



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 04/25/2008
Date of Incident: 11/01/2012
Date of Oral Report: 11/02/2012

FAMILY NOT KNOWN TO:

Fayette County Children and Youth Services

REPORT FINALIZED ON: 07/25/2013

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:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Fayette County was not required to convene a review team in accordance with Act 33 of 2008 related to this report, as they determined the report to be unfounded within 30 days.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Subject Child	04-25-2008
[REDACTED]	Biological Mother	[REDACTED] 1986
* [REDACTED]	Biological Father	[REDACTED] 1983
[REDACTED]	Mother's Friend	[REDACTED] 1985
[REDACTED]	Friend's Daughter	[REDACTED] 2007

*Not a household member

Notification of Child Near Fatality:

On November 1, 2012, the 4-year-old subject child was able to obtain his [REDACTED], liquid allergy medication and ingested nearly half of the bottle. The child initially showed no symptoms of ill-effects that day, but began throwing up in the morning of November 2. Due to the child throwing up, the mother took the child to the hospital that morning. The child's condition was deemed critical by [REDACTED] who believed the mother's delay in seeking treatment was [REDACTED] and the cause of the child's condition.

Summary of DPW Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed the county's entire case record for this family. No interviews took place as part of the review, as the record was self-explanatory as to the county's rationale. There was no county review for the Department to attend, as the report was unfounded within 30 days.

Children and Youth Involvement prior to Incident:

Prior to this incident, the agency had not been involved.

Circumstances of Child Near Fatality and Related Case Activity:

The events outlined in this section are described in the caseworker's structured case notes.

According to the referral form provided by the county, the agency received a call from [REDACTED] (as noted, referral documented at 4:44 PM) on November 2, 2012 advising them of the child's condition. The reporting source stated that the child's [REDACTED] and the child was dehydrated. This was a result of the child drinking half of a bottle of [REDACTED] the day before. The mother was requesting to remove the child from the hospital however; the treating physicians believed the child would die if removed from the hospital.

After speaking to the hospital, the on-call caseworker met with the Assistant Administrator to discuss the referral. They attempted to contact the agency solicitor, however, the solicitor did not answer. The worker left a message for the solicitor to return the call.

At 5:40 PM on the 2nd, the on-call caseworker responded to the hospital and made contact with the child, the father, and the mother in the child's hospital room. The child was being [REDACTED], but had just eaten prior to the worker's arrival and he was coloring. The worker asked the parents to explain what happened that necessitated taking the child to the hospital.

The incident took place on November 1, 2012. According to the mother, she wasn't home at the time of the incident and she had left the child in the care of her friend [REDACTED] who was also caring for her own child. The mother stated that when she asked [REDACTED] what happened, she said that the two children were playing together while [REDACTED] was in the bathroom. When the mother returned home at approximately 4:15 PM, she and [REDACTED] discovered that the child had obtained his liquid [REDACTED]. The mother claims she was aware of how much was in the bottle prior to him drinking it and believes he ingested approximately two teaspoons full of medication. The mother claimed that she "checked on Google" and the child appeared to be "fine" so she didn't seek medical treatment.

The following morning, the mother said the child woke up and said he was hungry and that his stomach hurt. The child tried to have a bowel movement, took two bites of a Pop Tart, and then began vomiting. This was approximately 9:00 or 9:30 AM. The mother wasn't sure if this was due to the medication, as she had also been throwing up recently. When he didn't stop throwing up, the mother became concerned and called the child's father. The child's father left work, came home and took the child and mother to the Emergency Room (ER).

When they arrived at the ER, the father was allegedly upset and reported that the child drank "half" of the bottle of [REDACTED]. When the mother was informed that they were going to admit the child, she became upset about him having to stay at [REDACTED] and she requested he be transferred to [REDACTED].

After meeting with the family, the worker advised [REDACTED] that she should contact ChildLine to report the incident. The hospital staff believed the child's lab results show that the child was throwing up prior to the morning as reported by the mother.

At 6:13 PM, the worker called the Assistant Administrator and discussed possible placement options. The father was approved as a potential placement, as he does not reside with the mother.

