pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/09/2014
Date of Incident: 02/05/2017
Date of Report to Child Line: 02/05/2017
CWIS Referral ID: [redacted]

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

Fayette County Children and Youth Services

REPORT FINALIZED ON:
07/27/2017

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))

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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.

Fayette County Children and Youth Services (FCCYS) 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	10/09/2014
	Sibling	[redacted]2009
	Biological Mother	1984
	Biological Father	1982
	Sibling	2005
	Sibling	2003
	Sibling	2009

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) attended the local county review team meeting on 03/06/2017. In addition, WERO obtained and reviewed all records pertaining to the family. Fayette County submitted an indicated status determination on 04/05/2017 indicating the mother for causing serious physical neglect of the victim child through an egregious failure to supervise; further, allowing the child to ingest [redacted] and resulting in the near fatal incident.

Children and Youth Involvement prior to Incident:

The following outlines the involvement of the county with the family prior to the incident.

05/05/2013-06/08/2013 - A General Protective Services (GPS) report was received and validated for domestic violence. The report stated that the father was attacking the mother and threw the child across the room onto a couch. The father was allegedly drunk during the incident. The child was not injured and the mother was ensuring safety of the child. The mother appeared appropriate and was meeting the

needs of the children. The father was reported to be on the run and could not be found. The county closed the case on 06/18/2013.

On 02/02/2014 and 02/07/2014 – Two consecutive GPS reports were received with allegations relating to a lack of food in the home, parental drug abuse, and the mother [redacted] for pills. The referrals were almost exactly the same reports. There was no direct knowledge that the mother was using drugs, only speculation. The reporting source cited that the maternal grandmother feeds the children. The reports were screened out on 02/02/2014 and 02/07/2014.

02/19/2014 – 04/21/2014 - A GPS report was received with allegations of a lack of food in the home because the mother was [redacted] for drugs and using crack cocaine. Additionally, the kids were being left alone with older siblings. The report was screened out for a lack of information. Subsequent information was received; therefore, FCCYS opened a new GPS report. It was unclear if the mother was living in the home at the time of the report. The children did report that they did not have food all the time, but they often ate at the maternal grandmother's house. Additional reports came into the agency stating that the mother was using drugs in front of the children regularly. She was also reported to be pregnant. The mother denied using drugs and the father refused to work with the agency. The children were seen and assessed to be safe. The mother refused a drug test. There was not enough evidence to support dependency action and drug concerns could not be validated. The county closed the case on 04/21/2014.

11/05/2014 - 12/29/2014 - A GPS report was received that the mother had given birth about 2-3 weeks prior. She was given a drug test which was positive for [redacted] Cocaine, [redacted] and possible other drugs. Maternal grandmother had the children at the time of the report. A safety plan was implemented and an in-home crisis service was put in the home. The initial visit was the only time the mother tested positive; being negative every time thereafter. The county closed the case on 12/29/2014.

04/02/2015- 04/02/2015 – A GPS report was received with allegations that the mother was using drugs and would use the children's urine for the FCCYS drug tests. The children were allegedly not being cared for and were outside with no supervision as late as 11:00 PM. The report was screened out as speculation only.

09/10/2015 - 03/21/2016- A GPS report was received that the mother was smoking crack in front of the children. Drug test indicated a positive drug screen; the urine was sent to the lab for testing; however, test came back from the lab with a negative result. On 10/23/2015 the mother tested positive for Cocaine, [redacted] The case was accepted for services on 11/09/2015. A plan was established to do pop-in visits until receipt of the lab results, which subsequently returned a negative result. [redacted] An in-home provider was placed in the home. The father of the victim child of this near fatality report was present in the home at this time. He was a significant support along with the

maternal grandmother. [redacted] Follow up visits by the ongoing worker and supervisor resulted in the mother testing negative. There were no apparent safety threats and the county closed the case on 03/21/16.

06/09/2016 - 06/09/2016 – A GPS report was received with allegations of the mother using drugs (specifically [redacted]), not having food in the home and the children not being fed. The report was screened out as it appeared to be speculation and information/concerns that had already been assessed.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/05/2017, FCCYS received a report that a two year old female child ingested an unknown amount of [redacted] According to the reporting source, around 12:30 PM on this day the child was believed to be grabbing a piece of candy out of the candy jar in the kitchen. When the mother went back into the kitchen she noticed her pill bottle was in the sink and she saw the child had a pill in her mouth. The child was asked to spit the pill out and she did. The mother did not know how many pills the child had ingested. [redacted] The mother had medication on the back of the kitchen sink and there was a chair pushed up to the counter so the child could access the candy. The medication was above the sink basin. The mother took the child to a local emergency department where the child appeared drowsy. [redacted]

FCCYS was informed that the child would be transferred to Children's Hospital of Pittsburgh. According to the transferring hospital, the mother was reluctant to agree on the child being transferred to the hospital citing financial issues and inconvenience due to her other children. The mother eventually did consent and the child was transferred. Later that day, FCCYS was notified by the hospital that the child was stable, doing well, and would be [redacted] on 02/06/2017. On 02/07/2017, the report was certified as a near fatality. Per [redacted] physician, the incident was preventable and the child was in critical condition at the time of admission.

