



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 05/15/2013
Date of Incident: 11/10/2014
Date of Oral Report: 11/14/2014

FAMILY KNOWN TO:

Lawrence County Children and Youth Services
(No prior history with Beaver County Children and Youth Services)

REPORT FINALIZED ON:

July 15, 2015

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 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, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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 child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Beaver County Children and Youth Services (BCCYS) convened a review team in accordance with Act 33 of 2008 related to this report. An internal review took place on December 11, 2014. Because Lawrence County Children and Youth Services (LCCYS) were present for and participated in BCCYS's meeting, they were not required to conduct their own meeting.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	05/15/2013
[REDACTED]	Brother	[REDACTED] 2010
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1985

Notification of Child Near Fatality:

There are two counties involved with this near fatality. At the time of the incident, the parents were residents of Lawrence County, but the incident took place in Beaver County. This family had been transient between the two counties in the months prior to the incident. In addition, the circumstances surrounding how the report was made and when are problematic. The child had [REDACTED] Children's Hospital of Pittsburgh (CHP) on November 10, 2014 with chemical burns to the inside of her mouth and lips from ingesting liquid Drano, but the report was not registered with ChildLine until November 14, 2014. The report timeline will be detailed in the "Case Activity" section of this document. BCCYS was informed of the report on November 14, 2014. As was the Western Regional Office of Children, Youth and Families. The Regional Office made contact with BCCYS to ensure they were aware of the report and to gather information regarding the report.

Summary of DHS Child Near Fatality Review Activities:

Information contained in this report was gathered from a review of the electronic records of both Lawrence and Beaver Counties, participation in the meeting that took place on December 11, 2014, and a review of Beaver County's final report on the incident. In addition, the medical report from CHP's [REDACTED] was obtained, as was a copy of the [REDACTED] news station's typed report from their website.

Children and Youth Involvement prior to Incident:

LCCYS had two reports on this family prior to the near fatality incident. The first report was for General Protective Services (GPS) and received on June 6, 2014 and was made

because the mother used heroin and the police found her passed out in the home with the children present. At that time, the father was in the home and the police determined he was not under the influence and was able to care for the children. Mother was arrested and jailed. At this time, the police also informed LCCYS that there were multiple reports with this family concerning being around meth labs. At the start of the assessment, the father was non-compliant with the caseworkers and absconded with the children. After a diligent search, the worker was able to locate the children, who were being cared for by a family friend in Beaver County while mother remained in jail. The agency inquired about safety for these children while in the friend's care. The friend advised the caseworker that she was concerned about the father, but the mother "had a letter notarized" that "granted" this friend "temporary custody" so father "could not get the children." The LCCYS caseworker provided this information to BCCYS and closed the assessment. Because the county deemed this caregiver to be appropriate, the no safety threats were identified and the children were deemed safe in her care.

The second referral was a Child Protective Services (CPS) report dated October 5, 2014. The allegation was that the female child (subject of this near fatality report) had a bruise on her buttocks from being hit by her father. At the time of the report, a home visit was conducted that same day at the maternal grandmother's home, with whom the mother and children were temporarily staying. The mother reported that the father was incarcerated. The worker did observe a minor bruise on the child and the mother did admit that the father spanked the child however the mother ran out of the home and into the woods with the alleged victim child before the worker could complete the visit. When the mother ran out of the home with her daughter, she left her son with the maternal grandmother. This visit ended and further attempts were made to contact the mother and grandmother, neither of which responded to any calls or messages left. The worker also attempted to speak with the father, who was allegedly in jail, but the caseworker learned that the father had not been in jail as reported. Messages were left for him as well; however, he never responded either. After multiple unsuccessful attempts to contact the family members and children, the agency submitted the report on October 31, 2014 as unsubstantiated. Although this referral was still active until November 14, 2014 (when the near fatality and CPS report was received in Beaver County), there are no case notes showing activity between October 31 and November 14, 2014. When the new information regarding the meth lab was received on November 14th, this referral was closed and a new one was opened.

