



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 04/03/2012
Date of Incident: 02/26/2015
Date of Oral Report: 02/26/2015

FAMILY KNOWN TO:

Greene County Children and Youth Services

REPORT FINALIZED ON:

08/20/2015

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. 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. Greene County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on July 14, 2015.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	04/03/2012
[REDACTED]	Brother	[REDACTED] 2011
[REDACTED]	Father's Paramour's Son	[REDACTED] 2002
[REDACTED]	Father's Paramour's Daughter	[REDACTED] 2008
[REDACTED]	Biological Father [REDACTED]	[REDACTED] 1982
[REDACTED]	Father's Paramour	[REDACTED] 1984
* [REDACTED]	Biological Mother [REDACTED]	[REDACTED] 1991

Summary of DHS Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families reviewed the family's involvement with Greene County Children and Youth Services (CYS) via their electronic case management system (CAPS). In addition, the Department participated in the Act 33 meeting that took place on 07/14/2015.

Children and Youth Involvement prior to Incident:

According to Greene County CYC CAPS, there were six reports prior to this incident, dating back to March 2013. All of the prior reports were for General Protective Services (GPS) concerns and all were closed at the intake level. A summary of each report follows.

The first report, dated 03/12/2013, was made because the reporting source heard a "loud thud" and a child screaming for "20 - 30 minutes." Greene County CYC made an unannounced home visit that same day and made contact with the victim child and his brother at their mother's residence. The mother reported that the boys were "fighting earlier" and the one child slapped the other in the face, causing him to cry. The caseworker verified there was food in the home and documented that the beds in the residence were "appropriate for the children." A Safety Assessment Worksheet (SAW) was completed on 03/13/2013 which documented the children were safe. No Risk Assessment was completed. The agency officially closed the referral on 03/21/2013.

A second report on the family was received on 06/24/2013 for what was only described in CAPS as "lack of/inadequate supervision." As with the first report, the agency dispatched a worker to the mother's home on the same day as the report. The mother answered the door and permitted the worker access, however, she informed the caseworker that the children were temporarily staying with their father because she did not have a lot of food. The caseworker did not go to the father's home this day, nor did she contact him. Instead, she received reports from the father on 07/01/2013 about food concerns and domestic violence, contacted the mother that day, and then made contact with the mother and children at the maternal grandmother's home. The home visit appeared to focus on the mother having adequate food for the children and the issues between the mother and father, as they do not get along with each other. Although the original concerns were documented as lack of/inadequate supervision, this was never discussed during any contact. On 07/05/2013 the agency made contact with the mother and children at her residence and observed adequate food and the home did not present any safety threats. One last attempt to contact the family was made on 07/17/2013 but there was no answer. The agency completed a SAW for this family on 07/03/2013 that documented the children were safe at that time and the Risk Assessment rated the overall risk as "Low." The agency officially closed the referral on 07/23/2013.

The third report on this family was received on 10/25/2013 for what was described in CAPS only as "Custody issues" (no allegations of maltreatment to the children noted). The first contact with the children was made at the father's residence on 11/05/2013. The father informed the caseworker that he moved in with his girlfriend [REDACTED] on 10/25/2013, in whose house he was residing. The worker found the home to be safe and appropriate, with the father meeting the needs of the children. There was no custody agreement in place, so the father was not returning the children to the mother's care. On 11/20/2013, the mother went to the agency to drop off a release of information [REDACTED] and the caseworker noted the mother appeared intoxicated. The worker [REDACTED] contacted the caseworker that same day and stated that the mother also went to their office in the same state. The mother [REDACTED] as to the reasons for agency involvement. The caseworker gave [REDACTED] accurate information as to their concerns. The worker completed preliminary and closing SAWs documenting the children safe in father's care. The Risk Assessment was rated "Low" risk. The case was closed once again at the intake level.

A fourth report was received on 03/05/2014 for "Lack of supervision" (no further clarification in CAPS). The children were back in the mother's care on this date and the agency made contact with them on March 5th at their mother's residence. According to the mother, one of the children ran from the apartment down the hall and when she ran after that child, she left the other in the apartment alone. The worker again checked for adequate food and felt the mother's explanation sounded plausible. No concerns were noted. The SAW was completed on 03/17/2014 and documented the children safe in mother's care. The referral was closed at intake on that same day, with no Risk Assessment completed.

Another report on this family was received on 03/28/2014. The only information contained in CAPS for this referral was that the "Children were acting

inappropriately sexually with each other." This report was made by a mandated reporter [REDACTED]. This report was screened out by the Intake Supervisor with no explanation as to why.

While reading through the case notes for the previous reports, it was discovered that the agency received a phone call on 04/30/2014 that described concerns for the welfare of the children, however, this information was not entered as a new report. It was only entered into CAPS as a structured case note. According to the case note, the caller stated that one of the children (not identified) had [REDACTED] but the mother did not obtain [REDACTED] for it as ordered by the doctor. Based on the case notes contained in CAPS, the county did not make contact with the children or family until an unannounced home visit was conducted on 06/02/2014. During that home visit, the mother showed the worker the [REDACTED] for the children. Also on this day, both parents agreed to participate in Family Group Decision Making (FGDM), with the father consenting via phone. A SAW was completed for this contact and the children were determined to be safe.

