smelled the lannate on her son and saw the broken jar. The mother confirmed that the VC was alone in the garage and somehow got a hold of a glass jar of lannate insecticide. The cabinet holding the household chemicals was tied closed with twine and the family was advised to obtain a permanent lock or one could be provided. No other health or safety hazards were noted.

The child was scheduled for a follow-up appointment with his Primary Care Physician on 08/02/2016. A subsequent home visit occurred on 09/16/2016 where the importance of supervision was stressed to the mother. The mother did obtain a new lock that was visible on the cabinet. No ongoing concerns for health or safety were noted. The case was made unfounded on 09/23/2016 and the family was not opened for on-going services.

The PA State Police (PSP) were notified of the incident and a Trooper was assigned to the case. PSP closed the case without any pending charges.

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;
    - Agency gave child locks to the family to lock up chemicals.
    - Agency reported to see family in a timely manner.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - None noted

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - Parents should have called poison control when child drank chemicals instead of drinking the solution they gave him.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - None noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - Education parents on calling poison control when a child ingests something that is possibly toxic.

Department Review of County Internal Report:

The Lancaster County Fatality/Near Fatality Review Team held an Act 33 meeting in conjunction with their MDT meeting on 08/24/2016 where medical information and case history were presented. The County report was received by the Region on 11/16/2016. On 12/09/2016, CROCYF notified [redacted] LCCYS 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:
    - The Agency immediately responded to the hospital after receiving the report.
    - The Agency conducted interviews and a visit to the home in tandem with PSP.

- County Weaknesses:

    - The case record did not contain medical records from the primary care physician or indicate any follow-up contact with the physician regarding general health after [redacted] noted the child presented as malnourished. Although, the agency did speak with the mother about overall care. The mother also reported attending routine well-child appointments and the follow-up appointment after the child's hospitalization. The Agency obtained a clearance for medical records, obtained records from the hospitals regarding this incident but the agency did not follow through with obtaining any records from the primary care physician.

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

    - The following areas of non-compliance were noted.
        - The case was made unfounded on 09/23/2016. The closing Safety Assessment Worksheet (SAW) was dated 08/17/2016 and is therefore out of compliance with regulatory guidelines. The child and family were seen after the date of the closing SAW but they did not update the SAW to reflect the subsequent visit.
        - For the preliminary and the closing SAWs, the explanation for determination for each safety threats is N/A. Although no safety threats were identified, the justification should explain how the worker came to this conclusion.

    A Licensing Inspection Summary will be issued under 3130.21(b) related to the Safety Assessment and Management Process to address these areas of non-compliance.

Department of Human Services Recommendations:

The investigation was completed in a timely manner and LCCYS worked in collaboration with partnering community agencies. It is recommended that the Agency review that Safety Assessment policy and protocols with staff and ensure adherence to guidelines. The Agency should also obtain medical records from the primary care physician when general health concerns are noted by emergency medical personnel and to verify compliance with post care follow-up recommendations.

It is recommended that the county work with community partners to promote routine education messaging, such as Mr. Yuk campaign, to public regarding accidental poisoning and need for emergency medical attention. Special consideration should be made for outreach message to Amish communities where families do not have immediate access to telephones.