pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/29/2013
Date of Incident: 04/19/2015
Date of Report to ChildLine: 04/19/2015
CWIS Referral ID: [redacted]

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

Allegheny County Children, Youth and Families

REPORT FINALIZED ON:
12/18/15

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.

Allegheny County Office of Children, Youth and Families (OCYF) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/21/2015, with a secondary meeting being held on 06/15/15.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	03/29/2013
[redacted]	Biological Mother	[redacted]1995
[redacted]	Biological Father	[redacted]1992
[redacted]	Paternal Grandmother	[redacted]1963
[redacted]	Paternal Aunt	[redacted]2000
* [redacted]	Sibling	[redacted]2015
* [redacted]	Maternal Grandmother	[redacted]1966
* [redacted]	Maternal Grandfather	[redacted]1960

* 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 Western Region Office of Children Youth and Family Services obtained and reviewed case records pertaining to the family. Follow-up interviews were conducted with the Allegheny County Intake Caseworker and Supervisor on April 20, 2015. Subsequent follow-up phone calls were made to obtain ongoing information from the Intake Caseworker and ongoing Family Services Caseworker and Supervisor. The Western Regional Office also participated in the second Allegheny County Act 33 meeting on June 15, 2015 where medical professionals, law enforcement and Allegheny County Office of Children, Youth and Families staff presented updated and historical information regarding the incident.

Children and Youth Involvement prior to Incident:

The family was previously referred to Allegheny County Children, Youth and Families (CYF) in March 2014 with the father being listed as the alleged perpetrator regarding allegations of serious physical maltreatment on a child not identified in this Act 33 report. The father had been babysitting the mother's six-month-old nephew (the nephew was not a household member) when a report of alleged serious physical abuse was received by Allegheny County CYF regarding the father as a caregiver.

Information was obtained that the father had a child (who is this Act 33 victim child), therefore a referral was made to Allegheny County CYF to assess the safety of the father's own child. Upon completion of the assessment, the family was accepted for ongoing services and services were initiated. The mother was referred for parenting and the father was referred to a father program. Mother and father also reported attending [redacted] while the family was involved with Allegheny County CYF. The safety plan established by the family documented that the father was not to be left unsupervised with his own child. This plan, per the county report, was put in place by the family. The parents were inconsistent with home visits and Allegheny County CYF closed the family's case in July 2014. In October 2014, father entered a guilty plea to the criminal charges connected to the abuse of the mother's nephew. Allegheny County CYF had closed the case before the criminal court proceedings were completed. Due to the premature closing of the case, Allegheny County CYF was not aware of father's conviction or probationary status. Due to the length of the probation sentence, the father was still serving probation at the time the county received the report regarding the Act 33 victim child.

Circumstances of Child Near Fatality and Related Case Activity:

On April 19, 2015, Allegheny County Children, Youth and Families received a report stating the victim child was found unresponsive on mother and father's bed after reportedly ingesting [redacted]. An empty bottle of [redacted] was lying beside the victim child. Initially, the father stated he woke up at 1:30 a.m. to get a drink and when he returned to the bedroom he saw the open bottle [redacted] on the bed. Father reported the victim child was playing and talkative. Father and mother reportedly observed the victim child and stated she did not show any signs of ingesting [redacted]. Father initially stated he slept until 11:30 a.m. and mother stated she slept until 11:00 a.m. At approximately 12:30 p.m. the victim child reportedly began to have difficulty breathing due to the possibly ingesting [redacted]. Mother and father took child into the bathroom and splashed cold water on her face and they called 911.

Emergency Services arrived and [redacted] The victim child was transported to St. Clair Hospital at which time [redacted]. The victim child was then life flighted to Children's Hospital of Pittsburgh (CHP) at approximately 4:00 p.m. Victim child [redacted] at CHP. The child [redacted] on 04/21/15 with [redacted]

Upon interviewing the parents, the mother reported father had woken her at 2:00 a.m. on April 19, 2015 and told mother [redacted] bottle was open and empty. Mother reported the same information as the father in that she and father observed the victim child for approximately thirty minutes upon noticing the open bottle. Mother stated the victim child appeared alert and was talking normally. Mother stated she woke up at 11:00 a.m. with the victim child and observed her to be alert. Mother reported at 12:30 p.m. the victim child began having difficulty breathing. Mother and father splashed water on her face and called 911.

