pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/02/2015
Date of Incident: 02/08/2017
Date of Report to ChildLine: 02/08/2017
CWIS Referral ID: [redacted]

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

Crawford County Children and Youth Services

REPORT FINALIZED ON:
09/05/2017

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.

Crawford County Children and Youth Services (CCCYS) convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/03/2017 which was within 30 days of the date of the oral report of suspected child abuse which was 02/08/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Father	[redacted]1987
	Mother	[redacted]1994
	Sibling	[redacted]2013
	Victim Child	12/02/2015
* [redacted]	Paternal Grandmother	[redacted]1963

* 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 Family Services (WRO) obtained and reviewed all current records and medical records pertaining to the family. Follow-up interviews were conducted with the Intake caseworker and Family Service caseworker to follow-up on criminal charges and ChildLine determination status. WRO participated in the County's Act 33 meeting that occurred on 03/03/2017.

Summary of Circumstances Prior to Incident:

The family was not known to Crawford County Children and Youth Services prior to the incident that occurred on 02/08/2017.

However, [redacted], this was reportedly the second incident in four months where the victim child ingested father's medication. The victim child was transported to Children's Hospital of Pittsburgh (CHP) from a local hospital on

10/09/2016 for ingesting the father's medications. He was 10 months old at the time. On 12/24/2014, the victim child's sibling was evaluated for ingestion of laundry detergent. No reports were filed with CCCYS or ChildLine for either of these incidents.

Circumstances of Child Near Fatality and Related Case Activity:

CCCYS received a report of a near fatality on 02/08/2017. The victim child and his sibling were taken to a local hospital due to suspicion that they had taken the father's [redacted] medication and overdosed. The victim child was transported by helicopter to CHP. The victim child's sibling was transported to CHP via ambulance. [redacted] physician from the local hospital stated that the victim child was in serious/critical condition. [redacted] observed that, while parents were in the ER, the father was remorseful and appropriately concerned for the children. Both parents provided support to the children while in the ER.

CCCYS requested a courtesy visit from Allegheny County's Office of Children, Youth and Families (ACOCYF). ACOCYF was asked to take photographs of both children and gather minimal information from the parents.

The CCCYS caseworker met with father on 02/08/2017 and paternal grandmother when they came to their office. Father reported that he had an accident in 2015, [redacted]

Father reported that he was caring for the children and was asleep. He reported that he fell asleep at approximately 3:00am, mother came to the home after working the third shift at approximately 6:00am, to spend time with the children. He saw the children run to their mother. The next thing that he remembers was waking up at 8:30am. The victim child was on the couch with the mother and the victim child's sibling was in the bed with him. When father woke up, he found his pill boxes, which had a week's worth of medication in it, on the bedroom floor. One of the boxes was completely empty, another had half eaten/melted pills around it. Father believes that the victim child's sibling got it off of the dresser. Father became more concerned when he realized that the victim child was asleep longer than usual. The victim child's sibling woke up drowsy; however, it was very difficult to wake up the victim child; he was unresponsive.

Father disclosed that he did have a lock box but could not find the key and he did not feel that the children could reach the medication on his dresser. [redacted] a new lock box. Father reported that he plans to keep the lock box at paternal grandmother's home which is located next door to father's house.

When the victim child arrived at CHP, he was still unresponsive. The agency initiated a 30- day safety plan placing paternal grandmother in charge of supervising the victim child and his sibling while in the care of father. The plan was to be monitored by the agency via home visits, an In-Home service provider and telephone calls. The plan was agreed upon and signed by all parties. Despite the safety plan, mother reported that she was not allowing the children to go back to father's house, as this was the second time that this has occurred while the children were in his care. Mother reported that she works 3rd shift at a local restaurant which requires father to have the children the majority of the time. Mother plans to utilize maternal grandmother while she is at work. Mother reported that currently there is no custody order but she planned on going to Family Court to obtain full custody of the children.

CCCYS completed collateral contacts with both hospitals to obtain additional information regarding the victim child's initial condition upon arrival at the hospital.

[redacted]

Per the detective on the case, the 2015 accident the father is referring to is an automobile accident which resulted in him being convicted on a number of charges from the incident. He is required to attend [redacted] as a stipulation of his probation.

A home visit was completed at mother's home on 02/10/2017, at which time mother reported that she went to father's home on 02/08/2017, changed the victim child's diaper and they ate breakfast. Mother reported that the children appeared to be very sleepy so they laid on the couch and fell asleep. Mother stated that father woke her up at approximately 8:30am and said that someone had gotten into his medication. Mother stated that she tried to wake up the children and the victim child's sister was drowsy; however, the victim child was very difficult to wake up. Mother stated that she immediately called her parents and then took the children to the local emergency room. Mother stated that the victim child was transported by helicopter to CHP. They were not permitted to ride in the helicopter so mother and maternal grandmother rode in the ambulance with the victim child's sibling.

