REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/312016
Date of Incident: 07/03/2017
Date of Report to ChildLine: 07/03/2017
CWIS Referral ID: [REDACTED]

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

Montgomery County Office of Children and Youth

REPORT FINALIZED ON:
1/11/2018

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.

Montgomery County Office of Children and Youth (MCOCY) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/01/2017, and the review team determined that there was abuse and therefore, the report was "Indicated" within 10 days of receipt of the investigation.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
	Biological mother	1987
	Victim child	07/31/2016
	Paternal aunt of the child	1988
	Child's twin sister	2016
	Sibling	2012
*	Sibling	2009

* did not live in the home at the time of the incident, and resides in the care of his bio-father in (in which mother refuses to provide an address).

Summary of OCYF Child Near Fatality Review Activities:
The Southeastern Region Office of Children, Youth and families (SERO) obtained and reviewed all current case records pertaining to the family, including the initial referral, all medical records, and safety assessment and supporting documentation.

Children and Youth Involvement prior to Incident:
Family is not known to Montgomery County Office of Children and Youth (MCOCY).

Circumstances of Child Near Fatality and Related Case Activity:
Montgomery County Office of Children and Youth (MCOCY) received a Child Protective Services (CPS) report on July 3, 2017, alleging that the nearly 1-year old child ingested medication and was unconscious and hardly breathing. The medical team at Hospital and the child was revived. The victim child was then airlifted to DuPont Hospital where it was determined that she had ingested The victim child did not appear to have any medical complications or adverse effects as the result of the overdose.

the victim child was placed in a foster home upon from DuPont Hospital.

Police Department along with the MCOCY intake caseworker, began their investigation immediately at the onset of receiving the CPS call. The victim child's bio mother was interviewed, and she stated that at the time of the incident, she was home alone and was not sure how the child ingested the medication. At a subsequent interview, the mother stated that she had a friend over at her house earlier that day, and was fixing the friend's hair. The mother stated that friend claimed to have lost two pills while in the home. The mother further stated that she believes her friend reached into her purse for something and may have accidentally dropped the pills on the floor. The mother asserts that she has never used drugs and does not allow known drug users into her home. Despite this assertion, the father of two of the siblings fatally overdosed in the home (06/18/16). The victim child's biological father overdosed and died on 1/12/16 as a result, several months prior to the child's birth. reported that he has knowledge the mother had a previous substance abuse history, prior to having children.

The mother reported to police that on the day of the incident, she was rushing around the house and did not notice anything unusual with the victim child. The victim child's eldest sibling was watching the child and her twin sister, and told the mom that the victim child looked 'funny.' The mother instructed her eldest child to give the victim child a bottle and she took the children to a fair in The mother did not check the victim child, even after being alerted that the victim child may not look well. The mother stated that she thought the victim child was hot and tired, but did not think she needed immediate medical attention. The mother stated that she stopped to pick up a friend on the way to the fair. The mother's friend is a nurse and observed the victim child and directed the mother take her child to the hospital.

On July 13, 2017, the report was indicated naming the mother as perpetrator for not obtaining medical care immediately. Currently, there are no pending criminal charges.

At the time of the incident, there were two siblings living in the home. The victim child's 5-year-old sister, and the child's twin sister. The victim child is currently placed in a foster home. A paternal aunt that previously resided in the home, agreed to a safety plan and has moved into the family home to care for the remaining children. The mother has moved into her mother's home. The eldest child is currently with his bio father, and his father has obtained custody of this child. MCOCY has requested for the mother through with expectations that recommendations are followed. The mother was also referred for parenting classes. The mother also participates in supervised visits with the victim child. Additionally, the family receives in-home case management services through MCOCY. All of the children are developmentally on target and are up to date with all their medical care.

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

- [REDACTED] MCOCY [REDACTED] placed the victim child in an appropriate foster home through one of their OCY providers
- At the time of the report, the family did not have an open case or services with MCOCY. Subsequently, [REDACTED] MCOCY assumed case management for the entire family.
- The mother is referred [REDACTED] through [REDACTED] The mother was also referred for parenting classes.

Department Review of County Internal Report:

- MCOCY did a good job conducting the investigation
- The agency did complete an internal report as there was a scheduled review team meeting. PA DHS concurs with the county agency's report.

Department of Human Services Findings:

County Strengths:

- MCOCY immediately contacted [REDACTED] Hospital to gather additional information on the child's condition.
- MCOCY immediately contacted law enforcement to conduct an investigation of child abuse.
- MCOCY maintained consistent phone collateral calls and face-to-face visits with DuPont Hospital medical personnel and ongoing physician.
- MCOCY's collaboration with law enforcement during the investigation was consistent.
- MCOCY obtained and reviewed the child's medical records.
- MCOCY [REDACTED] and placed the victim child in an appropriate placement home, upon the child's release from the hospital.
- MCOCY assessed the remaining children in the home for safety in a prompt manner.
- MCOCY identified additional paternal relatives as a kinship referral source for the remaining children.
- MCOCY immediately arranged supervised visits between the victim child and her family, to ensure that the family has an opportunity to maintain contact with the child in a safe and structured environment.
- MCOCY decided within 10 days of the date of the report and appeared to take all information obtained during the investigation into consideration when making the decision to "Indicate" the report.
- MCOCY made the necessary referrals for the mother to receive [REDACTED] as well as parenting services.

- MCOCY is working with partners such as [redacted]

County Weaknesses:
- PA DHS has not identified any gaps in services for this near fatality.

Department of Human Services Recommendations:
PA DHS concurs with MCOCY's recommendations -
- A statewide program to increase public education regarding the impact of addiction on children.
- Public Service Announcement regarding safe storage of all medications out of the reach of children.
- Improve education to pediatricians who can increase parental knowledge of the safe keeping of all medications and the impact of drug involvement on children.
- Operationalize a Mobile Engagement process via the State/County Drug and Alcohol departments to respond to the scene when an overdose occurs in order to offer education and supportive services. Assure that resources are developed to allow this response each time Narcan is administered and then to allow a follow up contact later.
- Increase awareness of Mobile Engagement services that make six drug and alcohol sessions available to this vulnerable population at no cost.
- Replicate the mobile engagement services program in other counties.
- Require individuals to whom Narcan is administered to be transported to the hospital for full assessment and notification to the mobile engagement team.
- Create more proactive preventive services – increase funding for prevention, intervention and crisis services related to drug involvement.
- Allow county Health Department Medical Director to certify a situation as a near fatality if child is administered Narcan but not transported to a hospital.
- Provide additional training to ChildLine staff for consistency in determining a situation as a near fatality and thus, triggering an ACT 33 case review.
- MCOCY to establish relationships with DuPont hospital as it is now an affiliated hospital with [redacted] Hospital.
- MCOCY to continue providing ongoing case management services to the family, with the goal of reunification.