It was later reported by Paternal Grandmother (PGM), who also resides in the home, [redacted] PGM stated she heard father leaving the home at 6:30 a.m. [redacted] and returned at 7:30 a.m. During the investigation, father later admitted to leaving the home as reported by PGM.

Medical professionals informed the parents and Allegheny County CYF the victim child would have shown symptoms of ingesting [redacted] within approximately one hour. This report put the timeline of the victim child ingesting [redacted] in the early morning hours into question. The parents' inconsistencies in providing a clear timeline of events were concerning and lead to the removal of the victim child from the home. The victim child was placed in kinship care with her maternal grandparents. Mother gave birth shortly after this incident and the newborn sibling was placed in the care of her maternal grandparents with the victim child.

Mother and father were arrested and charged with Endangering the Welfare of Children and Recklessly Endangering another Person. Mother has been released from jail. Father remains in jail due to violating his probation. Mother and father had a Pre-Trial on August 14, 2015 and are currently awaiting a non-Jury trial, scheduled for October 7, 2015. Allegheny County CYF submitted a Pending Criminal Court CY-48 to ChildLine on May 14, 2015 due to the lingering criminal matter.

The children remain in the care of the maternal grandparents. The mother is currently residing with her sister and has supervised visits with the children. [redacted]

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;
  - CYF responded immediately to the report, conducted a thorough report and ensured the safety of the focus child.

- The Act 33 Review Team did not have any statutory or regulatory compliance issues.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - CYF closed the previous case in July 2014 with a safety plan in place. A plan that was established by the family, stating father was to not have any unsupervised contact with his own child. This safety plan is not a sustainable plan as the case was then closed. Having the statement that father is not allowed unsupervised contact would appear to indicate there are ongoing safety concerns. An assessment prior to closing should have taken place to alleviate all concerns regarding the parents (father) caring for the child in their care.

- 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 recommendation was made to provide [redacted] with a lock box and to mandate all bottles are regulated with child-proof caps. While it cannot be known that all patients would utilize the lock box these added safety features could lessen the likelihood of children obtaining [redacted]

  - A recommendation was made to change the [redacted] process when it is known children are in the home. This would possibly apply to younger, more vulnerable children, if not all children. With the increase [redacted] as an ongoing concern having these [redacted] in the home adds to possible misuse by teens.

  - A recommendation was made to develop a safe case closure protocol that establishes guidelines to ensure child safety prior to closure. The protocol would be advised to include guidance on the duration and type of monitoring to be completed for any safety plan(s) prior to closure.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - When a family is known to the agency as being involved with [redacted] it would be recommended that the county and in-home providers ensure during the home assessment process and home visitation routine an assessment is completed and documented as to whether the parents have a secure system (lock box, safe, lockable medicine cabinet) to store [redacted] This would add measures to assessing for a safer home environment. The county should then document and note whether the family is following safety procedures.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - It was recommended in the Act 33 meeting, that all community drug programs provide "take home" patients with lock boxes.
    - Recommended review and reinforcement of the established joint investigative protocol developed by the Office of the District Attorney, law enforcement and CYF.

Department Review of County Internal Report:

The Department received the County Internal Report via email on August 14, 2015. The Department agrees with the recommendations given by the review team.

Department of Human Services Findings:

- County Strengths:
    - The county worked cooperatively and in tandem with law enforcement and medical professionals.
    - The county utilized kinship care to maintain family engagement and sibling connection.
- County Weaknesses:
    - There were no weaknesses identified regarding the assessment or case management of the Act 33 referral.
    - The county's premature closure of the 2014 case while the family was on an active safety plan and prior to the outcome of the father's criminal charges involving physical abuse of a child would be seen as a weakness. The implementation of the safety plan, whether created by the family or the agency, indicated that a concern for safety was recognized by all parties. The county's mere involvement with the father's allegations prompted the safety plan. The agreement with the plan would have suggested the child was unsafe if unsupervised with the father. By allowing the plan to remain in effect upon closing the case indicates that the threat continued to exist.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There are no statutory or regulatory areas on non-compliance by the county agency.

Department of Human Services Recommendations:

- It is recommended that the county implement a practice clearly documenting in the home assessments to show that parents and/or caregivers known to

[redacted] have safely secured the medication.

- It is recommended that the county revisit the use of safety plans and when it may, if at all, be appropriate to close a family while an active plan exists.