Circumstances of Child Near Fatality and Related Case Activity:

According to the county documentation, Lawrence County Children and Youth Services (LCCYS) received a report in the evening of November 11, 2014 that the child had been flown via medical helicopter to CHP due to ingesting Drano. The reporting source saw a Facebook post about the child and contacted LCCYS. On November 12, 2014, a caseworker from LCCYS called Children's Hospital of Pittsburgh to inquire the circumstances surrounding this child's hospitalization. After obtaining a release of information from the mother, the hospital [REDACTED] called the caseworker back and informed the worker that the mother's story of how the child was injured was consistent with the injury and the medical staff had no concerns and believe CY intervention was unnecessary.

On November 14, 2014 the caseworker learned of a news story on one of the Pittsburgh stations that appeared to involve this child. The caseworker watched the video, which involved an eighteen month old child being in a home where methamphetamine was being manufactured and the child drank "Drano" and had to be hospitalized. The caseworker immediately recognized that this report involved the subject child and contacted CHP.

The caseworker spoke to the assigned social worker at CHP, who consulted with one of the physicians, [REDACTED]. The physician stated that at that time, the child's condition had improved to the point she was [REDACTED] this day (November 14th) and the information provided did not change that fact. CHP made no mention to the LCCYS caseworker of making a report [REDACTED], however, CHP made a referral later that afternoon and it was registered to Beaver County Children and Youth Services (BCCYS), as that is where the incident occurred.

When BCCYS received the report [REDACTED], there was no mention of the child's [REDACTED]. As such, Beaver County requested Allegheny County Children, Youth and Families to conduct a courtesy visit with the child at the hospital. When the Allegheny County worker went to the hospital, the child had [REDACTED], so Allegheny County informed BCCYS that the child had not been seen. As such, BCCYS contacted LCCYS and advised them that the child was not seen. As a result, a Lawrence County caseworker went to the maternal grandmother's home to make contact with the mother and child, as that is where they were residing.

The family was non-compliant with allowing the caseworker access to the home and claimed that the mother was not home at that time. The caseworker went to his vehicle to contact the police for assistance and while waiting, the mother and child were dropped off by a taxi (taken from CHP) and went into the home. Almost immediately after entering the home, the mother and grandmother walked out of the home and down the street, each carrying a child. The caseworker followed in his vehicle and tried to engage the adults, but both ran in separate directions, each with a child. The police eventually arrived on scene and were made aware of the situation and concerns for the children's safety. They agreed to contact the agency should mother be located.

On November 17, 2014 the BCCYS caseworker spoke with [REDACTED] regarding the child. [REDACTED] stated that this case met the requirements to be classified as a near fatality because the child sustained burns to her mouth from lye and had to be admitted to [REDACTED] expressed concern for lye being kept in the home, as it "is not a common item to be found in the home."

Both agencies from Lawrence and Beaver County maintained regular contact with one another to keep each other aware of the efforts to locate the mother and children. Each county worked diligently to locate the mother and children, which included enlisting the help of law enforcement agencies in the areas where she may have been staying. After numerous attempts by the LCCYS caseworker to locate the mother and children (with the assistance of the [REDACTED] Police), they were eventually located on November 20, 2014 at a crisis shelter. The mother reported that she ran from the agency because her friends told her that she should. [REDACTED]

[REDACTED] they were placed in foster care. [REDACTED]

The family members were ruled out as a placement resource because the agency had concerns that the parents would come to the home and abscond with the children, as they have already demonstrated these behaviors twice. The paternal grandfather understood the agency's concern and did not contest their decision.

On December 11, 2014 BCCYS conducted the Act 33 review team meeting, which LCCYS staff attended. A detective from Beaver County's District Attorney's office was also present for the meeting and stated that charges were imminent. However, they were being careful as to when to charge so that some charges did not negate/cause problems for other charges they were pursuing. At the time of the meeting, the Beaver County caseworker had been unable to make contact with the parents to complete her investigation. It was decided that the worker could make contact with the parents during their supervised visitation at LCCYS.

