



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 08/29/2012
Date of Incident: 10/13/2014
Date of Report to ChildLine: 10/17/2014
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE AGENCY AT THE TIME OF INCIDENT OR WITHIN THE PRECEEDING 16 MONTHS:

Lawrence County Children and Youth Services

REPORT FINALIZED ON:

9/1/15

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:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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. Lawrence County has not convened a review team in accordance with Act 33 of 2008 related to this report, as the Child Protective Services (CPS) investigation was completed within the 30 day period.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	08/29/2012
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Biological Father of Victim Child	[REDACTED] 1984
* [REDACTED]	Biological Father of Siblings	[REDACTED] 1990
* [REDACTED]	Maternal Grandmother	[REDACTED] 1967
* [REDACTED]	Paternal Grandmother of Siblings	Unknown

*Indicates the person is not a household member

Summary of OCYF Child Near Fatality Review Activities:

The Department of Human Services, Western Region Office of Children, Youth and Families (The Department) obtained and reviewed all current and past records pertaining to the family file. The Department conducted interviews with the Lawrence County intake caseworker and supervisor on October 20, 2014 and November 10, 2014. The agency did not have an Act 33 meeting as the investigation was "Unfounded" on November 12, 2014 which is within 30 days of the date of the report. The Department interviewed the on-going caseworker on July 14, 2015.

Children and Youth Involvement prior to Incident:

A General Protective Services (GPS) report was accepted for assessment on June 3, 2014 related to the conditions of the home. It was alleged that the home was

disgusting and dirty; the children were locked in their rooms with a potty chair so they did not have to leave the bedroom; there was feces on the walls and floors; the rooms had child proof locks and baby gates to keep the kids in the bedroom and the home was infested with bed bugs. The agency rated the case at high risk and it remained high throughout the assessment. Weekly home visits, announced and unannounced, were completed and all of the children were seen at those visits. The condition of the home was improved at times, and other times showed concerning. The last home visit was conducted on July 30, 2014 and it was noted that the conditions were significantly improved. The family did not request services. The agency closed the case on July 31, 2014 as the risk was determined to be low at that time. The safety assessment deemed the children to be safe.

Circumstances of Child Near Fatality and Related Case Activity:

The agency received a CPS report on October 17, 2014 regarding the victim child. [REDACTED] Children's Hospital of Pittsburgh (CHP) stated that on October 13, 2014, the victim child presented unresponsive and was in respiratory distress. The parents had taken the victim child initially to Jameson Hospital in [REDACTED] and there she needed [REDACTED]. She was then transferred to CHP and admitted [REDACTED]. The victim child remained [REDACTED] until October 15, 2014. The toxicology screen returned October 13, 2014 positive for [REDACTED]. [REDACTED] The victim child was certified by the physician to be in serious/critical condition as a result of suspected child abuse or neglect. It was unknown how she got the medication. The victim child was expected to survive [REDACTED] in the next day or so. The parents were at the hospital and were reportedly appropriate.

[REDACTED] The agency contacted the [REDACTED] Police and followed-up in writing with a law enforcement referral. The agency contacted the mother by phone who reported that the siblings were currently staying with their paternal grandmother. The mother reported that on October 12, 2014, she and the children were at the paternal grandmother's home until around 4:00 PM when they all went back to the mother's home until around 7:30 PM; they then went to the maternal grandmother's home from about 7:30-9:00 PM. The mother left the siblings with the maternal grandmother and she and the victim child returned home. The victim child was put in her crib. The mother stated that she went to bed around 1:00 AM and about 10-15 minutes after that she noticed that the victim child's breathing sounded different so she put the victim child in bed with her. The mother stated that she woke up around 9-9:30 AM and found the victim child barely breathing. She took the victim child's temperature and it was 101. She then contacted the maternal grandmother who told her to take the victim child to the hospital emergency room. The parents took the victim child to Jameson Hospital. [REDACTED] the mother was asked and denied using drugs, including [REDACTED].