At 6:15 PM, the agency received the [REDACTED] Child Protective Services (CPS) report [REDACTED]. The mother was listed as the alleged perpetrator. According to the hospital, the child's [REDACTED]. This level was considered to be critical. The investigation was registered for Serious Physical Neglect due to the delay in the mother seeking medical treatment and this causing a serious condition. Shortly after this, the worker contacted the solicitor to discuss the placement options. The solicitor was in agreement that the father should be considered a placement resource.

At 6:45 PM, the worker contacted the Uniontown Police to make them aware of the incident. An officer was assigned to contact the worker back. The officer arrived at 6:58 PM, just as the caseworker began interviewing the father. This interview took place while the mother left the hospital to get food for herself, the father, and the child.

The worker began by advising the father of the CPS investigation. The father expressed no concerns with the mother's care of the child, he denied drug abuse by himself or the mother, and stated neither he nor the mother had any [REDACTED]. He reported that he was involved in the child's life and spent about half of the time with him, as the mother watches the child when he works. He stated that he and the mother don't get along, but they do what they can "for the sake of the child." The father was willing to care for the child and agreed to take a few days off of work to do so.

At 7:05 PM, the mother returned to hospital with her friend [REDACTED] who was the caregiver of the child when the incident occurred. The worker and police officer interviewed [REDACTED] about the incident. According to [REDACTED], she was watching the child and her own daughter because the mother had gone out to seek employment. She went to the bathroom and said she was gone approximately 5 minutes. When the mother came home, the children were playing. The medicine was on the mantel and both children reported to the mother that the child took his medicine. [REDACTED] believes that her daughter may have opened the medication. Afterwards, she claimed the children seemed fine, both slept well. When the child woke up in the morning, he complained that he didn't feel well. She reported that he threw up at least once and he was taken to the ER. She denied any drug use by the parents and described both parents as being "good parents."

After speaking with [REDACTED] the caseworker then interviewed the mother regarding the incident. She was advised of the investigation. The mother denied any drug use and agreed to provide a urine sample at a later date, as she was unable to urinate at that time. The mother's account of what happened matched [REDACTED]. The worker asked the mother how she was able to determine how much medicine the child had ingested. She reported that she had the bottle filled for the child on October 9 and he was to take one teaspoon daily. The [REDACTED] and the bottle was currently at 50cc. The worker also asked the mother why she didn't immediately seek medical treatment. She stated that he was not impaired the day he drank the medicine and continued playing. She had also noted she had been sick and assumed initially in the morning of

November 2 that he was suffering from the same ailment. The caseworker discussed safety planning and the mother agreed to the child staying with the father with her having supervised contact.

After safety planning with the mother, the caseworker interviewed the mother's friend's daughter, who was with the child during the incident. This child told the caseworker that the identified child "took his med by himself." This child stated that the medication was on the stand by the mirror and the identified child opened the bottle, poured a cup, and drank it. The child clarified that the "cup" used was the medicine cup that was stored on the medicine bottle. This child said that the identified child only filled the cup once and then the identified child's mother came home.

Immediately following the interview of the other child in the home, the caseworker spoke with the identified child. The worker began by asking the child why he was sick. The child responded that he took his medicine, which was located on the stand by the mirror. When the worker asked him how much he took, the child said "one time." Due to the child's age and attention span, the worker was unable to get any more information from him regarding the incident. The child was being [REDACTED], but the worker saw no signs of impairment. The child was eating [REDACTED] food while the worker spoke with him.

Since the father was going to be used for safety planning, the mother had him obtain demographic information from his roommate so that background clearances could be done to help assure child safety. The father reached his roommate, who willingly provided the information.

At 8:45 PM, the caseworker visited the father's residence to assess its safety for the child. The worker found the home to be adequately stocked and safe for the child. While at the residence, the worker contacted ChildLine to run a child abuse history check on the roommate. According to ChildLine, the roommate had no prior history as a perpetrator.

On November 3, the caseworker spoke with Fayette Co. CYS's regional program representative regarding the near-fatality report. Also on this day, the worker faxed a police report regarding the incident (CY-104) to the Uniontown Police.

Also on November 3, the on-call caseworker completed a preliminary safety assessment on the household, which included the child, his mother, and mother's friend and her child. No safety threats were identified and the child was deemed "safe." Both children that resided in the home were identified in the safety assessment.