Mother reported that, when she and maternal grandmother arrived at the hospital, the victim child was unresponsive however, the victim child's sibling was stable and [redacted] later that evening. The victim child's sibling went home with maternal grandparents. The agency had mother sign a safety plan stating that she would not allow the children to be with father overnight and, if father has visits, they would be supervised. On 02/09/2017, the victim child [redacted] into mother's care.

Both the mother and father's homes were visited on multiple occasions by the agency during their involvement with the family. The agency reported no concerns in regards to mother's protective capacities; the home was reportedly clean, the children were well cared for and bonded with mother, there was plenty of food in the home and mother was reportedly following the safety plan and assuring that paternal grandmother is present while the children are in father's care. Likewise, the father's home was found to be clean and appropriate. It was noted that the children were not fearful of him and were well cared for by all of their caregivers.

On 04/07/2017, the agency submitted the Child Protective Service Investigation Report with a status of "Indicated" for causing serious physical neglect of a child and subcategory; repeated, prolonged, egregious failure to supervise. The county has concluded that father failed to secure his medication in a location that was out of reach for the victim child and victim child's sibling.

As of June 19, 2017, criminal charges have not been filed due to the ongoing police investigation.

The case was not accepted for services due to mother's protective capacities. The family was recommended to continue to utilize community resources both formal and informal when required. The agency closed the case on 04/07/2017.

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;
- CCCYS received the report on 02/08/2017 and the report was given an immediate response time. The request of a courtesy visit to be made by ACOCYF was immediate.
- Supervision occurred routinely and timely.
- The initial safety assessment was completed timely and contained adequate information to justify the need of a safety plan. The closing safety assessment was completed timely and contained information to justify that the children were in a safe living environment.
- The initial home visit occurred on 02/10/2017. The closing home visit was completed on 04/05/2017
- The County Near-Fatality/Fatality review team convened and discussed the case on 03/03/2017.
- All contacts were entered in the agency's electronic record keeping system.
- Brief Services (in-home service provider) was authorized for the family on 02/21/2017. The initial discussion about authorizing Brief Services began on 02/09/2017.

- The County completed the investigation into the abuse timely and gathered valuable information in regards to the abuse. The County was in compliance with statutes, regulations and services to children and family. There was meaningful collaboration with law enforcement and other community service providers.

- Deficiencies in compliance with statutes, regulations and services to children and families; There were no agency deficiencies 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;
- The Crawford County review team recommended that the County follow up with all collaterals once a release of information is sent to the receiving entity. It was noted that some Counties would wait for information to be sent by the external entity after the release of information was sent.
- The Crawford County review team also recommended that the County follow-up with the local hospital on reporting ingestions of medications and harmful substances. It was recommended that there be outreach in regards to the specific circumstances with this case.

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

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
- The Crawford County review team recommended that there be consideration to possibly altering expungement laws as it relates to the CPSL. Had the prior ingestions been reported, there was concern that the information may not have been available to the current intake investigation and provide adequate case history in order to effectively implement safety interventions in the home.
- The Crawford County review team also recommends that the State provide further or additional clarification as to the roles and activities of the County review team for fatalities and near fatalities. Additional training or Regional outreach would provide insight in how to ensure the review team is functioning effectively and providing adequate insight into Child Welfare practices.

Department Review of County Internal Report:

WRO received Crawford County's Child Near Fatality Team report on 04/03/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 03/03/2017.

Department of Human Services Findings:

County Strengths:

- There was immediate and excellent interaction and cooperation with the treating hospital physician, social worker and medical staff. Children and Youth responded immediately following the near-fatality to ensure the safety of the victim child and his sibling. There was collaboration between the county and the police department to interview all parties involved.
- The agency immediately met with father at the agency office to discuss the allegations and to secure timelines of the events.
- The agency met with mother and children in her home to assure that mother was capable of assuring the safety of the children and demonstrated protective capacities.
- The agency and family members signed and agreed upon a safety plan by utilizing family members and service providers.
- The agency's caseworker maintained ongoing supervision to discuss the case plan and to determine how they would assure the safety of the children with both parents.
- The agency completed several announced and unannounced home visits to assure that the family was following the safety plan.
- The agency notified the local police barracks about the incident and allegations
- There was teaming among the agency, agency supervisor and the family.
- The agency complied with all report and investigation timelines.

County Weaknesses:

- None noted

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

- None noted

Department of Human Services Recommendations:

A protocol needs to be developed for ingestion cases that should be provided to medical care providers to ensure that these cases are reported to County Children and Youth Service agencies and/or ChildLine.