



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

██████████

Date of Birth: 10/11/2006
Date of Incident: 02/29/2016
Date of Report to ChildLine: 03/07/2016
CWIS Referral ID: ██████████

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

York County Office of Children, Youth, and Families

REPORT FINALIZED ON:
09/21/2016

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.

York County Office of Children, Youth, and Families (YCOCYF) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/30/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Biological Mother	[REDACTED] 1970
[REDACTED]	Biological Father	[REDACTED] 1961
[REDACTED]	Victim Child	10/11/2006
[REDACTED]	Mother's Paramour	[REDACTED] 1971
[REDACTED]	Maternal Cousin	[REDACTED] 2010
[REDACTED]	Maternal Cousin	[REDACTED] 2010
[REDACTED]	Full Sibling	[REDACTED] 2005

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed current and past case records pertaining to the [REDACTED] family. A follow-up interview was conducted on 03/09/2016 with the assigned caseworker and supervisor. The CRO participated in the county review team meeting on 03/30/2016.

Children and Youth Involvement prior to Incident:

On 09/21/2011, YCOCYF received a GPS referral regarding the victim child and three other children. The mother was allegedly driving with the children in a van and did not have the children secured in car seats. When the police officer told the mother she could not drive with the children in the van without having them properly secured in car seats, the mother proceeded to walk down the middle of a major highway with the children. There were no other cars in the opposing lane because the officer stopped traffic to avoid any accidents. The entire incident was

recorded on the officer's dash camera. The mother was charged with child endangerment and resisting arrest. YCOCYF interviewed the mother on 09/29/2011. YCOCYF verified that the mother had car seats for the children and walked through the home to detect any other issues of concern. YCOCYF offered family group decision making but the mother declined. YCOCYF found the home and the children to be safe. The case was not accepted for service and was closed on 10/28/2011.

On 09/13/2013, YCOCYF received a GPS referral regarding the victim child's 16-year-old adopted male sibling. The referral alleged the police responded to a complaint that two teenage youths were playing with a Taser gun. When officers responded, the victim child's sibling gave police false identification. Police contacted YCOCYF and the victim child's sibling was returned to his adoptive mother. YCOCYF offered the family ongoing services. The victim child's sibling then went on the run again [REDACTED]. The victim child's sibling was located [REDACTED]. The case was substantiated and accepted for service on 09/18/2013. The victim child's sibling was placed in several different [REDACTED] homes and ran away again on 09/19/2014. The police were notified and YCOCYF remained active with the family during his run away status. The victim child's sibling turned 18-years-old on 12/17/2014. YCOCYF was able to speak to the victim child's sibling by phone [REDACTED] [REDACTED] however, he would not disclose his location [REDACTED]. On 01/02/2015, [REDACTED] and YCOCYF terminated services to the family.

Circumstances of Child Near Fatality and Related Case Activity:

The near fatality incident occurred on 02/29/2016 at the home of the 9-year-old victim child. YCOCYF was initially notified on 03/02/2016 of the near fatality. [REDACTED] contacted ChildLine on 03/02/2016 and registered the report for lack of supervision and certified the victim child to be in critical condition. When YCOCYF received the report on 03/02/2016 and reviewed it, there was no indication that the victim child was improperly supervised and at that time, all toxicology tests regarding the victim child had come back negative. YCOCYF contacted ChildLine and requested the report be decertified and registered as a GPS which was granted. YCOCYF accepted the GPS for assessment.

On 03/02/16 YCOCYF attempted contact with the family but they were unsuccessful. YCOCYF made contact with the family on 03/03/2016. YCOCYF interviewed the victim child and mother on 03/03/2016 at the hospital. The victim child was verbal and had no recollection of what happened and denied taking any medication or pills.

During the interview with the mother at the hospital on 03/03/2016, she reported that on the day of the incident, 02/29/2016, she left the home to go to her sister-in-law's house. Around 10:00 PM the paramour called the mother and said that the

victim child told him she was sick. The mother reported that she did not rush home because the victim child is quick to say she doesn't feel well. When the mother arrived home, the victim child was sleeping in her bed. The mother attempted to wake the victim child but the victim child would not wake up. The mother thought the victim child was playing a game and intentionally not waking up to trick her. The mother kept saying the victim child's name and the victim child still would not wake up. The mother reported she thought the victim child wasn't breathing so the mother drove the victim child to York Memorial Hospital around 1:00 AM on 03/01/2016. The victim child [REDACTED] and transferred to Hershey Medical Center in the early morning of 03/01/2016. During the interview the mother admitted to smoking marijuana, but denied that she had any at the home. The mother also admitted to having [REDACTED], but denied that the victim child would take them.

On 03/03/2016, the victim child [REDACTED] [REDACTED] for the child to follow-up with her primary care physician. The victim child did not require any ongoing medical treatment, and was not seen for continued medical care related to the incident.

On 03/07/2016 YCOCYF received the results of additional toxicology tests which indicated the victim child tested positive for [REDACTED] [REDACTED]. Upon receipt of the toxicology report, YCOCYF requested the incident be re-evaluated to a Child Protective Service (CPS) report based on [REDACTED] original concerns and had it re-certified as a near fatality. The mother and her paramour were identified as perpetrators at that time.

On 03/08/2016, YCOCYF conducted a home visit to follow-up with the family about the recent toxicology report that was received concerning the victim child. During this interview, the victim child indicated that she took her mother's pills. She chewed the pills and reported they tasted nasty so she drank water afterwards. She denied that anyone forced her to take them. The mother was asked what she planned to do to prevent the situation from happening again. The mother reported that she would put her medication away from the reach of the children.

