pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/04/2016
Date of Incident: 02/04/2019
Date of Report to ChildLine: 02/04/2019
CWIS Referral ID: [redacted]

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

Blair County Children, Youth, and Family Services

REPORT FINALIZED ON:
09/30/2019

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.

Blair County did convene a review team in accordance with the Child Protective Services Law related to this report. Blair County convened a review team in accordance with the CPSL related to this report. The review team was convened on February 28, 2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Child	04/04/2016
	Mother	[redacted]/1983
	Father	[redacted]/1978
	Family Friend	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 Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the [redacted] family. CROCYF representative engaged Blair County Children, Youth, and Families Services' (CYFS) Casework Supervisor, [redacted] and Caseworker [redacted] to discuss the incident and subsequent findings.

Summary of circumstances prior to Incident:

On 06/02/2005, Blair County CYFS received a General Protective Services (GPS) report alleged the mother and infant [redacted] for heroin. Notes indicate that the [redacted] on 06/01/2005 and the [redacted] on 06/02/2005. At the time of this report, the mother had two other children. The CYFS agency opened the family for services on 06/07/2005, and case

was eventually closed when the three children were placed in foster care with paternal grandparents.

Blair County CYFS received another GPS report that the mother was participating member of Blair County's Drug Court, but she lost her job which resulted in a violation of probation with a potential of incarceration for six months. A family friend assumed childcare responsibilities for the child, and the referral was screened out.

An anonymous reporting source initiated a GPS referral on the family on 03/05/2013. The reporting source addressed concerns that were communicated to her by another individual but she would not offer any identifying information as to where the information was obtained. The reporting source stated that it was odd that the mother would relinquish her custodial rights of three children to a man living in a nearby community. The reporting source stated that when the children visit past caretakers, she was informed that the children [redacted] The reporting source does not know the name or address of the individual who is caring for the children. Due to the lack of information, the CYFS agency screened out the referral.

Another GPS referral was received by the CYFS agency on 01/06/2014 with concerns that the [redacted] There were no criminal charges initiated since the mother consumed all the drugs, and she did not have any drug paraphernalia in her possession. At the time of the [redacted] she was not in a custodial role for any of her five children, and the report was screened out.

On 12/03/2015, a GPS referral was received by the CYFS agency with concerns that the mother has a [redacted] She also [redacted] for [redacted] She also [redacted] for crystal methamphetamine. At the time of the referral, the mother did not have custody of any of her children and the case was screened out. It is noted that the CYFS agency will receive a telephone call [redacted]

On 09/20/2018, another GPS report was received by the CYFS agency that alleged that the [redacted] but that she is actively using crystal methamphetamine. The [redacted] at the time of the referral and the reporting source stated that the identified child, on several occasions, was found wondering the streets. The CYFS agency was able to utilize a safety plan with a non-offending parent who would be responsible to the care of the child. Family Preservation Services were initiated with the family. The mother consistently [redacted] and no safety threat were identified resulting in the CYFS agency closed the case on 11/15/2018

<u>Circumstances of Child Near Fatality and Related Case Activity:</u>

On 02/04/2019, the identified child was taken to a local Hospital's Emergency Department for an "unresponsive episode" and there were concerns that the child

ingested something. The father discovered the identified child unresponsive when he came home from work. It is reported that cardiopulmonary resuscitation (CPR) was initiated and a call to 911 was made. Emergency Medical Technicians (EMTs) were dispatched, and the child was transported to the hospital. When the identified child was found, the child's mother was in the home's kitchen with a friend. The father reported that he found the identified child lying on the living room couch with her head in a pillow. The father stated that heard the child wheezing and when he checked on the child, he noticed her lips were blue, and he immediately called 911. The child's mother stated that her friend's purse was also on the couch. It is undetermined if the purse contained any drugs, etc. but the theory was that the child may have come into contact with opiates via the friend's purse. It is noted that the mother's friend departed the apartment and her whereabouts are unknown. Thus, the investigating police officers have been unable to question her in relation to the contents of her purse. The identified child remained unresponsive until the EMT's administered Narcan, but the child remained in a state of drowsiness.

The attending physician at the local hospital certified the child to be in critical condition. It is reported that the physician stated that if Narcan was not administered to the identified child, the child may have died before arriving at the emergency room. A blood test revealed that the child's white cell count was elevated at 12.2. Other indicators were within normal limits. It is documented in the family's case record that the identified child's drug screen showed trace amounts of Tylenol, and the screen was positive for methadone. The physician also ordered a computed tomography (CT) scan was also completed, and the results were normal. The attending physician made the decision to transfer the identified child to [redacted] The attending physician at [redacted] reported that if the father had not found the identified child, the child would have died due to significant asphyxia. The identified child responded well to the treatment she received for a methadone overdose, and she was discharged on 02/05/2019 into the care of her father. The child's mother was incarcerated at the Cambria County jail for outstanding warrants and within a few days was released. She resided with relatives in the Altoona, PA area and eventually moved back in with the identified child and the child's father during April 2019. Both of the identified child's parent have [redacted] Mother's friend's whereabouts remain unknown. The identified child's mother and her friend were both defined as alleged perpetrators by commission; Causing Serious Physical Neglect of a Child / Repeated, Prolonged, or Egregious Failure to Supervise.

On 04/05/2019, Blair County CYFS unfounded the CPS report. There decision was based on, "Since mother placing child on the couch to nap, and going to the kitchen to talk with a friend isn't a repeated, prolonged, or egregious failure to supervise in and of itself, this case is made unfounded. Should test results of the items from the home suggest child's condition was intentionally, knowingly, or recklessly a result of a repeated, prolonged, or egregious failure to supervise, a new report may be registered."

The agency proceeded to initiate a GPS with the family in order to monitor safety and well-being of the child and to allow the police time to receive test results from a police

laboratory (pills from couch, children's Tylenol bottle). Blair County CYFS closed the case on 05/24/2019 stating, “Child is safe and parents are responding to child in an appropriate way. [redacted] No further agency involvement required at this time, therefore this case is being closed.” As of this report, the police have yet to receive test results from the laboratory, but their investigation is ongoing.

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

  The County Review Team stated that an MDIT meeting could be scheduled if needed to help move forward with the investigation.

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

  The County Review Team stated that there were communication deficiencies with police in regards to the forensic interview being scheduled and then cancelled by the identified child’s father

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse

  NA

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

  NA

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

  NA

Department Review of County Internal Report:

The CROCYF received Blair County CYFS’ Child Near Fatality Child Review Team Summary / Minutes on 07/05/2019. Upon review of the documentation, CROCYF assessed that the information efficiently described the incident, the actions taken by the agencies involved, and the status of the case. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

  At the time of this report, the CROCYF has not identified areas of strength.

- County Weaknesses:

  At the time of this report, the CROCYF has not identified areas of weakness.

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

  At the time of this report, the CROCYF has not identified areas of regulatory non-compliance.

Department of Human Services Recommendations:

The CROCYF has no recommendations in regards to this incident and the subsequent investigation by Blair County CYFS.