REPORT ON THE NEAR FATALITY OF:

Date of Birth: 08/28/2014
Date of Incident: 10/25/2016
Date of Report to ChildLine: 10/25/2016
CWIS Referral ID:

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

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
04/10/2017

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))

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street, Room 260, Pittsburgh, PA 15222 | 412-565-3658 | 412-565-7808 | www.dhs.pa.gov

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 team 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.

Allegheny County Office of Children, Youth and Families (ACOCYF) has convened a review team in accordance with the Child Protective Services Law related to this report. The Act 33 review team was convened on 11/28/2016 which was 34 days after the date of the initial report on 10/25/2016. Allegheny County's review team reviewed the case on 12/12/2016. Given the volume of reports received by Allegheny County their initial review was four days late.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
	Victim Child	08/28/2014
	Mother	1984
*	Father	1981
	Sibling	2012
	Maternal Grandmother	1949

* 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) reviewed the case record pertaining to the victim child's family. The WRO staff participated in both of the county's Act 33 meetings. The Act 33 meeting occurred on 11/28/2016. The County Review team reviewed the case on 12/12/2016. ACOCYF holds two Act 33 meetings to adhere to the regulatory guidelines. During the second meeting, medical professionals and law enforcement presented their information. The Intake and Ongoing caseworkers presented the current case information. The WRO also reviewed all information in Child Welfare Information System.

Children and Youth Involvement prior to Incident:

ACOCYF provided WRO with the three previous referrals they said they had with the family. All three referrals were in 2015. The first two referrals had an outcome that

there were substantiated concerns. These two referrals were closed at the end of the Intake Investigation. The first referral was received on 03/24/2015, the victim child received burns from a cup of coffee. She had blisters on her hands. It was later determined the burns came from a space heater. The victim child did receive medical care from the local hospital. The incident occurred in the maternal grandmother's home. However, a home visit was made to the mother's apartment and the apartment was found to be appropriate. The case was closed on 04/17/2015. Within two weeks of case closure on 04/29/2015 the agency received a referral that both children had bruising and scratches. The maternal grandmother appeared to be the main caregiver of the children and she was not capable of caring for the children. The maternal grandmother's home was in deplorable condition. Even though the caseworker met with the family at the maternal grandmother's home there was no documentation that the home conditions were addressed. The injuries to the children appeared to be accidental. The mother did not have the children evaluated medically for the injuries. The case was closed on 06/12/2015.

The third referral was received on 10/23/2015 when the agency received a referral that the victim child had bruising above the eye. Her older sibling had scratches on her face and a bruise on her forehead. The mother did not have children evaluated medically. During this investigation the agency spoke with the children's pediatrician's office and confirmed that they were scheduled for a well-child care visit. They also confirmed that the older sibling was receiving services . The family home was described as being cluttered. The outcome was determined to be invalidated and the case was closed on 12/08/2015.

During the current investigation, ACOCYF learned the mother The mother also reported that she had Services to address her children's developmental delays and behavior problems. The mother had a Protection from Abuse (PFA) court order against the father.

The agency also learned that in January of 2015 that Children's Hospital of Pittsburgh (CHP) The victim child was referred The mother was to bring the victim child back There was no record of the victim child returning for follow-up

ACOCYF was able to determine that the mother was involved with them as a child; there was limited documentation of the agency's involvement. The mother reported that she was involved with the agency because of truancy.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 10/25/2016, ACOCYF received a Child Protective Service (CPS) report in regards to a near fatality of a 2-year-old female. At the time of the incident, the victim child was residing with her 4-year-old sibling, mother and maternal grandmother. The report stated the victim child was unsupervised in the living area of the home. The mother reported that she had two [redacted] pills on the coffee table within reach of the victim child. The mother was not sure if the victim child ingested the medication. The victim child [redacted] in transit to Monongahela Valley Hospital.

According to the mother, when she found the victim child she was showing symptoms of tiredness and grogginess. The mother called 911 and the [redacted] Police Department responded to the call. The police officer who responded to the call reported that the mother rushed outside with the victim child in her arms. The victim child was going in and out of consciousness. The mother reported that the victim child had possibly ingested [redacted] Emergency Medical Services (EMS) arrived and the victim child was transported to the Monongahela Valley Hospital. While the victim child was in the Emergency Room she was coming in and out of alertness. [redacted] The victim child was in critical condition. She was then transported by medical helicopter to Children's Hospital of Pittsburgh (CHP). The victim child [redacted] and was admitted [redacted] at CHP. [redacted] The mother was arrested on 10/25/2016 and charged with endangering the welfare of children.