On November 5, the newly assigned intake caseworker made contact with the child's father. The worker explained that she was hoping to re-interview everyone again in hopes to lift the safety plan that was put in place. The father told the worker that he had no concerns with the child being in the mother's care and described the mother as a "good mother" that had an accident with the medication.

The worker asked the father to recount what he recalls regarding the incident. The father said that the mother had the child Thursday evening into Friday morning. The father went to work on

Friday and mother called approximately two hours after he arrived to tell him that the child was throwing up and they wanted to take him to the hospital. The father left work to take the child to the hospital. When he got to the home, the mother told the father that the child took more of his medication the night before when the mother wasn't home. The father was under the assumption that the child took half of the bottle, but later found out it was "only a little more than he was prescribed." The medication was on the mantle and he assumed that either his son or the other child in the home got it down. When the child got to the hospital, the father stated the hospital told him the child also had a viral infection and was dehydrated, so they [REDACTED]. The father said that the child's mother wanted to take the child out of [REDACTED] and take him to [REDACTED] as they have had "bad experiences" with [REDACTED]. The father said that the doctor "flipped out" on the mother and said that the child would "die" if they removed him from [REDACTED].

The father stated that the child hadn't really seen his mother lately because he "wasn't fully understanding what the safety plan meant" and he didn't want to get anyone in trouble. As a result, he said the mother has had no contact with the child. The worker explained that the mother was permitted to have contact provided he supervised the contact. The mother and father had no formal custody arrangement, but work out visitation between them when father doesn't have to work.

The caseworker contacted the mother on November 5 to schedule a home visit with her on November 6 to discuss the incident.

The caseworker completed the scheduled home visit with the mother on November 6. Present for the visit were mother, father, the identified child, mother's friend that lives in the home with her, and the friend's child. The home was found to be appropriate, with adequate supplies. The mother again reiterated her understanding of what happened by saying the medication was on the mantle in the dining room and the children climbed up to reach it while mother's friend was in the bathroom. Mother happened to come home while her friend was still in the bathroom and the children told her that the child took his medication. When mother asked how much he took, the children showed her that they filled the cup. The mother stated it was a little more than what he "normally takes." The mother researched side effects on the internet and the child wasn't showing any of those side effects. The next morning when mother and child awoke, mother claimed that both she and the child were sick and throwing up. She called the child's father to take them to the ER and she believed that the child was throwing up because of the flu and not due to the medication. The mother stated the hospital never informed them of why they felt the child was throwing up. The child attended a follow-up medical appointment on November 5 and the doctor felt [REDACTED] was fine and didn't prescribe any medication or further treatments or appointments.

The caseworker addressed safe storage of medication with the parents. The mother reported that the father was keeping the medication at his residence and he will administer it according to directions. The worker was able to briefly speak to the child, who stated he was feeling better. The worker finished obtaining demographic information on the parents. After finding the information gathered surrounding the incident acceptable, the worker advised the family that the safety plan was being lifted at that time.

A second safety assessment dated November 6 was completed by the newly assigned caseworker. This assessment also documented that no threats were found and the children in the home were safe. This document, as with the first assessment, included all household members, but the new worker now included the identified child's father on her assessment.

On November 7, the worker received the medical records from [REDACTED] regarding the incident. While reviewing the records, the caseworker discovered an entry by the treating physician stating he took "protective custody" of the child on November 2, 2012 at 4:40 PM. The supervisor of the case consulted with the on-call worker that responded to the hospital that evening. The on-call worker stated that no one ever informed her that they took emergency protective custody. After hearing this, the investigating worker spoke with the agency solicitor to advise him of this information. The solicitor stated that because the hospital did not follow proper procedure regarding taking a child into custody and the agency investigated the incident and developed an "appropriate safety plan with no custody transfer," no further legal actions needed to be taken by the agency.

On November 9, the worker sat with her supervisor for a formal 10-day supervisory review. During that supervision, it was determined that since there was no evidence of neglect, the report would be unfounded.

As of the next supervisory review that was held on November 19, the agency was still awaiting medical records from the child's pediatrician. Once those records are received and reviewed, the supervisor directed the worker to unfound the report by the 30th day and close the case. The risk to the child was determined to be low due to the incident being accidental in nature.

