



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 08/27/2012**  
**Date of Incident: 03/22/2015**  
**Date of Report to ChildLine: 03/22/2015**  
**CWIS Referral ID: [REDACTED]**

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

Northumberland County Children and Youth Services  
Potter County Children and Youth Services

### **REPORT FINALIZED ON:**

09/03/2015

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.

Northumberland 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 04/15/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	8/27/2012
[REDACTED]	Sibling - full	[REDACTED] 2006
[REDACTED]	Mother	[REDACTED] 1988
[REDACTED]	Father	[REDACTED] 1987

**Summary of OCYF Child Near Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the Agency casework dictation that outlined contact with the family. Follow up interviews were conducted with the Northumberland County Children and Youth Services (NCCYS) Caseworker, Supervisor, and Intake Services Director on 05/07/2015 and 05/19/2015. The regional office also participated in the County Internal Fatality Review Team meeting on 04/15/2015 where details of medical reports, criminal interviews, and case history were presented.

**Children and Youth Involvement prior to Incident:**

Two prior General Protective Services (GPS) referrals were received by NCCYS for this family. On 05/21/2014 a referral was received alleging that on 5/2/14, the sister had abrasions on her left cheek and right eye. The sister reported that she was walking down the steps backwards and fell. Her mother gave same account and injuries appeared consistent. Then on 05/15/2014, the sister went to school with stomach pain and reported that she was walking down stairs and fell over boots. The school had concern that the sister had internal damage, so the mother was called and gave same explanation. The victim child's sister was seen by doctor and was fine. Referral further alleged that on 05/21/2014, the sister went to school

stating that she was tired because she and the victim child were in her room all night long. The sister reported that she had to keep her brother safe because her mother and father were fighting and her mother was telling the father that she was going to leave him. The sister also reported that the father picked her up and threw her across the room. An Assessment was conducted and the parents admitted that things had been stressful lately and they had been arguing quite a bit. Most of the stressors involved financial difficulties. Parents reported they are [REDACTED] help from the maternal grandfather and they are arguing significantly less. Follow up visits were conducted with the family including seeing the sister alone at school. No concerns or worries reported. Home was clean and safe for the children and all basic needs were being provided. The referral was closed on 06/05/2014.

On 12/08/2014, a second GPS referral was received alleging poor home conditions. The referral was investigated and the home was observed to be appropriate for the children with no fire/safety hazards other than a water leak in the basement in which the landlord was responsible for repairing. The parents assured that the children did not have any access to the basement. Contact was made with the city's code enforcement officer who reported no safety concerns for the children. The family then relocated to a new residence which was found to be clean and safe. No other concerns were observed and the referral was closed on 01/28/2015.

#### **Circumstances of Child Near Fatality and Related Case Activity:**

On 03/22/2015, NCCYS received a report [REDACTED] [REDACTED] The victim child was brought to GMC/Shamokin [REDACTED] by his mother presenting as unresponsive, barely breathing but had a pulse. The victim child was responding to painful stimuli only. Scratches were also noted on his right chest and forearm. [REDACTED] physician certified the victim child to be a near fatality as it was unclear if he would survive. The victim child was Life-flighted to Geisinger Medical Center (GMC) Janet Weis Children's Hospital in Danville, PA [REDACTED]

The victim child's mother reported that earlier in the day around 8:30 am she found the victim child playing with her make-up and the mother's pills were lying nearby. [REDACTED] was in a container [REDACTED] that was not child proof. At the suspected time when the victim child may have ingested the pills, the mother was in the bathroom and the father was in the kitchen making breakfast. At the time the mother was unsure if the child had gotten into the pills. [REDACTED]

[REDACTED] Later in the day, the victim child did not wake up from a nap and the mother got concerned, taking him to the GMC/Shamokin ER by car. The mother brought her [REDACTED] into ER and there were [REDACTED] pills unaccounted for and they were unsure about any [REDACTED] pills missing.

NCCYS responded to the GMC/Janet Weis Children's Hospital on 03/22/2015 and spoke to the attending medical team. The victim child was doing well and was expected to make a full recovery. It was also noted that the scratches initially

observed when the child was brought the ER were actually make-up that was in turn washed off. The child was able to be awakened intermittently but was still sleepy from the medication ingested.