The caseworker visited the siblings at the maternal grandparent's home the evening of October 17, 2014. The home was noted to be very crowded with approximately 3-4 adults and 6 children in the home. The maternal grandmother showed the caseworker the medication bottles that were in the bathroom. All the medications were in individually wrapped packets that separate each dosage. There were over 19 medications in the household, but there was no hydrocodone. All of the medications were noted to be secured in a high cabinet.

Given the fact that the agency could not determine how the victim child got the hydrocodone, the decision was made to place her in foster care. A foster home was identified and she was scheduled [REDACTED] on October 18, 2014. The caseworker went to the hospital to pick up the victim child and the parents were both at the hospital. The father stated that the mother had the children at the maternal grandmother's home the evening of October 12, 2014 and that only the mother and victim child returned home around 9:30-10:00 PM. He stated that the victim child was put in her crib shortly after coming home; the mother went to bed around 1:00 AM, and the father slept on the couch in the living room. He stated that when the mother woke up she found the victim child having trouble breathing and that she took her temperature. The mother contacted the maternal grandmother who told her to take the victim child to the ER. The father reported that he was living in [REDACTED] but stayed at the mother's home Monday-Friday because he was employed in [REDACTED]

[REDACTED] The mother was interviewed and provided the same information that she had provided during the initial phone conversation with the caseworker. The parents were both provided with a drug test. The father tested positive for marijuana. The mother's initial test showed a possibility of amphetamines and she consented to a second test. The results of the second test did not show up on the device. The victim child was transported to a provider foster home [REDACTED]

On October 20, 2014, the caseworker visited the parent's residence in [REDACTED]. The home was observed to be in disarray with clutter all over; cigarettes, cigarette boxes, tobacco used to make cigarettes, dirty dishes, garbage, etc. The mother was drug screened and tested negative for all substances. The father showed the caseworker his medications that were located in a high cabinet in the kitchen. There were 5 separate [REDACTED] none were [REDACTED]

[REDACTED]

[REDACTED] The agency Unfounded the CPS report on November 12, 2014 as the parents deny possessing the substance given to the victim child.

[REDACTED]

The father stated that he had custody of the children Friday from 6:00 PM to Sunday at 6:00 PM every weekend during school and that his girlfriend lives in the downstairs apartment and helps him care for the children. The parents share 50/50 custody in the summer and holidays. The caseworker then went to the father's home to do an assessment. The father's home was appropriate. The sibling's father reported that the maternal grandfather [REDACTED]

The caseworker then made an unannounced visit to the maternal grandmother's home. The maternal grandfather was at the home but stated that he lived at a different address which he provided. He stated that he [REDACTED] and that they are kept in a lock box in his apartment. He denied that he ever brought any of his medications to the maternal grandmother's home. The grandmother showed the caseworker [REDACTED]

The maternal grandmother confirmed the story provided by the mother in regards to the events the evening of October 12, 2014; and the fact that the mother contacted the grandmother the morning of October 13, 2014. The maternal grandfather reported that there were frequently people coming in and out of the mother's home. The mother confirmed this.

The caseworker completed background checks on the father of the siblings, and his girlfriend and there were no records [REDACTED]

[REDACTED] the parent's attorney scheduled a hearing in custody court regarding the three older siblings. Given that the allegations made did not regard the older siblings, the judge ordered 50/50 shared custody with the father having the children during the week and the mother having the children from 4:00 PM Friday until 5:00 PM Sunday.

Weekly visits were initiated for 1 hour for the victim child and her parents, and separate weekly visits were set up for the victim child, her siblings, their father, his girlfriend and her two children with the goal of reunifying the victim child with her siblings and their father.

On October 29, 2014, the agency contacted the police officer assigned to the criminal investigation, informing him of a forensic interview scheduled for the oldest sibling [REDACTED]

The office reported no further criminal action with the case as no one could determine where the victim child got the medication. The criminal investigation was closed on October 29, 2014.

[REDACTED] The 6 year old sibling had a forensic interview [REDACTED] and was not able to be interviewed due to her attention span. [REDACTED]

[REDACTED]

[REDACTED]

The Child Permanency Plan (CPP) was developed and signed by the parents on November 13, 2014. The agency scheduled separate weekly visitation for the mother, father and victim child, and for the victim child and the parties mentioned above. The goals included visitation with the victim child, parenting, [REDACTED] maintaining an appropriate household, and participating and completing Time-Limited Family Reunification.

