pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/23/2003
Date of Incident: 06/16/2017
Date of Report to ChildLine: 06/16/2017
CWIS Referral ID: [redacted]

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

Monroe County Children and Youth Services

REPORT FINALIZED ON:
12/07/2017

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.

Monroe County has not convened a review team in accordance with the Child Protective Services Law related to this report as the report was determined to be unfounded within 30 days.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted] *	Victim Child	12/23/2003
	Sibling 1	[redacted] 2005
	Sibling 2	2001
	Mother	1978
	Father of [redacted]	1980
	and [redacted]	
[redacted] *	Father of [redacted]	Unknown

* 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 Northeast Regional Office of Children, Youth and Families (NERO) obtained and reviewed all case records pertaining to [redacted] family.

Summary of circumstances prior to Incident:

Monroe County Children and Youth Services (MCCYS) received a referral regarding the family on 05/08/2013. This referral alleged sibling 1 was spending a lot of time at a neighbor's home, staying late on school nights and never wanting to go home. It also alleged that sibling 1 had a lot of bug bites, there was a lot of traffic in and out of the home, the father had been recently arrested in a drug sting, and the family did not have electricity for a period of time. At the time of this referral, the victim child and both siblings were residing in the home. MCCYS completed an intake assessment involving interviews with the children and parents, drug screening of parents, and collateral contact with law enforcement. The allegations were unsubstantiated and the case was closed at that time.

Another report was received by MCCYS on 03/27/2014 alleging the mother was stating that she was going to scald sibling 1 in the bathtub with hot water. The assessment revealed that the mother [redacted] The father took a family leave from work to care for the children. Interviews with the children and home visits did not reveal any child abuse or neglect issues and the case was closed at intake on 04/15/2014.

MCCYS provided services to the [redacted] family from 04/23/2014 to01/19/2016. The family had been referred to the agency when both parents filed for Protection from Abuse orders against one another. At that time, the agency was ordered by the court to complete a family assessment. The case was opened for services in response to substantiated concerns related to the mother's [redacted] issues and illegal drug use. [redacted] During the summer of 2015, the family experienced housing instability. Due to issues the family was experiencing, the parents of sibling 2 made a mutual decision that she would reside with her father. Sibling 2 remains in the care of her father. The case was closed once the family obtained and maintained stable housing, truancy issues were addressed, and the mother maintained a substantial period of sobriety [redacted]

MCCYS received another referral on 01/30/2016 alleging that the victim child was seen at the hospital after ingesting nail polish remover, chewing glass, and cutting her ankle and wrist with glass. It was reported that the police were called to the home during the incident and directed the mother to take the victim child to the hospital. An assessment was completed by MCCYS and the case was closed at intake as the agency determined that the parents acted appropriately in obtaining after care for the victim child [redacted]

On 05/24/2017, MCCYS received a referral that sibling 1 was missing a lot of school and when the school attempted to contact the parents, there was no response until an inappropriate text message was received. MCCYS determined that the number the school had for the parents was no longer theirs and the report was screened out and referred [redacted]

Circumstances of Child Near Fatality and Related Case Activity:

On 06/16/2017, MCCYS received a report of suspected child abuse regarding the victim child. The mother was named the alleged perpetrator. The report stated that the victim child had [redacted] It was reported that the mother stated that she stopped giving [redacted] to the victim child as she was gaining too much weight. The victim child attempted suicide by overdosing on [redacted] and was [redacted] The report was registered for serious physical

neglect/failure to provide medical treatment or care as the mother did not consult with a physician prior to removing the child from [redacted] The report was registered as a near fatality as the victim child was certified to be in critical condition when admitted to the hospital and in serious condition at the time of the report.

MCCYS commenced their investigation on 06/16/2017. Their investigation included interviews with the victim child, sibling 1, and the parents. Interviews revealed that at the time of the incident, the victim child was on the second floor of the home. The victim child then went to the mother who was on the first floor of the home with an empty [redacted] pill bottle and told her mother that she had taken [redacted] as well as [redacted] The mother then took the victim child to the Emergency Room at Pocono Medical Center (PMC). The victim child was transferred from PMC to Lehigh Valley Hospital where she remained hospitalized for five days and was then [redacted] MCCYS secured records from [redacted] and the child's primary physician. Review of the records and collateral contact revealed [redacted] for the victim child. The victim child had been [redacted] but the parents reported that they discontinued those medications in June 2016. There was no evidence to support any current medical recommendation for medication prior to the referral incident. MCCYS determined the report to be unfounded on 07/19/2017 and the case was closed with the agency. MCCYS recommended that the parents secure a lock box for medications. The mother reportedly would no longer be leaving any [redacted] unattended in the home but would be keeping [redacted] with her.

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

The county did not convene a review team as the report was determined to be unfounded within thirty days.

Department Review of County Internal Report:

The county did not convene a review team as the report was determined to be unfounded within thirty days.

Department of Human Services Findings:

- County Strengths:

  MCCYS responded immediately to the report and ensured the safety of the children as required.

MCCYS conducted interviews with all appropriate parties and secured medical records as required.

- County Weaknesses:

  Despite being requested in the course of a child abuse investigation, MCCYS had difficulties and experienced delays in securing documentation from medical providers.

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

  Pursuant to a prior compliance issue, MCCYS implemented a policy to ensure that subjects of reports are verbally notified of their rights prior to being interviewed. The policy requires that subjects sign an acknowledgement that the proper notifications occurred. The case record did not reflect that the subjects received verbal notification prior to interviews.

Department of Human Services Recommendations:

- The Department recommends that education occur with medical providers and agency staff regarding exchange of information during a child abuse investigation as outlined in the Child Protective Service Law.

- The Department recommends that MCCYS revisit their policy with staff regarding notification of rights to subjects of reports in child abuse investigations.

- The Department recommends that there be public service announcements related to reminding those on medications to keep them stored in an area that is not accessible to children or in a secured lock box. It is also recommended that pharmacies be required to label the medications regarding safe storage when there are children in the home.