During the victim child's hospitalization at CHP, [redacted] The drug screen was positive for Caffeine and Chlopheniramine which is a derivative found in cold/allergy medication and [redacted] also known as [redacted] It was noted that the family was appropriate and attentive to the victim child during her hospitalization. The victim child's activity level was normal and there were no lasting concerns for her recovery. On 10/27/2016, she was ready [redacted] the hospital.

During the caseworker's initial interview with the mother on the day of the incident she reported the [redacted] pills had been stored in a "Crown Royal" cloth bag along with a lighter, Excedrin Migraine, Dramamine, and sinus medication. She did not keep the medication in a lock box. The morning of the incident, the mother reported that she had taken the bag from the cabinet and placed it on the kitchen counter and left the room. She explained that she went into the living room to dress the sibling for school. Upon her return she discovered the victim child was standing next to the table and the bag was on the floor. There were bits of pills and a chunk on the floor. She then became upset, it was unknown how much the victim

child may have ingested. The mother picked up the victim child to see if the pills were still in the child's mouth. The victim child then became flushed and "groggy." The mother then called 911 and the victim child was transported to the hospital.

The caseworker interviewed the maternal grandmother who reported a similar story as the mother. She stated that they had gotten up late and were rushing to get ready that morning. ACOCYF accepted the family for service on 10/26/2016.

The caseworker made a home visit to the maternal grandmother's home on 10/27/2016. The mother reported that even though she had her own apartment she stayed with the maternal grandmother. The mother and her nephew were helping the maternal grandmother de-clutter her house. The home had adequate food, running water and electricity. However, the family members were not able to bath at the home so they had made other arrangements. The victim child was returned to mother's care [redacted] on 10/27/2016 with an agreed upon safety plan. The family was already engaged in community supports [redacted] ACOCYF completed a referral for [redacted] services to monitor the mother's ability to store her medication, to address proper parenting skills and supervision and assist mother in linking with other supports.

ACOCYF continued to assess the mother's abilities to safely care for her children. The agency learned [redacted] that there were ongoing concerns about the cleanliness and safety of the maternal grandmother's home. This is the home that the mother and the children spend the majority of their time. There is a past history of utilities being shut off. They had concerns about the supervision of the children [redacted] They had found that as long as providers were in the home on regular basis the home conditions improved; when they were not in the home they deteriorated. However, there were times that there were fleas in the home and service providers would refuse to make home visits. [redacted] They also learned that the victim child had not been brought back to CHP's [redacted] in January of 2016 [redacted]

On 11/07/2016, the father contacted ACOCYF. He stated he has not had any contact with the children since April of 2016 due to a PFA. The PFA allowed him visits, but he had concerns with the mother stating he violated the order which may result in him losing his employment. The father confirmed the mother used illicit substances during their relationship as well. He had concerns about her ability to care for the children. The caseworker made a home visit to his home and found it to be appropriate. The father was employed and in a relationship with another woman.

During visits with the mother by both the caseworker and service providers, she was not consistent in storing her medication properly. She repeatedly refused to store the medication in a lock box [redacted] in a bag. [redacted] were incorrect on a number of occasions. The mother stated that she wasn't sure that

the victim child had taken [redacted] She had not followed through with scheduling [redacted]
When given specific instructions on what she needed to do; she still did not follow through with scheduling the victim child's [redacted]

[redacted]

ACOCYF submitted the Child Protective Services Investigation Report with a status of "Indicated" to ChildLine on 12/09/2016. The mother was arrested on 10/25/2016 and charged with a Felony 3 count of Endangering the Welfare of Children. She had a Preliminary Arraignment on 12/02/2016. The Preliminary Hearing is scheduled for March of 2017.

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;
  - ACOCYF responded immediately to the CPS report and assured safety of the child and the sibling.
  - ACOCYF accepted the family for services and is providing continued assessments of services to the family.
  - ACOCYF placed the children with a relative until they were able to be placed in the care of their father.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - [redacted]
  - Following the near-fatal event, ACOCYF permitted the child to return to the mother's care with a safety plan that included the following conditions, to which mother agreed:
    - Mother was to store her medications securely and out of the children's reach.
    - Mother to provide an appropriate level of supervision for both children.
    - Mother was to take her medication immediately after taking it from its secure location.

- ACOCYF and [redacted] services agreed to monitor mother's [redacted] to ensure that medication was not being misused or misplaced.