[REDACTED]

The agency's position was not to move forward with transitioning the victim child to the sibling's father's home after observing the interactions during visitation. It was viewed that the sibling's father had a difficult time controlling the visits with four young children.

On December 31, 2014, the agency referred Time-Limited Family Reunification which continues to date.

The agency held a multidisciplinary team meeting on January 6, 2015 at which time the Assistant District Attorney stated that there would not be prosecution on this case as there were too many people in contact with the victim child and it was not able to be determined whom was responsible for the victim child getting into the pills. Additionally, it was not determined who possessed the pills.

[REDACTED]

the victim child was moved to a new foster home, where she continues to reside. The foster parents report that she is doing very well in their care. She is not exhibiting any delays or long term effects of the medication.

Weekly visitation with the siblings and their father continued. Dictation dated February 20, 2015 states that the siblings were with their biological father during the week and had unsupervised visitation with the mother Friday from 4:00 PM to Sunday at 5:00 PM. Dictation dated February 26, 2015 stated that the caseworker told the sibling's father that he was closing his case. [REDACTED]

[REDACTED]

The parents have not completed the goals established on their plan for reunification [REDACTED]

[REDACTED] The parents have not taken responsibility for what happened to the victim child and show no emotion regarding the incident. [REDACTED]

[REDACTED] The goal for the victim child is reunification with parents and the concurrent goal is adoption.

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

The agency did not complete a near fatality report as there was no Act 33 meeting.

Department Review of County Internal Report:

An internal report was not completed as the agency submitted the CY 48 with a status determination of unfounded within 30 days of the date of report.

Department of Human Services Findings:

County Strengths:

- The agency responded quickly to the CPS report by attempting home visits at the parents' and the maternal grandmother's residence. The victim child was seen within 24 hours of the report.
- The agency completed both announced and unannounced visits at both of the parents' homes, the sibling's father's home where the siblings resided and the foster home.
- The agency completed the out-of-home safety assessment for the victim child while placed in foster care.
- The agency made efforts to collaborate with law enforcement; however law enforcement closed its investigation after only speaking to the parents.
- Supervisory logs were maintained as required during the intake investigation/assessment.

County Weaknesses:

- The agency detained the three older siblings without completing an assessment on their father and his girlfriend with whom the children had regular visitation with as the parents shared 50/50 custody. The agency did not contact the biological father until the day after custody of the children was taken. Had they assessed the father prior to this, taking custody would not have been necessary. This was unnecessary trauma for the children to endure, as they were not placed together or with their sibling.
- The sibling's father reported on October 21, 2014 that the maternal grandfather had been [REDACTED]. The agency met with the maternal grandfather at the maternal grandmother's home on the same date; however, it is not documented that this was asked of the maternal grandfather.
- There were no Release of Information forms for the parents, or maternal grandparents or their household members regarding the medications [REDACTED] [REDACTED] which could have assisted identifying exactly what medications the child had access to.
- Despite the physician's [REDACTED] that the substance would have shown up on a toxicology screen only after a couple of hours of the substance being in the system; and given the fact that the victim child was in respiratory failure due to the drug, the agency could have established substantial evidence to indicate the parents, who were the caregivers for the child from 9:30 PM the evening before, until the time the victim child was seen in the emergency room.
- One of the goals on the Child Permanency Plan (CPP) was for the parents to participate in Time-Limited Family Reunification services. The CPP was signed November 13, 2014; however, the referral for the service was not made until December 31, 2014.
- The risk assessment that must be completed at the conclusion of the intake assessment was dated October 17, 2014, which is the date of the initial report. The risk assessment needs to be completed once the facts are gathered and the assessment is completed.
- A safety assessment was not completed at the end of the intake investigation/assessment.
- The agency did not follow-up with the outcome of the custody court hearing. It is unclear if the agency provided the information to the court as required. To date, the agency has not obtained a copy to the custody order.
- A safety assessment and risk assessment have not been completed regarding the mother's household where the siblings live under the court order of the mother having 50/50 custody. The victim's biological father also resides in this home.
- There was no documentation of home visits to assure the siblings' safety while residing in the mother's home.
- The siblings' father's case was closed; therefore the agency had not been monitoring the safety of the children while they were in their mothers care.
- There was no documentation of collateral contacts being made regarding the victim child's father's [REDACTED]

- There was little documentation to support collaboration/teaming between CYS and the Time-Limited Reunification Program staff. Copies of the provider reports were not provided to the Department.
- When the siblings were placed on October 20, 2014 and returned to their father's care on October 23, 2014, the Family Service Plan (FSP) regarding the parents and siblings was due by December 20, 2014 which was never developed.