The agency received the medical records from [REDACTED] on November 27. The worker reviewed the records and found nothing concerning regarding abuse or neglect.

After multiple phone calls to the pediatrician's office to inquire about the records, the worker was finally advised on November 27 that the doctor's office did not have a release of information on file. As a result, the worker hand delivered the release of information. Once at the doctor's office, the secretary informed the worker that the medical records clerk did find a release and sent the records out the week prior. The secretary told the caseworker to call the office if the records weren't received by November 29.

A third supervisory review was held on November 29. The report was ready to be unfounded provided the pediatrician's records could be reviewed first however they had yet to obtain them.

On November 30, the caseworker contacted the pediatrician's office regarding not having the requested medical records and needing them this day to complete a status determination for the abuse investigation. The secretary advised the worker that they would be printed out and ready for pick up in 45 minutes. The worker picked up the medical records and reviewed them, with no concerns noted by the pediatrician.

As a result of all of the information gathered through interviews and documentation, the agency submitted their CY-48 on November 30 with an "Unfounded" status determination. The parents were provided with the necessary paperwork as recorded in the structured case notes. A final

safety assessment was done at the completion of the investigation and once again included all of the household members and the identified child's father. The case was closed at this time as well. The agency believed the incident to be accidental in nature and no safety threats were noted.

Current Case Status:

Not only has the family remained closed with the agency, but according to CAPS, the county's child welfare case management system, there have been no other referrals for this child or the other family that was residing in the child's home.

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

Because the county was able to complete their CPS investigation within 30 days and they deemed it was not abuse, they were not required to complete a review or a report about the incident.

Department Review of County Internal Report:

As stated above, the county was not required to complete a report or conduct a review. Based on the information obtained by the county and contained in the structured case notes, the Department is in agreement with the agency's findings and case closure.

Department of Public Welfare Findings:

- **County Strengths:**

Fayette County CYS, and in particular, the responding caseworkers and supervisor, demonstrated numerous strengths in completing this CPS investigation.

- An on-call caseworker was dispatched to the hospital immediately upon learning of the report. While at the hospital, the responding worker took every opportunity to interview anyone that may have had information related to the incident. This included the identified child, both of his parents, the adult household member, and the household member's daughter.
- The worker asked good questions to each person in an effort clarify how much medicine each person believed the child had taken, where the medication was located at the time the child obtained it, why the child wasn't taken to the hospital until the next day, etc. Based on the dictation, it appeared as though the worker was being methodical with the questions in an effort to find inconsistencies in any accounts.

- Safety planning was done with both parents at the hospital. Both parents agreed upon the safety plan. The worker obtained the necessary information for the father's roommate so that he could be cleared as well.
- The same evening the safety plan was completed, the caseworker visited the father's home to ensure it would be a safe environment for the child.
- The newly assigned caseworker contacted both parents very soon after receiving the investigation and completed home visits. This was done so that the family could return to "normal" as quickly as possible without jeopardizing safety.
- The administration and agency solicitor were contacted early regarding how to proceed with the investigation and to consult regarding possible custody.
- The caseworker requested medical records from the treating hospital and child's pediatrician. In addition, the worker was vigilant to obtain the records by repeatedly inquiring when she could expect them. These records were viewed by the agency as critical in helping them make their determination. The worker and supervisor made sure they had the records in their possession in time to review them to support their determination.
- The supervisor and caseworker had regular supervisory reviews to discuss child safety and the progress towards a status determination. This assisted them in being able to make their determination within 30 days.
- County Weaknesses:
 - The household composition for this case consisted of two adult women living together as roommates, both of whom had their own child. When the agency completed their safety assessment worksheets, both children were included on them, however, only one adult was listed as a caregiver (the identified child's mother).
 - The issue with this is that while it is one household, there are actually two separate families. As such, each mother should have had their own file and been assessed individually as parents.
- Statutory and Regulatory Areas of Non-Compliance:

There were no areas of non-compliance found.

Department of Public Welfare Recommendations:

The agency should continue to use the same approach and proactive casework that was used in this investigation.

For future referrals, two families residing together should be separated into their own assessments. Not only does this assess their family unit, it also protects confidentiality of each family, as one family should not be privy to the other family's information.