LCCYS scheduled a supervised visit for the parents on December 16, 2014. The Lawrence County worker informed the investigating Beaver County worker, who was able to attend the visit and interview both parents regarding the incident. According to the mother, she had taken the children to visit her friends and the incident occurred in their home. She was in the kitchen making "oodles of noodles" for the children and taking the food out of the microwave. While doing so, the child was behind her and had gotten into the cabinet and poured it in her mouth. The mother claimed to have witness her drink it and immediately took the child to the bathroom and washed her mouth out with water. She also stated she called 911 and the poison control center.

The mother reported that the cabinet doors were shut, but not locked. The mother also stated that what the child ingested was "commercial lye." When asked why there was lye in the home, the mother stated that her friend does "commercial laboratory work" and needed the chemicals. The lid to the container was a flip-top and not a screw off lid. The mother believed the child opened the container with her teeth "as she does that with everything."

From the information gathered through interviews with the parents and the decision of the police to charge the mother with Endangering the Welfare of Children (EWOC), BCCYS completed their CPS investigation on December 17, 2014. BCCYS submitted the report with an "Indicated" status listing the mother as the perpetrator of abuse. The father was incarcerated at the time of the incident. The family had already been accepted for service by LCCYS.

Current Case Status:

The family's case is still active with LCCYS. The mother was charged with one count each of EWOC and Recklessly Endangering Another Person. She had a preliminary hearing for these charges on March 15, 2015, but has yet to go to trial or have a

disposition. In February 2015, mother was incarcerated for other charges and is due to be released in July 2015. The mother has been visiting with her daughter every other week, with the visits taking place at LCCYS. According to LCCYS, the mother is not receiving services while in jail. The father is not incarcerated, but according to LCCYS he has not completed all of the requirements for the service plan and has also not secured stable housing. He has been moving "from place to place." The father is, however, attending [REDACTED]. For these reasons, the children are still in foster care through a private provider and having supervised visits with family.

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Beaver County Children and Youth Services convened a review team on December 11, 2014 in accordance with Act 33 of 2008. Lawrence County Children and Youth Services was also part of this team for this incident. In their internal report, BCCYS documented the following findings:

- **Strengths:**

BCCYS made contact with all agencies and parties involved.

LCCYS did place the children once they were located.

- **Deficiencies:**

CHP did not make a report of suspected child abuse / near fatality until the child was [REDACTED]. This was the case despite LCCYS informing the hospital that they were involved with the family.

Both county agencies needed to interview the parents regarding the allegations prior to indicating the report.

The local police department was unable to attend the meeting. They may have been able to provide additional information regarding the incident.

- **Recommendations for Change at the Local Level:**

BCCYS complete research training on meth labs.

Local police departments will report their concerns to CYC when they are aware children are present in homes where meth is being manufactured (as per new law).

- **Recommendations for Change at the State Level:**

The county incorporated state and local changes into one section (responses above).

Department Review of County Internal Report:

The Department received a copy of the county's internal report in January 2015. After reviewing the county report, the Department is in agreement with the issues noted, but has additional strengths, deficiencies, and recommendations. These will be described in the next section.

Department of Human Services Findings:

After a review of the documentation contained in both Beaver and Lawrence Counties' case records, the Department has identified the following:

• **County Strengths:**

1. Lawrence County CYS paid good attention to detail regarding how this child was identified as a victim of abuse. They received a report about the child and another caseworker (not assigned to the case) informed the assigned worker of a news story that sounded like the child. The worker immediately contacted CHP to make them aware of the situation.
2. The counties (all three) worked very well together for the safety of the children, especially Lawrence and Beaver Counties. Beaver received the report of suspected abuse and contacted Allegheny County for a courtesy visit with the child. When Allegheny learned the child had [REDACTED], they immediately informed Beaver, who then notified Lawrence.

Also, while the mother was on the run with the children, Beaver and Lawrence Counties remained in regular contact with each other to coordinate their efforts in locating the children to ensure their safety.

3. Both counties sought the assistance of law enforcement to ensure the safety of the children.
4. The case notes were well documented, especially those done by the Lawrence County workers. They were detailed, factual, and informative. They gave a clear account as to what transpired during the contacts and helped describe the attitude and mentality of the persons involved at that time.