- ACOCYF did not confirm [redacted] The Team noted that this collateral contact occurred 12 days after the child's return from the hospital to mother's care.
- During ACOCYF's prior involvement with the family, documentation does not reflect that collateral contacts were made between ACOCYF and the children's pediatrician, mother's [redacted] and service providers working with the family. Documentation also does not reflect that Father was contacted during the previous referrals

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 Review Team discussed at length Allegheny County Department of Human Services (ACDHS)'s priority on continued enhancement of integration between [redacted] and child protection systems. The following challenges and recommended solutions were advanced:

- Challenge: Some [redacted] providers have received state licensure citations because they have provided information on the basis of a ACDHS release of information form when their policy indicates that information will only be released based upon a release of information form from their agencies and on their letterhead

  Recommendations:
- Send the DHS release of information form to state [redacted] and ask for validation in writing that the ACDHS form is consistent with [redacted] criteria.
- Amend all ACDHS provider contracts to require providers use and respond to the ACDHS release of information form for individuals whose services are partially or fully reimbursed by ACDHS or [redacted]
- Challenge: Some [redacted] providers refuse to send information even with an approved, legally acceptable Release of Information (ROI) form.
- Recommendations:
- ACDHS to amend all contracts to require providers respond to requests of information within five business days.

- Discuss with [redacted] how it will encourage/compel provisions of information from providers who do not directly contract with ACDHS
- Provide training and information to providers regarding use of information.
- ACCYF will send release of information forms only to specific staff as recommended by the ACDHS administrator of [redacted] These forms will be copied to agency executives with requests that they ensure timely and full provisions of information.
- ACDHS [redacted] Administrator will be informed of and will follow up with ACDHS-contracted providers that refuse to provide information.
- Challenge: Some caseworkers provide insufficient time for provider to complete and return ROI form, do not complete ROI form correctly, and/or may have unrealistic expectations regarding information that is legally shareable.
- Recommendations:
- Caseworkers will participate in [redacted] training.
- Caseworkers will be provided with information regarding proper completion of the ROI form.
- Caseworkers will allow a minimum of six business days for the provider to complete and return the form. If information is needed more quickly, the caseworker will notify the provider of the circumstances and ask for rapid provision of information.
- Challenge: Clients have the right to rescind or alter a Consent to Release Information form prior to the provision of information.
- Recommendations:
- If a client rescinds the consent to release information, the provider will notify the caseworker "we can neither confirm nor deny that this person received or receives services". This statement will inform the caseworker they must contact the client.
- The Review Team discussed how some clients may not have access to a lock box immediately. If parents were to keep their medication secured in a lock box, accidental ingestions may be reduced or eliminated
- ACOCYF will pursue the provision of lock boxes for families in need of securing medication to enhance child safety in family homes.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - The agency's internal quality assurance team will continue to monitor practice improvement and provide feedback to leadership and casework staff.

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

Department Review of County Internal Report:

A copy of ACOCYF internal report that was received was only in its draft format.

Department of Human Services Findings:

County Strengths:

On the referral for this incident:

- ACOCYF began their investigation as soon as they received the referral. They assessed safety of the child and sibling and interviewed the mother on the day of the incident. The agency made a home visit to the maternal grandmother's home the day of the victim child's [redacted] the hospital.
- ACOCYF established contact with the agencies that were providing services to the family prior to the referral. They ensured that the victim child and her sister continued to receive developmental services.
- ACOCYF referred the family to [redacted] Services.
- ACOCYF caseworker coordinated with the service providers to monitor the [redacted] were done during home visits. The service providers would report their findings back to the caseworker.
- ACOCYF ensured that an appointment was scheduled at CHP's [redacted] for the victim child [redacted]
- ACOCYF met with the Father, made a home visit to his home and provided services to him after the girls were returned to his care.

County Weaknesses:

- Each of the referrals in 2015 occurred after the victim child [redacted] From the records provided to WRO by the agency during the three investigations that were conducted in 2015 it does not appear that the agency knew [redacted]

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

- CPSL: 6365(d): The county agency did not convene the review team no later than 31 days from the receipt of the oral report from the Department of suspected child abuse. The county convened the review team on day 34.
- CPSL: 6365(d)(4)(v): As of this date the county agency has only submitted a draft report to the Region the final report has not been submitted. The county agency is to submit within 90 days of convening, submit a final written report on the near fatality.

Department of Human Services Recommendations:

- The Department recommends that there should be Public Service Announcements on how to keep medication properly stored and away from children.

- [REDACTED] physician should ask the patient if they have children in their home, the ages of children and how they store their medication.

- The Department agrees with the following Allegheny County Review Team Recommendations:
  - ACDHS will continue enhancement between [REDACTED] and child protection systems.
  - That ACOCYF caseworkers will participate in [REDACTED] training.
  - ACOCYF will pursue the provision of providing lock boxes for families to secure medication.