pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON NEAR FATALITY OF:

[redacted]

Date of Birth: 05/01/2014
Date of Incident: 02/14/2017
Date of Report to ChildLine: 02/16/2017
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
08/22/2017

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.

Indiana County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/06/2017.

Family Constellation:

First and Last Name	Relationship:	Date of Birth
[redacted]	victim child	05/01/2014
	Father	[redacted]1990
	Mother	1994
	Maternal Grandmother	1974
	Maternal Step-grandfather	1974
	Maternal Aunt	1996

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) obtained and reviewed all current records pertaining to the family. WRO was notified of the fatality on 02/16/2017. WRO participated in the ACT 33 meeting on 03/06/2017.

Children and Youth Involvement prior to Incident:

The child's father was known to Indiana County Children and Youth Services (ICCYS) as another child of his (who does not reside with him) was the identified victim in three Child Protective Service (CPS) reports. The father was not the perpetrator in those reports.

Circumstances of Child Near Fatality and Related Case Activity:

On 2/16/2017 ICCYS received a Child Protective Service (CPS) report on the victim child. The victim child was taken to a local hospital due to acting lethargic and not acting normal. Child was [redacted] and sent to Children's Hospital in Pittsburgh (CHP). At CHP the victim child was found to have [redacted] in his system. The victim child was in critical condition and admitted [redacted]

[redacted] Initially this CPS report was mistakenly sent to Washington County CYS on 02/15/2017. The CPS report was re-evaluated to Western Region Office of Children, Youth and Families (WRO) as ICCYS had a conflict of interest in conducting the investigation. The father and the mother were listed as the alleged perpetrators of abuse in this report.

A safety plan was developed for the victim child once he [redacted] on 02/17/2017. The victim child went to the maternal grandparents. The home the maternal grandparents live in is on the same premises as the home the victim child and the parents were living in. The victim child's mother and maternal grandparents made the father leave the residence. The father moved in with his parents. The victim child's mother and father were not to have unsupervised contact with the victim child as part of the safety plan. The father did not attempt to see the victim child during the investigation.

ICCYS conducted a home and safety check of the parent's home on 02/17/2017. ICCYS took pictures of [redacted] pill bottles and where they were located. [redacted] pill bottles were kept in a large diaper box on top a tall chest of dresser drawers in the parent's bedroom. There was no evidence the victim child opened or tampered with [redacted] pill bottles. All [redacted] pill bottles were intact with the safety lids on and the dry packets still inside.

According to the mother, she left for work at 7:30 AM on 02/14/2017 leaving the victim child in the care of the father. When she left, the victim child was playing normally. When she came home around 3:45 PM she noticed the victim child was lethargic. She could not get him to come around. She gave him a sponge bath, and walked around with him. The victim child just didn't want to wake up. She tried feeding him dinner. He ate two bites of food, and drank a little water. She asked the father if anything happened, and he just shrugged his shoulders. Mother stated that the victim child had never attempted to crawl up on top of the dresser in the parents' bedroom or get into the box where [redacted] is kept.

According to the father, on 02/14/2017, he and the victim child ate breakfast. They then watched Scooby Doo, then played cars. The victim child was running around playing. They watched Scooby Doo until about 10:00 am. They then laid on the couch together. The victim child napped, while dad played a video game. After the victim child woke up, they ate "cheezies", and shared a candy bar. The father then filled up the victim child's cup and changed his diaper. They played, wrestled, and put on a different movie. At 2:30 pm the victim child was sitting on the couch. The father went two rooms away to go the bathroom. He came back and the victim child was crawling on the side of the couch. The victim child handed his father the cup. The victim child acted tired, but the father thought it was from all the playing they were doing. The victim child laid on the couch for a second nap. About 15-20 minutes later, the child's mother came home. The victim child was hard to wake. The father said he takes his pills when he first gets up. He takes a handful, so he doesn't know if he dropped one or not. The father gets up around 7:00 am. The victim child shared a bedroom with his parents. The victim child would have been in

the bedroom when the father took his pills that day. The father did not notice if any pills fell or not. The father said he may have dropped a pill because the victim child never climbed up on the dresser before or attempted to get in the box where the pills were kept.

The victim child's parents took him to [redacted] in [redacted], but they were full. So, the parents took him to Indiana Regional Medical Center which thought the child was having seizures, so they gave him [redacted] interfered with the victim child's breathing. The hospital contacted CHP and the child was transported by helicopter to CHP. [redacted] CHP did a toxicology screen on the victim child which determined that he had his father's [redacted] in his system. [redacted] When the victim child arrived at CHP, he was listed in critical condition. [redacted]

WRO submitted the Child Protective Service Investigation form on 04/13/2017 with an "Unfounded" status. There was no evidence that the home conditions were unsafe and that the victim child was unsupervised. The Pennsylvania State Police investigated this incident and has not filed any charges.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

ICCYS did not submit a written report.

Department Review of County Internal Report:

- ICCYS did not submit a written report.
- Strengths in compliance with statutes, regulations and services to children and families;
    - None Identified

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

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None Identified

Department of Human Services Findings:

County Strengths:

- ICCYS saw the child while the child was inpatient at CHP.
- ICCYS conducted a home safety check and implemented a safety plan for the child upon discharge from the hospital.

County Weaknesses:

ICCYS did not write a county internal report.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.
3130.21 (b) The agency did not adhere to the Act 33 bulletin, by not completing a County Internal Report within 90 days of their Act 33 meeting.

Department of Human Services Recommendations:

- The Department needs to provide guidance as to the County's responsibility to submit a written report when the Child Protective Service investigation is completed by the Regional Office.
- When prescribing medication to a patient the physician should ask the patient if they have children in their home, the ages of children and how they store their medication.