FCCYS assessed the safety of the other children by seeing them all at school on 02/06/2017, a safety plan was established with the mother and the maternal grandmother that the other children would stay with the maternal grandmother until the victim child was released from the hospital. On 02/07/2017, the victim child was [redacted] under a voluntary safety plan. The child went into the voluntary care of the maternal grandmother until services could be put in place with the mother.

Based on a meeting internally at FCCYS, on 03/01/2017, a CY-104 was completed and sent to the local law enforcement due to the report being registered as a near fatality, even though based on the initial report the allegations did not require one to be completed.

On 03/10/2017, the caseworker met with the mother and discussed the case, stating that until a determination was made, [redacted] the safety plan would remain in effect; further, keeping the children with the maternal grandmother. This would additionally allow more time for the county to work with the mother prior to the children returning to her care. The mother was agreeable to the county's decision.

On 04/05/2017, the county indicated the mother for causing serious physical neglect through an egregious lack of supervision. The family was accepted for services on this date. [redacted]

On 06/05/2017, the county was informed by the police that charges were likely to be filed against the mother for endangering the welfare of a child. At the time of this report, no charges had been filed. FCCYS continues to work with the family and the case remains open.

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:

Fayette County CYS complied with all statutes and regulations. The agency provided information to the Office of Children Youth and Families as per ACT 33 guidelines. In addition, the Near Fatality Meeting was held on the 30th day of the investigation complying with the statutes. Appropriate releases and records were obtained and response time was appropriate. All interviews were completed including medical staff, mother, children, and family members. Notification letters were timely.

The agency did work with the [redacted] Police Department. A report was made on 03/01/2017 and the CY-104 was mailed out on this date as well. FCCYS provided all detailed information and cooperated with the criminal investigation.

Deficiencies in compliance with statutes, regulations and services to children and families:

The agency was unable to give appropriate notice to the father of the victim child. Attempts were made to discuss the report; however' a response to the letter was never received. He was, and remains, incarcerated.

Initially, the agency did not make a law enforcement referral as the abuse allegation was serious physical neglect, which does not necessitate a referral to law enforcement. However, two days after initially receiving the report,

the report was registered as a near fatality which could allow for a police referral. The agency did decide to ultimately refer the case to law enforcement, but it was approximately three weeks later.

Children's Hospital did not complete a comprehensive toxicology screen on the child that would include the [redacted] testing. This was a procedural oversight, but not uncommon. Without the comprehensive toxicology screen, there was no way to determine the amount of drugs that the child ingested and ultimately the degree of negligence of the parent.

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 Child Fatality Review Team concluded that there needs to be more regulation on [redacted] drugs. [redacted]

Questions arose to what follow up is completed to assure that there truly is an allergy to [redacted] - or is the purpose monetary or is the client seeking a stronger drug. Furthermore, the lack of regulation of [redacted] drugs without approved drug and alcohol assessments is dangerous and can lead to potential fatal consequences.

The increase in cash-pay for medications (no insurance required counseling) only further compounds the problem as clients can obtain [redacted] alternatives and utilize the extra drug to be sold on the streets. There needs to be stricter regulation all together within this particular field.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

No recommendations provided by the county.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

With the majority of drug and alcohol involved allegations, Health Insurance Portability and Accountability Act (HIPAA) regulations, specifically the information that can be provided, hinder the agency's ability to effectively monitor if the client is abusing the drug or not. Allowing drug and alcohol information to be released in its entirety would allow for better case assessment and lead to more children being safe from potential abuse or neglect.

Department Review of County Internal Report:

The county submitted their report in a timely manner within the required 90 day timeframe. The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

The county completed their assessment and investigation timely. The county conducted the Act 33 meeting timely and also submitted their report timely. The county worked well with outside agencies in gathering information and making their determination on the case.

County Weaknesses:

No weaknesses identified.

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

No statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

The Department respectfully agrees with the recommendations set forth by the local review team. In particular, the Department strongly endorses the recommendation regarding a review and revision to the monitoring of drug maintenance programs, especially take home procedures and practices.