



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

[REDACTED]

**Date of Birth: 01/29/2015**  
**Date of Death or Date of Incident: 08/17/2015**  
**Date of Report to ChildLine: 08/18/2015**  
**CWIS Referral ID: [REDACTED]**

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

Mercer County Children and Youth Services

**REPORT FINALIZED ON:**  
12/30/2015

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.

Mercer County Children and Youth Services (MCCYS) were not required to convene a review team since the report was unfounded within 30 days of the agency receiving the report.

**Family Constellation:**

<u>First and Last Name:</u> <u>(month/date/year):</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/29/2015
[REDACTED]	Mother	[REDACTED]/1989
[REDACTED]	Father	[REDACTED]/1987
[REDACTED]	Sibling	[REDACTED]/2012
[REDACTED]	Sibling	[REDACTED]/2013
[REDACTED]	Sibling	[REDACTED]/2005
[REDACTED]	Sibling	[REDACTED]/2008
[REDACTED]	Father of the siblings	[REDACTED]/1989
[REDACTED]	Paternal Grandmother/	[REDACTED]/1958
[REDACTED]	Guardian for [REDACTED]	

\* 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 Families (WRO) did receive the entire family file including previous involvement. The case file was reviewed in its entirety.

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

On 10/25/2010, MCCYS received a General Protective Services (GPS) referral in regard to the mother’s care of her two young male children as mother was allegedly addicted to drugs and was not caring for the boys. MCCYS assessed the case and it was closed on 12/23/2010.

On 04/24/2012, MCCYS received a GPS referral in regard to the victim child's older sibling. The referral stated the mother and her newborn child tested positive for THC. MCCYS assessed the case and did refer the mother to [REDACTED]; however, there was no documentation that the mother had completed the requested assessment prior to MCCYS closing the case on 06/21/2012. The mother's two oldest male children were in the custody of their paternal grandmother at the time of this report and were not in the home. The placement of the two oldest boys with the paternal grandmother was a result of a private arrangement between the mother and the paternal grandmother.

On 07/24/2012, MCCYS received a GPS referral with concerns that the mother was not following through with [REDACTED] and was not caring for the newborn child properly. The case was assessed and the family was opened for ongoing services for general protective services due to unstable housing and drug abuse by the parents. The family successfully completed their Family Service Plan goals of finding stable housing and testing negative for drugs. [REDACTED]. The case was closed on 08/08/2013.

On 12/27/2013, MCCYS received a GPS referral with concerns that a sibling had missed several well care visits and that the mother had not followed through with [REDACTED]. This case was assessed by the County and closed with a low risk on 01/24/2014.

On 08/4/2014, MCCYS received a GPS referral with concerns that the mother's paramour was maltreating the children. The case was assessed and closed with a low risk on 08/26/2014.

On 01/30/2015, MCCYS received a GPS referral that the victim child was born and the mother tested positive for THC. The mother has two older children that are not in the custody of the mother and two female children who are in the home. The case was assessed and the family was opened for services on 03/31/2015. It was found that the victim child's [REDACTED] tested positive for amphetamines, cocaine, THC and opiates and the mother tested positive for only THC. The father of the victim child was also testing positive for THC [REDACTED]. The case was opened for services due to these concerns when the near fatality report was certified on the victim child. MCCYS had been providing parenting, [REDACTED] services to the family at the time of the near fatality.

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

On 08/17/2015, the victim child was transported to Children's Hospital of Pittsburgh (CHP) via medical helicopter after ingesting [REDACTED]. The victim child originally presented at a local hospital and [REDACTED] and then transferred to CHP. The victim child was brought to local hospital by Emergency Medical Services (EMS) from the family home and was found to be having [REDACTED].

██████████. According to the mother, she walked into the room and found the victim child's three-year-old sister feeding the victim child a bottle of ██████████ of which the mother believes he ingested "half a bottle". She immediately called EMS. The patient required ██████████ at the local hospital due to pauses in breathing, dusky color change, and ██████████. At which point, the victim child was transferred to CHP ██████████ for further management. The victim child was ██████████ for a short period of time ██████████

██████████. According to hospital staff his condition improved drastically. The victim child's toxicology was positive for Tetryzoline (active ingredient in ██████████).