On 03/10/2016, the paramour was interviewed by YCOCYF and the police. He reported that he was out with a friend and didn't remember what time he returned to the home, but it was dark outside. The paramour reported that he was not home alone with the children during the day of the incident as the mother indicated. He was out with a friend at a bar. He planned to stop by the house to use the bathroom and leave again when the victim child told him she was sick. He reported the victim child, 5-year-old twins and the victim child's 10-year-old sister were at the home alone. He then called the mother to report that the child was sick. He stayed home with the children but fell asleep waiting for the mother to arrive. He denied giving the victim child any medication that night. He reported that he did not see the victim child take any medication that night and he did not witness the

mother giving the victim child any medication on the night of the incident. He said that the mother keeps her medication in a dresser drawer.

No criminal charges were filed, and the criminal investigation has been closed. The case was unfounded by YCOCYF and closed on 04/01/2016.

On 04/07/2016, approximately one week after closing the case for the near fatality of the victim child of this report, YCOCYF received another GPS report regarding this family. The GPS report alleged that the mother left her 4-year-old grandson, 11-year-old daughter (sibling of the victim child of this near fatality report), and a 1-year-old child in the care of her paramour. The paramour reported that he did not know he was supposed to watch the children that day so he left to get something to eat, leaving the 11-year-old child home alone to watch the 4-year-old child and the 1-year-old child. Under the supervision of the 11-year-old child, the 4 year-old child and 1 year-old child were outside playing. While riding his bike, the 4-year-old child fell off, bumped his head and had a seizure. The 11-year-old child called the ambulance. After the police and ambulance arrived at the home, the paramour came home. The officer noticed that the paramour was intoxicated. Soon thereafter the mother arrived home and followed the ambulance to the hospital.

YCOCYF did not confirm whether the 4-year-old child or 1-year-old child lived in the mother's home or if the mother was just babysitting these children. At the time this referral was received, there were also 5-year-old twins and a 9-year-old female child living in the mother's home, but these children were not home during the incident. YCOCYF interviewed the mother, paramour and 11-year-old sibling of the victim child of this near fatality report. YCOCYF spoke with the mother about afterschool programs and discussed with her that the 11-year-old child should not be supervising a 4-year-old that has seizures. YCOCYF closed the case on 05/05/2016.

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;
 - The county identified their strengths to be they collaborated with law enforcement and conducted interviews with all parties quickly. Additionally, due to the collaboration of law enforcement, the medical team, and YCOCYF, there was an expedited approach for disposition.

- 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; and
 - 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:

CRO received the YCOCYF Internal Fatality/Near Fatality Review Team report on 06/21/2016. The report was reviewed and found to be an accurate summary of the investigation.

Department of Human Services Findings:

- County Strengths:
 - YCOCYF acted expeditiously to coordinate interviews with law enforcement.
 - YCOCYF demonstrated appropriate collaboration with law enforcement and medical professionals throughout the investigation.

- County Weaknesses:
 - There was an apparent lack of supervision of the children during the time of the incident that did not appear to be addressed by YCOCYF. The mother reported that she left the children home alone with her paramour. The paramour said that he was not home alone with the children the night of the incident. There was no discussion about supervision of the children when the mother has to leave home in the near future and as a result, another GPS report came into YCOCYF on 04/07/2016 for lack of supervision.

 - The victim child took [REDACTED]
[REDACTED]
[REDACTED] The mother reported that she does not take the medication any longer. There was not any notable discussion around the mother's [REDACTED]

- YCOCYF received information that 5-year-old twins lived in the home from three different people they interviewed. YCOCYF included in their Internal Fatality/Near Fatality Review Team report that there were 5-year-old twins staying in the home. The 5-year-old twins were not included on the preliminary or conclusion safety assessments.
- ██████████ called to report this near fatality into ChildLine as a lack of supervision and certified the victim child to be in critical condition on 03/02/2016. When YCOCYF received the report on 03/02/2016, they believed there was not have enough information to make it a near fatality so they called ChildLine and had it changed to a GPS report. After YCOCYF spoke with the victim child and the mother on 03/03/2016 and received additional drug screen results on 03/07/2016, they decided to re-certify it as a CPS/near fatality.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. YCOCYF was found to be out of compliance in the following area:
 - 3490.55 (a)(b) - During the 03/03/2016 interview with the mother, she reported that she asked the children in the home what happened to the victim child, indicating that multiple children were in the home. However on the 03/03/2016 safety assessment, only the victim child and her 10-year-old female sibling were included on the safety assessment. The safety of all children in the home was not assessed within 24 hours.
 - 3130.21(b) (Safety) -During the visit to the home on 03/08/2016, YCOCYF reported the 5-year-old twins were at the home, but the safety of these children was not assessed.
 - 3130.21(b) (Safety) - The 5-year-old twins were not included on the preliminary or conclusion safety assessments.

Department of Human Services Recommendations:

- YCOCYF needs to review their process in regard to safety assessments. All children in the home must be assessed for safety, not just those children who are involved with the incident report. A Licensing Inspection Summary will be issued for safety violations.
- YCOCYF received a GPS referral for a very similar lack of supervision incident one week after they closed the near fatality. This subsequent GPS case was

also closed with no further services offered. YCOCYF will need to consider doing additional reviews around their procedural processes for families who have reoccurring GPS referrals.