pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/01/2018
Date of Incident: 05/27/2019
Date of Report to ChildLine: 05/27/2019
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lancaster County

REPORT FINALIZED ON:
12/19/19

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.

Lancaster County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/19/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	[redacted]/2018
	Mother	[redacted]/1991
	Father	Not reported
	Maternal Grandmother	[redacted]/1953

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in the Act 33 meeting with the Multi-Disciplinary Team (MDT) on 06/19/2019 to review and discuss case information. The MDT reviewed the case again at a follow-up meeting on 07/24/2019 and the CROCYF was present. Ongoing discussions were conducted with the Lancaster County Children & Youth Social Services Agency (LCCYSSA) staff.

Summary of circumstances prior to Incident:

There was no prior history with the family.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 05/27/2019, a report was received regarding the victim child who was brought to [redacted] Hospital emergency department with altered mental status and pinpoint pupils concerning for intracranial pathology. The child's computed tomography scan of the head was normal and Urine toxicology screen was positive for opiates. The family strongly denied any opiates in house or that the child was seen getting into any medications. The child experienced respiratory depression,

was intubated for safety, and transferred to [redacted] Medical Center [redacted] Pediatric Intensive Care Unit.

The Agency responded to [redacted] the following morning and interviewed the parents. The mother reported she had fed the child and went to another room to play. The victim child began to vomit and needed a bath to clean her off. The mother gave the child a bath and the child began to act strangely. The victim child became fussy, her lips changed color, and the she stopped breathing. The mother called for help and the father came into the room. He struck the child on the back in attempt to dislodge something that may have been causing her to choke. The maternal grandmother began to initiate cardiopulmonary resuscitation until emergency medical services arrived. The parents were unaware of any drugs in the home and denied current substance use. They agreed to drug screens and were willing to cooperate with the Agency investigation.

[redacted] verified through a procedure that the child's airway was not blocked. The victim child was removed from a ventilator and could breathe independently. A second toxicology screen was conducted on the child and sent for laboratory confirmation. All adult household members received a [redacted] The child was released from the hospital on 05/30/2019 to the care of her parents.

The physician at [redacted] reported that results from the child's drug testing indicated the child had ingested 4,100 Milliters of morphine. He advised that in order to test positive in this manner the child would have had to come into contact with heroin or Morphine Sulfate Contin

Weekly home visits occurred to monitor the child's care. The parents continued to deny and knowledge of how the child gained access to the medication reportedly to have been ingested. The family made changes to the home including ripping out carpet and creating a new play area for the victim child. No concerns were observed during visits and the family members continued to submit to [redacted] The Agency referred the mother to [redacted] The father also had reported [redacted] issues and was also reported to no longer use.

On 7/24/19, the report was determined to be unfounded due to the victim child receiving appropriate supervision and it was unknown how she came into contact with opiates. The family was found to be providing for the needs of the victim child and community supports were in place for the family.

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;

- An appropriate response time was assigned, and the Agency met with the mother, father, and child within 24 hours.
- The Agency provided a clear sequence of events to the Act 33 committee.
- The Agency completed Safety and Risk Assessments on the family to help guide their practice.
- A collaborative investigation has occurred for this case between the police, hospital and medical staff and Children and Youth Agency.
- The child was discharged from the hospital and returned home, the caseworker made weekly home visits during the remainder of the investigation.
- The family was offered to be open for ongoing services.
- The Agency arranged for the parents to be drug screened throughout the investigation.
- The family was referred to the [redacted]

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - There were challenges with the drug screens occurring due to the parent's schedules. Additional attempts could have been made to work around the father's schedule and to coordinate drug screens along with scheduled home visits.
  - It does not appear that the child's primary care physician was informed of the incident nor consulted to see overall how the child was doing medically and developmentally prior to the incident. Discharge paperwork was sent to the primary care physician by the hospital [redacted]

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - It was recommended for a [redacted]
  - While there was extensive discussion during the Act 33 review as it left the team with many unanswered questions. The parents adamantly denied having drugs on them that the child could have gotten access to and reported being at various picnics throughout the day, however; during the Act 33 review discussion the doctor reported the drugs would have been ingested shortly before the child would have shown symptoms, not earlier in the day. The team was unable to come up with additional recommendations for change regarding this near fatality.

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

- None noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None noted.

Department Review of County Internal Report:

LCCYSSA held an Act 33 meeting on 06/19/2019 and a follow-up meeting on 07/24/2019 where medical information and case information was presented. The County report was received by the Region and the CROCYF notified the Administrator, via letter, that the report was reviewed, and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
  - The county responded immediately to the report and worked collaboratively with medical and law enforcement partners.
  - The Agency monitored the child weekly during the assessment period.
  - The family was linked with a [redacted] Contact was made with the provider to monitor follow through with recommendation.

- County Weaknesses: and
  - Although contact was maintained and records were received from hospitals who treated child, there is no record of contact with primary care physician.
  - The mother and father were drug tested immediately after the initiating the investigation, but the grandmother did not comply with a drug screen until 3 days later. The household members obtained drug screens only one other time whereas they were referred to provider for weekly drug screens. Although [redacted] additional efforts should have been made to ensure additional testing due to allegations.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None noted.

Department of Human Services Recommendations:

None