Both parents were present at the hospital and were cooperative with interviews. The mother reported that the victim child has a little bean bag-type chair and he was asleep in the chair that morning. The chair was located in the parent's bedroom. The mother stated that the father was making breakfast and she had gone to the bathroom. She stated that the victim child had makeup on him when she returned to the room. This was at approximately at 8:00 am. She reported that the victim child had pulled his chair over to the dresser and apparently applied the makeup that was on the dresser. The mother stated that when she saw the victim child with the makeup, he was away from the dresser. The mother stated that she did not notice the lid off [REDACTED] bottle. The victim child then ate breakfast and took a nap around 11:00 am. The mother stated that she tried to wake him from his nap at approximately 1:00 pm but he wouldn't open his eyes and swatted her away. The mother stated she then went upstairs and found her pill bottles were still closed but she counted the pills and found 16 pills were missing from [REDACTED] bottle. The parents then took the victim child to the emergency room. The mother reported that she knew that [REDACTED] was on her dresser but that the lids were on and she didn't think that victim child would be able to reach them. The mother is somewhat limited cognitively [REDACTED]

The father confirmed that he had been making breakfast for the family so he had been downstairs in the kitchen when the incident occurred. The father reported that the mother informed him that the victim child got into her makeup. The father didn't have any other information other than when the mother attempted to wake victim child up from his nap there was something wrong and they immediately took victim child to the emergency room.

The parents consented to the implementation of a plan of supervision to assure for the safety of the children during the investigation. On 03/22/2015, a paternal aunt was cleared to care for the victim child's sister. Upon the child's [REDACTED] on 03/24/2015, multiple family members presented themselves as resources for the family to maintain their cohesion throughout the early weeks of the investigation. Maternal and paternal relatives either stayed in the home with the family or the family stayed with relatives. Potter County Children and Youth Services aided in the assessment of the paternal grandparents' home where the family stayed for several weeks. The safety plan was lifted on 04/17/2015 to allow the sister to return to school as they had been displaced with the grandparents out of the school district. The family was open to learning new parenting skills and acceptance of guidance in regards to assuring safety of their children. The family was opened for ongoing protective services on 04/17/2015.

The mother denied requesting the flip-top [REDACTED] bottles and was unsure why she did not receive child proof caps [REDACTED]

[REDACTED]

The parents understood the necessity for child proof caps on all [REDACTED] brought into the home where they are also to be stored in a location where the children cannot access. Visits to the home throughout the investigation verified the parental compliance with these standards. The investigation was made unfounded on 05/14/2015 as the mother's actions did not meet the criteria for child abuse.

**Summary of 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;
  - No strengths were noted by the team.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - No deficiencies were noted. The agency was not active with the case at the time of the near death report.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - The team recommended discussing medication during intake assessment/ CPS investigations when family has young children. The implementation of a check list for workers to check family homes could include appropriate child proofing.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - No recommendations were made.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - It was recommended that pharmacies only give flip-top lids on [REDACTED] bottles when specifically requested or required by the patient.

**Department Review of County Internal Report:**

The County Internal Near Fatality Review Team held an Act 33 meeting on 04/15/2015 where medical information and case history were presented. The County report was received on 07/16/2015. On 08/07/2015, CROCYF notified NCCYS Administrator, via letter that the report on [REDACTED] was reviewed and the regional office agreed with the recommendations of the Act 33 review team.

### **Department of Human Services Findings:**

- County Strengths:
  - NCCYS worked cooperatively with Geisinger Medical Center staff and were able to promptly receive medical information to aide in the investigatory process.
  - NCCYS responded promptly and within required time frames to immediately assure the safety of the child remaining in the home and assure adequate supervision of all children during the initial assessment period.
  - The CPS investigation was completed within established time frames.
- County Weaknesses: and
  - NCCYS lacked support from local law enforcement that were unresponsive to the notification of the incident and did not participate in the Act 33 meeting.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - No areas of non-compliance were noted.

### **Department of Human Services Recommendations:**

- NCCYS should identify key law enforcement contacts within each jurisdiction that can support collaboration of investigation.
- NCCYS should elicit a representative from the law enforcement community to be a regular member of the Act 33 team.
- It is recommended that counties add into their intake process, when looking at safety of children in their homes, addressing medication safe storage.