• **County Weaknesses:**

1. Three different options were available to Lawrence County CYS when they learned that their child in the hospital was the same child from the news report:
 - a. LCCYS could have contacted BCCYS as soon as they realized that this child was the child from the news report and they informed CHP of this information. They could have alerted BCCYS that a CPS and possibly a near fatality report was coming their way. This could have given BCCYS an opportunity to respond to the hospital prior to the child's [REDACTED].
 - b. LCCYS could have registered the report with ChildLine as suspected child abuse, as they were aware of the circumstances of surrounding the child's injuries.

- c. LCCYS could have immediately gone to CHP or contacted Allegheny Co. CYF to make contact and ensure safety prior to the child's [REDACTED].

None of these occurred and the child [REDACTED] prior to contact and the mother subsequently was able to abscond with the child for five days.

2. In the report dated June 4, 2014 LCCYS closed the assessment because the caregiver showed the worker a "notarized statement" from the mother giving her custody. This "notarized statement" reportedly prohibited the father from getting his children from this person. This "notarized statement" was not legally binding. The father could have come at any time and this person had no legal right to keep the children from him. While she agreed to call the agency if this happened, the children would have already been turned over to his care.

These children were left in the care of a non-family member. The closing safety assessment did not include the caregiver so her protective capacities could be assessed.

3. In the CPS report dated October 5, 2014, LCCYS initially made contact with the mother and alleged victim child on the day of the report, but the mother ran out the front door with the child and was concerned with police involvement. Although contact was attempted numerous times, the report was completed / determined on October 31, 2014 and there was no case activity until November 14, 2014. No contact with the AP was ever made. The agency still had 33 more days to complete the investigation.

In addition, the preliminary safety assessment completed for this investigation does not seem to accurately reflect the situation, as no threats were found:

- [REDACTED] had an explanation of "There are no injuries to explain at this time." The case note for this contact says that the worker observed that the child had a bruise from being hit by her father. The mother admitted he hit the child.
- [REDACTED] was found not valid, but the mother ran out the front door (absconded from the home) with the child while the caseworker was in the home.
- Although the explanation for [REDACTED] says mother ran with the child, the worker did not think there was a threat to the children. It seems as though this could not be determined because mother did not allow the investigation to continue further.
- The explanation for [REDACTED] was that it was "Unknown if the children's needs are being met at this time."
- [REDACTED] This is despite the mother running out the door with the child while the worker was present. The child was not seen again until after she had ingested lye at a home where meth was being manufactured. It was also the second consecutive referral where a parent left the home (while a caseworker was present) in an effort to avoid agency intervention.

4. BCCYS completed a safety assessment for their CPS investigation.

The safety threats sections were blank and no safety decision was made for these children.

- **Statutory and Regulatory Areas of Non-Compliance:**

Based on the issues noted above, both Lawrence and Beaver County Children and Youth Agencies were out of compliance with the Safety Assessment and Management Process and will receive citations under Chapter 3130.21 (b).

In addition, Lawrence County CYS did not interview an alleged perpetrator of abuse and submitted the report with 32 days left to make contact. This citation will be cited under Chapter 3490.55 (d)(4).

The counties will receive their citations upon receipt of this report.

Department of Human Services Recommendations:

1. Because the child arrived at the hospital prior to a news report about her, the hospital was unaware of the exact circumstances that led to the child being around lye. It seems as though hospital staff (at every hospital) should have a mechanism to monitor news stations as a means to gather information where parents may not be exactly forthcoming. While it is realized that this may be difficult, if not impossible, to do it seems as though it could be beneficial.
2. Mandated reporters, including law enforcement, should be educated on the requirements to report children that have been exposed to meth labs that are known to a police department.
3. Counties should look into training and education regarding custody, i.e., which documents can be enforced. These types of documents can ensure or jeopardize safety of children.
4. Safety Assessment Worksheets (SAWS) should be used as a tool to justify the worker's decision. The explanations and decisions should be made from information gathered by the caseworker and from what's documented in the record. The safety assessments should be congruent with what is documented in the case notes. In addition, they need to be done completely, i.e., each section when required. Lastly, the supervisors that are reviewing and approving these documents need to ensure they are done accurately and completely.