The mother reported that she was in her bedroom and the two older sisters, age 2 and 3, and the alleged victim child were on the bed. The mother reported she was on the phone texting her mother. The mother reported she turned away and when she turned around the 3-year-old sister was feeding the victim child ██████████ using the bottle like it was a baby bottle. The mother reported she turned around when she heard "yummy" and "mmmmm". The mother was initially unsure of where they got the ██████████. The mother reported the victim child acted normal at first, but then started "acting weird". The mother reported she was not exactly sure how much he ingested from bottle. She reported the siblings are always trying to help out.

MCCYS requested that Allegheny County Children, Youth, and Families (ACCYF) make immediate response to see child at CHP. A MCCYS caseworker went to the family home and assured safety of the victim child's siblings. A different MCCYS caseworker went to the hospital to see the victim child and talk to the Attending Physician. The Attending Physician advised that there were no concerns for physical abuse, but there were concerns for supervision. MCCYS interviewed the mother at CHP and saw the victim child. The victim child was doing well and was exhibiting no injuries or complications from the incident. The mother advised that she had all of the children in the bedroom while she was cleaning the room. She turned her back to text her mother and upon turning back around she observed the victim child's 3-years-old sister feeding the victim child the ██████████ like it was a baby bottle. The mother advised that the victim child started acting "weird" and she yelled for the victim child's father to take him to the Emergency Room. The father proceeded to take the victim child to the local Emergency Department at which time the victim child was found to be in serious condition and transported via medical helicopter to CHP where he was ██████████ and found to be in critical condition upon arrival at the hospital. MCCYS drug tested the mother at the hospital and she admitted to smoking THC and was positive. The father refused to be tested. The victim child was ██████████, 08/18/2015 to the care of his parents.

A home visit was conducted on 08/20/2015, and MCCYS again interviewed the parents about the incident. The father was not home at the time of the incident, but arrived home shortly afterwards. The mother again expressed that she was cleaning the bedroom, turned around to text her mother and when she turned back around the victim child was being fed ██████████ from the older sibling. MCCYS caseworkers did not interview the other children in regard to the incident. MCCYS

could not locate the family for several weeks after the 08/20/2015 home visit. It was determined on 09/16/2015 that the family had moved out of state to New York and a referral was made to ██████ County Children and Youth in New York. MCCYS unfounded the Child Protective Services report on 09/15/2015 and closed its case on 09/16/2015 due to the family moving out of state. However on 11/19/2015, ██████ County Children and Youth in New York referred the case back to MCCYS as the family moved back and expressed concerns that the parents had not followed through with follow-up medical appointments for the victim child. MCCYS immediately did a home visit and assured safety of the children. MCCYS accepted the case for assessment once again due to concerns for drug usage and missed medical appointments. ████████████████████ is the in home provider and they are in the home three days a week. The plan is to accept the case for ongoing services.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

There was no County Internal Report as the case was unfounded within 30 days.

- Strengths in compliance with statutes, regulations and services to children and families; None
- Deficiencies in compliance with statutes, regulations and services to children and families; None
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. None

**Department Review of County Internal Report:**

The County provided no Internal Report as the case was unfounded within 30 days.

**Department of Human Services Findings:**

- County Strengths: The agency immediately assured safety upon receiving the CPS report which was certified as a near fatality report and conducted interviews at CHP before the victim child was discharged.
- County Weaknesses: MCCYS has a long history with this family dating back to 2010. The agency was active with this family when the near fatality report was certified. The file suggests a long history of drug abuse by the

mother; however, there did not appear to be much compliance by the mother with [REDACTED] and no consistent contact by the agency with the [REDACTED]. Throughout the months prior to the near fatality the mother consistently tested positive for THC and the father consistently refused to test or comply. On the day of the near fatality, the mother tested positive for THC and the father refused to test. Also, the oldest sibling who was 3-years-old was never interviewed about the near fatality incident. She may have been able to provide some details in regard to the incident.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. The Agency did not attempt to interview the children in the home in regard to the incident as required by 3490.55 (d)(1). Due to their ages, an interview may not have gained much useful knowledge about the incident; however, an attempt should have been made given the severity of the allegations.

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

This family has a long history with MCCYS for concerns of drug use and lack of medical follow through in regards to the children. From reviewing the file it appears that although monthly visits were made with the family while the case was opened, the caregivers continued to test positive or refused to test at all and the children were never interviewed during the home visits. Lack of continuing contact with service providers was also noted. During home visits, the children appeared to be clean and having their basic needs met. The parents were minimally compliant with [REDACTED]. It is recommended that the agency look at county practices related to meaningful home visits. It is essential that in in these cases that the agency maintain regular contact with service providers and that these contacts are documented in the case file.