pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE NEAR FATALITY OF:

[redacted]

**Date of Birth: 01/12/2015**
**Date of Incident: 09/09/2016**
**Date of Report to ChildLine: 09/12/2016**
**CWIS Referral ID:** [redacted]

**FAMILY KNOWN TO WITHIN THE PRECEDING 16 MONTHS:**

Tioga County Department of Human Services

**REPORT FINALIZED ON:**
03/29/2017

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))

## 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.

Tioga County Department of Human Services–Family Services (TCDHS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/06/2016.

## Family Constellation:

| First and Last Name: | Relationship: | Date of Birth |
|---|---|---|
| [redacted] | Victim Child | 01/12/2015 |
| [redacted] | Biological Father | [redacted]1988 |
| [redacted] | Biological Mother | [redacted]1992 |
| * [redacted] | Paternal Grandmother | [redacted]1954 |

* 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 Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective Services (CPS) investigation. NERO staff participated in Act 33 near fatality meeting on 10/06/2016. Law Enforcement was also present at this meeting.

## Children and Youth Involvement prior to Incident:

The family was reported to TCDHS on 03/17/2015 due to the victim child's father attempting to commit suicide while in a caregiver role. The victim child's father had taken thirty [redacted] pills [redacted] This incident took place on 03/05/2015. The victim child was 2 months old at the time. The victim child's father [redacted] He was in the military and served time in Afghanistan. The victim child's mother and paternal grandmother also lived in the home at the time of the incident. The case was not accepted for services and was closed on 04/22/2015. The family

had extended family and community supports to help care for the victim child [redacted]

**Circumstances of Child Near Fatality and Related Case Activity:**

On 09/12/2016, TCDHS received a report of a near fatality on the victim child. The incident occurred on 09/09/2016. The report stated that the victim child was taken to Corning Hospital in [redacted], New York after ingesting 3-5 of his father's [redacted] pills. Upon arrival to the hospital, the victim child was lethargic and unresponsive. His heart rate and respirations were lower than normal. The victim child would respond to being stimulated but would not open his eyes. [redacted] The victim child was then flown to Strong Memorial Hospital in [redacted], New York in the afternoon on 09/10/2016. [redacted] the victim child [redacted] on 09/11/2016 to his parents' care and they all went home. The victim child was home from the hospital by the time the incident was reported to the TCDHS on 09/12/2016. Dr. [redacted] of Corning Hospital declared this incident a near fatality. The victim child's father was listed as the alleged perpetrator in the incident since he was home with victim child at the time of the incident.

On 09/12/2016, TCDHS's on-call caseworker responded to the report and spoke to the victim child's parents about the time leading up to the incident. The father was home alone with the victim child when the incident occurred. The mother woke up early in the morning, went to the bathroom and got the bottle [redacted] the father had stopped taking because he did not like the way [redacted] made him feel. The mother said she opened the bottle and took one [redacted] because she was feeling anxious about her family. The mother never put the lid back on the pill bottle and left the bottle sitting on a desk in the hallway. The mother then left for work. The victim child and his father spent the morning at home. The father laid the victim child down for his nap. The father checked on the victim child who was sleeping, and then went outside to smoke a cigarette on the porch. He was outside for a couple of minutes and then he came back in to the house and saw that the victim child was standing in the hallway with the bottle of pills in his hand. The father contacted the mother at work to see how many pills were in the bottle, as there were only 2-3 pills left. The father contacted 911 and then the victim child's paternal grandmother, who is a nurse. The father left the home with the victim child and took him to paternal grandmother's home and they met up with the paramedics and went to Corning Hospital, in New York. The on-call caseworker felt that the victim child was safe to remain in his home with his parents.

On 09/13/2016 this case was assigned to a TCDHS caseworker who went out to the home to meet with the family and to assess the safety of the victim child in the home. The caseworker suggested that the family follow up with the victim child's primary care physician. There were [redacted] provided for the victim child from the hospital.

