pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/15/2016
Date of Incident: 04/19/2017
Date of Oral Report: 04/19/2017
CWIS Referral ID: [redacted]

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

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

08/23/2017

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. 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.

York County Children, Youth and Families (YCCYF) has not convened a review team meeting because they received the report on 04/19/2017, and determined the status of the investigation to be unfounded and submitted the CY 48 to ChildLine on 05/16/2017. Since the determination was made within 30 days of the report to ChildLine a review team meeting was not required.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	11/15/2016
	Biological Mother	[redacted]1988
	Biological Father	[redacted]1986
	Paternal Grandmother	[redacted]1954
	Paternal Grandfather	[redacted]1954

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all past and present case records pertaining to the family. The Central Region reviewed various reports, assessments, and case documentation provided by YCCYF. Central Region staff also had ongoing telephone and email communications regarding this case.

Children and Youth Involvement prior to Incident:

The family was known to YCCYF at the time of the incident. YCCYF had received a General Protective Service (GPS) referral on 11/16/2016. The concerns were parental substance abuse. It was reported that both parents had a history of [redacted] drug abuse as well as heroin abuse. [redacted] At the time of the child's birth, he was transferred to [redacted] unit at York Hospital. [redacted] the child went home with his parents on

11/30/2016. [redacted] provided drug tests on the parents from 11/21/2016 to 12/22/2016. The drug tests were all negative. On 12/22/2016 the GPS allegations were determined to be invalid and the case was closed.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/19/2017, at 1:51AM the victim child was taken to the York Hospital by both parents due to ingesting nicotine fluid. The mother stated at around midnight she was breast feeding the child while she was changing the battery to an e-cigarette and had to turn the device over to change the battery. She said while turning the device over some of the liquid nicotine spilled onto the child's cheek and it ran into his mouth. The mother had stated he vomited three times and had one episode of diarrhea. [redacted] had stated there is suspicion for child abuse due to the child ingesting the amount of nicotine in the way it was described. [redacted] The physician had certified the child to be in critical condition due to nicotine poisoning. The child was life flighted to the Children's Hospital of Philadelphia (CHOP) poison center on 04/19/2017. The child was life flighted to CHOP due to the concern that cotinine (the predominant metabolite of nicotine) remains in the system for 40-60 hours. The more serious side effects of cotinine are; coma, heart palpitations, or the person stops breathing. [redacted] There were no signs of abuse or trauma. Toxicology screens all came back negative for any other substances.

Prior to the child being transported to the Children's Hospital of Philadelphia, YCCYF Caseworker and [redacted] Police Department interviewed the parents. The mother was listed as the alleged perpetrator. The parents have no other children. On 04/20/2017, a safety plan was put in place stating the parents could not be alone with the child. The paternal grandparents reside in the home and agreed to supervise both parents at all times with the child. On 04/21/2017, the child [redacted] the Children's Hospital of Philadelphia.

Throughout the investigation the parents were cooperative and appropriate. The mother denied intentionally causing any harm to her child and the parents sought medical treatment immediately. On 05/15/2017, YCCYF determined the nicotine ingestion was accidental and the investigation was unfounded, the case was closed. [redacted] Police Department also closed the case with no charges filed.

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

An Act 33 meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine. The report was received by ChildLine on 04/19/2017, and the CY 48 was filed on 05/16/2017.

Department Review of County Internal Report:

An Act 33 meeting was not required because the investigation was unfounded within 30 days of the report to ChildLine.

Department of Public Welfare Findings:

- County Strengths:
  YCCYF responded to the incident in a timely manner and interviewed all parties and provided thorough documentation of these interviews in the case record.

  YCCYF obtained all medical documentation from the York Hospital and Children's Hospital of Philadelphia.

  Although only the mother was listed as the alleged perpetrator YCCYF also did not permit the father to have any unsupervised contact with his child until a thorough investigation could be completed to determine if he had any involvement in the incident.

  They worked collaboratively with the [redacted] Police Department.

  YCCYF submitted all regulatory required documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses:

  There were no county weaknesses noted by the Central Region Office pertaining to this near fatality.

- Statutory and Regulatory Areas of Non-Compliance:

  There were no regulatory areas of non-compliance regarding this near fatality.

Department of Public Welfare Recommendations:

The Central Region Office recognizes York County Children, Youth, and Families on-going compliance with regulations regarding child fatalities and near fatalities. YCCYF continues to work collaboratively with law enforcement, medical personnel and service providers. The Central Region recommends continuation in these areas.