



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 10/19/2016
Date of Incident: 02/10/2018
Date of Report to ChildLine: 02/10/2018
CWIS Referral ID: [REDACTED]

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

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:

09/10/2018

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.

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 02/28/2018.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	10/19/2016
[REDACTED]	Sibling	[REDACTED] 2015
[REDACTED]	Half-Sibling	[REDACTED] 2014
[REDACTED]	Biological Mother	[REDACTED] 1993
[REDACTED]	Biological Father	[REDACTED] 1983

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [REDACTED] family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff discussed the case with the county on 02/28/2018 and 03/28/2018.

Summary of circumstances prior to Incident:

The agency received a General Protective Services (GPS) referral on 02/16/2014 regarding the half-sibling. On, 02/15/2014 the child was born and both mother and child [REDACTED] The mother admitted to [REDACTED] within the previous week. A safety plan was established where the maternal grandmother provided supervision throughout agency involvement. The mother completed [REDACTED] drug screens. She was living in the home of the maternal grandmother. The agency closed the case on 04/17/2014 with no need for additional services.

The agency received a GPS referral on 01/31/2018 regarding the half-sibling and concerns that he had ingested approximately 12 mL of Visine. The mother immediately contacted poison control and [REDACTED] The child [REDACTED] no concerns for the child or the mother. The agency screened this case out on 2/01/2018 after a

follow-up phone call with the mother. No additional services were offered or requested.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/10/2018, Lancaster County Children and Youth Agency (LCCYA) received a report of suspected physical abuse involving the victim child. The child was brought into [REDACTED] with concerns of choking, lack of breathing, and unresponsiveness. The child was immediately intubated. The mother stated that the other children had been eating chicken and she feared that the child had ingested some and choked. The hospital toxicology tests revealed that the child was positive for opiates. The child was transferred to [REDACTED] after the results of the toxicology scan were known.

LCCYA was in immediate contact with the Lancaster City Police, who were in the process of getting a search warrant for the home while the father was being questioned at the police station. The agency accompanied the officers to the home where they found drug paraphernalia, needles, and baggies with leftover residue between the mattresses in the master bedroom. The agency worker then attended the interview of the father who stated that the drugs were his and that he had started using again and the mother did not know. When interviewed about the incident, the mother denied knowing that the father was using heroin. She reported that she had fed the baby and laid her down in a pack 'n' play. After giving the siblings a shower, she gave the child a bath and laid her on the couch. She stated that her son got chicken out of the refrigerator and took it in the living room. She noticed that the child started wheezing so she thought she had choked on chicken. She seemed to recover so she put her in a swing, but then her eyes started to roll. When the child did not react to water being splashed on her, the mother contacted emergency medical services (EMS) and hung up when they said someone was on their way. She then called back because the child stopped breathing and was turning colors. She attempted cardiopulmonary resuscitation on the child until police arrived. The child was transported to the hospital by EMS.

The agency instituted a safety plan with maternal relatives that would supervise the contact between the parents and the children. The mother stayed with the maternal grandmother during the assessment. The child was discharged to her on 02/14/2018 under the plan. [REDACTED]
The mother did complete a drug screen [REDACTED]

The agency continued to monitor the case throughout the assessment. Attempts were made to speak further with the father but he was not able to be interviewed by the caseworker. On 03/28/2018, Lancaster City Police took the father into custody, charging him with one count of endangering the welfare of children and one count of possession of drug paraphernalia. He was also charged for delivery of heroin and criminal conspiracy from an incident that occurred in January 2018. The father was committed to Lancaster County Prison and is awaiting criminal trial.

LCCYA filed their investigation report with ChildLine on 04/11/2018 with a status of indicated naming the father of the child as the perpetrator. It was believed that the

child ingested heroin and the father admitted to having heroin in the home. The parents did not provide an explanation of how the child ingested the heroin. The safety plan was lifted and the mother was able to return to her home with the children.

The agency opened the family for ongoing services to monitor the mother. The agency will be providing guidance and supportive services to help with parenting, stable housing, and assuring the children are present at medical appointments. The child was also referred to [REDACTED]. The family supports remain in place for the mother and children.

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 family the same day.
 - The Agency assessed the other children in the home to assure their safety.
 - The Agency conveyed the seriousness of the report and discussed safety concerns.
 - The Agency completed Safety and Risk Assessments on the family to help guide their practice.
 - A very collaborative investigation has occurred for this case between the hospital, police and Children and Youth Agency.
 - A safety plan was implemented to assure the ongoing safety of the children and avoided placement of the children.
 - The family was accepted for ongoing services.
 - The victim child was referred to [REDACTED]

- Deficiencies in compliance with statutes, regulations and services to children and families;
 - None noted.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
 - A Family Service Plan would be developed to include goals addressing [REDACTED], parenting, stable and safe housing and meeting the needs of the children.

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

The Central Region Office received the Lancaster County Child Fatality Team Report on 05/25/2018. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 02/28/2018. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Lancaster County Administration on 06/06/2018.

Department of Human Services Findings:

- County Strengths:
 - Collaboration between LCCYA, law enforcement, and hospital staff was observed throughout family involvement. The agency was able to be present during all interviews and the home search which provided first-hand knowledge for the case.
 - The agency worker engaged the mother throughout involvement, assuring that she identified supports and discussing services that could be offered to the family.
 - The agency made multiple attempts to engage the father and allow him to represent his information beyond the initial interview.
- County Weaknesses:
 - None noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - 3130.21(b)(Safety Assessment Bulletin) – The Safety Plan completed by the agency on 02/10/2018 was signed by the family and all supervisory parties, as well as the worker (who is an agency supervisor) completing the plan. However, the plan was not reviewed and signed by a supervisor of that worker.

Department of Human Services Recommendations:

Public Service Announcements on accidental ingestions should be an ongoing and continually updated service provided. Focus should go beyond ingestions of cleaning supplies, medications, small toys etc. to broaden the discussion on the near fatal harm of ingestion of opioids.