pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/18/2013
Date of Incident: 05/10/2016
Date of Report to ChildLine: 05/10/2016
CWIS Referral ID: [redacted]

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

Clearfield County Children and Youth Services

REPORT FINALIZED ON:
10/14/16

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.

Clearfield County convened a review team on 05/31/2016 in accordance with the Child Protective Services Law related to this report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim child	12/18/2013
[redacted]	Sibling child	[redacted]2015
[redacted]	Mother	[redacted]1993
* [redacted]	Victim Child's Father	[redacted]1991
* [redacted]	Father of Sibling Child	[redacted]1992

* 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 activities for this near fatality included a review of the electronic record and participation in the county's meeting held on 05/31/2016.

Children and Youth Involvement prior to Incident:
According to case records, Clearfield County Children and Youth Services (CCCYS) had one prior General Protective Services (GPS) referral on this family, which was received on 12/28/2015.

According to the record, the agency received a referral alleging the mother may be using illegal drugs and not meeting the needs of the youngest child in the home as a result. The referral was assigned a three day response time. Over the course of the assessment, the assigned worker made five unannounced home visits and sent two letters in an attempt to make contact with the family. According to the case record, the mother finally contacted the agency on 03/21/2016. The agency was not able to make face-to-face contact with the mother and children until 03/24/2016.

On 03/24/2016, the assigned caseworker conducted an announced home visit to address the concerns reported back on 12/28/2015. After this contact, the assigned worker made a collateral contact with the child's pediatrician. The pediatrician's office

reported no concerns for the mother's care of the children. Based on the case notes, it appears as though the agency closed the referral at that time.

Circumstances of Child Near Fatality and Related Case Activity:
On 05/10/2016, the agency received a call from [redacted] advising them that they received a report that the child had ingested [redacted] that she found lying on an end table. Apparently, the mother found the child "slumped over" and contacted 911. [redacted] reported that EMS responded to the home and [redacted] to revive the child. Due to the child's condition, she was flown via medical helicopter to Children's Hospital of Pittsburgh (CHP). [redacted] advised the agency that mother was going to be charged with Endangering the Welfare of a Child (EWOC) and possession of a controlled substance.

On 05/10/2016, the agency dispatched a caseworker to the babysitter's residence, as this is where the sibling child was currently located. The babysitter has a child that plays with the victim child, so she has watched the children on occasion. She had heard about the incident and went to locate the sibling child and found him at one of the mother's neighbors. She offered to keep the child and took him to her house. While at the babysitter's residence, the paternal grandfather of the sibling child arrived and requested to take the child with him until mother could care for him. The worker contacted the supervisor and this safety plan was approved. The worker then made a visit to the grandfather's home to ensure it was appropriate and safe for the child. The home was deemed safe and a safety plan was signed by this grandfather and his paramour.

The caseworker also contacted Allegheny County CYF and requested a courtesy contact with this child while she was at CHP. Allegheny County CYF completed this for Clearfield County CYS.

[redacted] more information was learned about the incident. According to the mother, she was napping when the incident occurred. When she woke up, she reported seeing the child on the kitchen floor and she appeared "very sleepy." She stated she noticed a "trail of crumbs from a pill" on the floor. Mother gave the story that a week before, a friend of hers was at her residence and dropped [redacted] on the floor and she decided to keep it and put it in a "mailbox container." The child must have found it and ingested it. The mother is the person that called 911. The mother denied using [redacted]

The child [redacted] the mother's care on May 11, 2016 under the safety plan that she would stay with the maternal grandmother and the maternal grandmother would assist in supervision of mother and child. The assigned worker met with mother, child, maternal grandmother, and grandmother's paramour upon their arrival at grandmother's home. During this visit, the worker spoke with mom about the incident. The mother reviewed how she found the child once more and again admitted to finding the [redacted] and placing it in a wooden container she puts mail in, which sits on a stand that the child can reach. The mother denied knowing who

dropped the pill, but said she kept it because she thought "whoever lost it was going to come back for it."