Statutory and Regulatory Areas of Non-Compliance by the County Agency

- 3490.57 (a): The agency did not comply with the Juvenile Act regarding the fact that they knew where the siblings' biological father was living. The agency failed to assess him to determine if he was a fit and willing parent [REDACTED]
- 3490.61 (c), (d), (e): The family had been accepted for services; however, the agency closed out the case on the siblings, therefore, the agency did not monitor the safety of the siblings nor did they assure that contacts were made with the children, parents and service providers. There is no evidence to support that the agency is monitoring the provision of services and evaluating the effectiveness of the services provided under the FSP.
- 3490.55 (d): The agency did not obtain a release of information to consult with the physicians [REDACTED] medication located in the parents', and maternal grandmother's home to ensure that none of the medications could result in a positive [REDACTED] toxicology screen.
- 3490.232 (f): The agency did not use the risk assessment process to aid in its assessment and to ensure that the assessment is comprehensive; to help determine the need for services; or to assist in the development of the FSP.
- 3490.321 (h) (2): The agency did not complete a risk assessment at the conclusion of the intake assessment. The risk assessment was completed the same day that the CPS referral was made (October 17, 2014).
- 3130.66 (b): [REDACTED] a FSP was due no later than 60 days from the date the children entered placement. There is no record that a FSP was developed with the mother and biological father of the children.
- 3130.21 (b): The agency failed to complete the safety assessment on the mother's household at the conclusion of the intake investigation or within the required six month interval.

Department of Human Services Recommendations:

- The agency must make efforts to assess both biological parents prior to obtaining an emergency custody authorization or attempt to locate a relative placement prior to placing children in foster care. The agency needs to review protocols established regarding this practice to ensure this becomes agency practice. The agency must provide a written plan as to how the

agency will assure this practice does not continue. The plan needs to include agency teaming efforts, supervisory and administrative oversight or quality assurance efforts in place.

- The agency needs to reevaluate the practice of closing cases on siblings when there is a need for general protective services. There needs to be protocol established regarding agency involvement and participation in custody cases. In this particular case, the agency did not seem to be aware that the parents had 50/50 custody and the siblings were at the mother's home on a regular basis. The information was not shared with the provider agency. The agency needs to establish protocols regarding collateral contacts with providers and teaming effort to develop plans with provider agencies. The protocol needs to include agency teaming efforts, supervisory and administrative oversight or quality assurance efforts in place.
- The agency needs to reevaluate its intake investigation protocols and procedures to obtain releases to ensure that collateral contacts are made with the appropriate medical providers and experts are consulted when a child has ingested [REDACTED]. The plan needs to include agency teaming efforts, supervisory and administrative oversight or quality assurance efforts in place.
- The agency needs to review its practice in completing risk assessments as required in the regulations. There needs to be supervisory and administrative oversight to ensure the risk assessment tool is utilized in the assessment process and to assist in goal development. The plan needs to include agency teaming efforts, supervisory and administrative oversight or quality assurance efforts are in place.
- The agency needs to review the agency protocol regarding the development of the FSP and the time-frames for completion. There needs to be on-going supervisory oversight to ensure the caseworkers develop the plans with the families, and that there is on-going discussion during contacts with the parents regarding their progress toward goal achievement. This needs to be documented in the file. There needs to be administrative oversight or quality assurance efforts in place.
- The agency needs to review its practice in completing safety assessments as required in the regulations. There needs to be supervisory and administrative oversight or quality assurance to ensure the safety assessment tool is utilized in the assessment process and to assist in goal development.