The TCHDS CPS review team reviewed this case on 09/19/2016. The caseworker completed a developmental screening of the victim child using the appropriate Ages and Stages questionnaire and she noted no areas of concern with his development. The case was discussed at an Act 33 near fatality meeting on 10/06/2016. The consensus was that there was not enough evidence to prove serious neglect by either parent. The caseworker presented the case again for CPS review on 10/12/2016. Acts by both the mother and father were deemed not to be a repeated, prolonged, or egregious failure to supervise the victim child. The outcome was determined to be unfounded per the CPSL and it was sent to ChildLine on 10/12/2016.

TCDHS continued with General Protective Services (GPS) for the family to follow up on any community supports that would be beneficial for the family. The victim child's father agreed to participate [redacted] The victim child's mother is aware of community supports, such as [redacted] services; however, she has not participated in any services to date. The victim child is enrolled in [redacted] During the caseworker's home visits, the victim child appeared well cared for and happy in his environment. TCDHS closed this family's GPS on 12/09/2016 since it was determined that the victim child is safe, his parents were meeting his basic and medical needs, and the parents maintain a strong family support network.

**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;
    - Met with family within response time
    - The team discussed mom's involvement in the incident & recognized her responsibility leading up to the incident.
    - The timeline presented at the Act 33 meeting was well put together.
    - Ages & Stages completed on the Child that showed no signs of delay.
    - Caseworker & Supervisor were persistent with getting medical information from the hospitals.
- Deficiencies in compliance with statutes, regulations and services to Children and families;
    - There should be dialog between state abuse registries.
    - There was negligence by mandated reporters in New York reporting the incident of abuse. The phone call to ChildLine was made 3 days after the report should have been initiated.

- The levels of the drug in the VC's system should have been checked to know how much of the drug was consumed.
- Mom should have also been drug tested to see if there were other drugs within her system

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

    - More education for mandated reporters to educate them on when and what reports should be turned in for an investigation.

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

    - None noted

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

- None noted

**Department Review of County Internal Report:**

- NERO received the TCDHS Child near fatality report timely on 12/29/2016.

- NERO staff gathered updated information from TCDHS staff via phone on 01/11/2017.

- NERO concurred with the agency's findings that the parents acted appropriately in handling the situation with the victim child's potential poisoning and this incident was not an indicator of any repeated, prolonged, or egregious failure to supervise the victim child.

**Department of Human Services Findings:**

- County Strengths:
    - The TCDHS had determined that the victim child's father was receiving [redacted] services amid previous concerns about his [redacted] in 2015. County staff noted that the family had extended family and community support to provide sufficient care for the victim child.

- The TCDHS followed up with assisting parents to enroll the victim child in [redacted] to aid in the victim child's continued development and for the victim child's father to have time to care for his [redacted] while the victim child's mother continued working.

- The TCDHS was able to have the nurse from the hospital in New York State participate in the Act 33 meeting via telephone, which helped to determine timelines and actions by persons providing care at her facility.

- County Weaknesses:
  - The TCDHS, located on the New York State border, could benefit from stronger relationships with hospitals providing emergency medical care for children in Pennsylvania.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - No areas of non-compliance

**Department of Human Services Recommendations:**

- NERO recommends that there is some communication with New York Statewide Central Register of Child Abuse and Maltreatment (SCR) about mandated reporting by neighboring out-of- state medical facilities that provide care for children who are suspected of having been abused in the Commonwealth of Pennsylvania. There may be a need for clarity to enhance the timeliness of interstate reports. This may include providing a directory of contact numbers for the Pennsylvania counties that border New York State.

- There should be continued emphasis on the community awareness for the prevention of poisoning in children. This can be accomplished by providing parents and other caregivers with written or electronic information as to the proper storage and disposal of any drugs, chemicals or other potentially dangerous substances in the home.