Clearfield County CYS referred in-home services for the family and those services were put in place [redacted] as well as a referral to [redacted] The mother also began services [redacted] (the mother tested positive for [redacted]). The family continued to follow the safety plan and supervise the mother while she was with the child. In addition, both fathers in the case were already involved in their children's lives and continued to do so through the incident and afterwards. The victim child's father expressed a desire to care for the child upon [redacted] the hospital, however, Clearfield County CYS determined mom's safety plan was sufficient at that time, however, he could have petitioned for full custody. At that time, he did not have the money for the attorney's fees to do so.

The family was accepted for services on 06/09/2016. According to the case notes, the child abuse investigation was also completed on this day by the agency submitting an "Indicated" status on the mother for causing serious physical neglect of a child through an egregious act of failure to supervise. The mother admitted to finding the [redacted] and keeping it, rather than disposing of it. As previously stated, the mother was [redacted] In addition, the family was referred and receiving [redacted] Family Preservation Services, and [redacted]

On 06/23/2016 the agency determined that the mother had made sufficient progress to the point where the children were deemed safe with the mother. The case record showed the mother had been testing negative for all substances since mid-May 2016 and she was cooperating and using all of the services put in place.

[redacted] The victim child spends her time equally between her mother and father and the sibling child resides full time with the mother. The mother continues to cooperate fully with the agency and other services, including [redacted] and the other services put in place. Family Preservation Services are no longer being provided, as the mother successfully completed that program.

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 agency responded in a timely manner to assure the safety of the other children in the home.
    - The agency implemented an emergency response after being notified of the report and contacting the hospital.

- 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;
    - None noted.

- 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.
    - The calls made to ChildLine need to be prompt.
    - The team identified that there needs to be education on the calling procedures.

Department Review of County Internal Report:

The Department received Clearfield County CYS' internal report on 07/28/2016 and reviewed it as part of this process. The Department found the report to be in compliance with the law. The Department is in agreement with the strengths identified, however, is unsure of the source of the recommendations made in the report as far as the report to ChildLine.

Department of Human Services Findings:

- County Strengths:
    - The agency responded immediately to the home to ensure the safety of the other child. They utilized family for the safety plan and completed background checks and a home visit after hours to ensure this was a safe home for the children.
    - The agency contacted Allegheny County CYF to request a courtesy visit of the child while she was at CHP.
    - The agency maintained contact with the hospital to update them of their involvement with the family.
    - Upon discharge, the agency developed a safety plan for the mother and children until they determined the children could safely be unsupervised in mother's care.
    - The agency quickly referred services to the mother.
    - The agency [redacted] to ensure that the mother completed necessary services.
    - The CPS report was completed in a timely manner.
    - The near fatality meeting was well attended and included providers, law enforcement, and the District Attorney.

- County Weaknesses:

- For the GPS report dated 12/28/2015, the agency never made face-to-face contact with the children until 03/24/2016. Although the agency documented conducting five unannounced home visits and sending two appointment letters, these efforts were not sufficient enough to assess the situation.

  One attempt was made in December 2015 upon initially receiving the report, however, only two attempts were made in January 2016, one attempt in February 2016, and then two in March 2016 (contact made on the second visit).

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

  3490.232 (e) The county's electronic case management system does not have a closure date of this GPS report. Based on the case notes, it appears that the assessment was not completed within 60 days as required. The first Safety Assessment was completed on 03/24/2016 and the closing Safety Assessment was done on 03/30/2016.

  3490.321 (h) (1) It does not appear that the agency completed a Risk Assessment for this GPS report.

  The county agency will be receiving a licensing action on these two issues and a plan of correction will be requested.

Department of Human Services Recommendations:

1. The agency's coordination and completion of their internal meeting was effective. The agency should continue to follow that protocol, as the meeting was well attended.

2. The agency should examine their policy/procedure for completing assessments when it is difficult to make contact with a family. This review should include a closer look at the types, times, and frequency of visits being made in relation to the age(s) of the child(ren) and the allegations.

3. Making reasonable efforts to make face-to-face contact with families during an assessment is an issue that could arise in every county. As such, the Department should consider providing guidance as to what are considered "reasonable efforts" in cases such as this. The guidance should also include minimal intervals and methods of making contact with families with whom the agency is having difficulty contacting.