After many attempts by the FGDM provider to schedule the meeting, the FGDM meeting took place on 07/26/2014. The meeting was very difficult to manage and the parents could not agree, so it was deemed to be unsuccessful. As a result, the agency accepted the family for services on 07/28/2014 due to the ongoing issues between the parents and their effects on the children. A SAW and Risk Assessment were completed on 07/28/2014 and the case was transferred to ongoing services.

After the case was accepted for services and prior to the near fatality, the agency received a report on 09/05/2014 for what was described in CAPS as a "non-accidental" burn to the finger of the same child involved in the near fatality. The agency responded immediately and completed the investigation in a timely manner. The treating physician felt the burn was consistent with a cigarette burn, but mother stated he touched the stove. The child was non-verbal and unable to state how the injury happened. The agency did not feel that they had enough evidence to substantiate non-accidental trauma, however, the family remained open for services and a Family Service Plan (FSP) was completed on 09/28/2014.

Over the next several months, the parents continued to have ongoing custody disputes and demonstrated inability for them to have an amicable relationship for the sake of the children. As a result, the agency continued to work with the family and assess safety and risk to the children. The agency assisted the parents in enrolling the children [REDACTED]. A structured case note dated 02/11/2015 documented that the worker informed the father and his paramour that they had made significant progress in alleviating the issues in their home and the case was going to be recommended for closure. The near fatality incident occurred two weeks later.

Circumstances of Child Near Fatality and Related Case Activity:

Please note that the information contained in this section was obtained from Greene County CYC's CAPS system, as well as conversations with county staff during their Act 33 meeting. The case notes for this investigation were not very detailed and lacked specific information as to how they arrived at their status determination.

According to the case record, Emergency Medical Services (EMS) was called to the father's residence on 02/26/2015 due to a two year old child ingesting up to six [REDACTED] while in the care of his father and father's paramour. The child, accompanied by his father, was transported to Ruby Memorial Hospital in West Virginia. According to hospital records, the father reported that the child "crawled on top of the counter and ate about six tabs of [REDACTED] [REDACTED] the paramour's six year old daughter. This happened approximately 45 minutes to an hour prior to arriving at the hospital. The medical report also said that upon arrival at the Emergency Department (ED), the child needed physical stimulus to stay awake. As a result, the child was [REDACTED] [REDACTED] at Ruby Memorial Hospital. The attending physician at Ruby Memorial Hospital certified the child to be in critical condition as a result of suspected child abuse/neglect.

At 6:45 PM on 02/26/2015 the on-call caseworker for CYs was informed of this report [REDACTED]. The worker and a supervisor (who happened to still be present in the building) made the determination that they would go to the hospital together. After advising the agency director of the report, the caseworker contacted the Pennsylvania State Police (PSP). PSP informed them that they were initially called to that residence, however, were cancelled by EMS because EMS was on the way to the hospital with the child. As per the case note entry, PSP advised the worker that they could not respond because they "do not have this as a case" and there were no Criminal Investigators present at the barracks at that time. The worker contacted the agency director, who then called the PSP Corporal. The Corporal advised that "if needed" they would look into the issue the next day. According to the director's case note entry, the PSP corporal informed her that they were never told that the victim of the overdose was a child. The caseworker and supervisor then left for the hospital.

Upon arrival to the hospital around 9:00 PM, the workers were advised that the parents had been gone for at least two hours. After a few minutes, the parents returned to the child's room and were upset according to the documentation. They insisted that the children were safe in their care. The worker explained that there were obviously safety concerns, as the child was hospitalized due to an overdose of [REDACTED] from lack of supervision.

According to father's paramour, she stated that she and the children were in the living room and the father was in the bathroom. The victim child said that he was thirsty and wanted milk. The paramour said that she heard the chair moving in the kitchen and she assumed he was drinking milk at the table. When she did not hear him for "a couple of minutes," she checked on him and found him with a pill bottle in his hand and "a few pills in his hand." The paramour said that the child started acting "abnormal, like really sleepy/out of it" so she called for the father and they decided to call 911. The case note documents that the [REDACTED]; however, medical records reflect [REDACTED]. The paramour stated that [REDACTED] 45 pills and [REDACTED]. When she counted the pills, there were 35 in the bottle and three in the child's hand. It was assumed he had ingested six pills and that he had moved the chair over to the counter and climbed up to reach them,

as they were on top of the microwave. The incident happened between 2:30 and 3:00 PM.

While the parents were present, the worker has making/receiving multiple calls regarding the situation. [REDACTED]

[REDACTED] it was decided to attempt to develop a safety plan for the children, as the father and his paramour refused to place any children voluntarily.

When discussing safety for the children, a plan was developed where the victim child's sibling would go to the paternal aunt's home and the paramour's children would go to their maternal grandparents' home. The workers obtained clearance information on the safety plan members and cleared the homes for the children. The workers also visited both homes in the early morning hours of 02/27/2015 to ensure the homes were safe and that the children were, indeed, in those residences. (It should be noted that the father did not allow his sons to go with their mother, as he refused her access to the victim child upon his admission to the hospital.) The SAW for this contact identified two threats to the victim child only [REDACTED]. Father's children were deemed "Safe with a comprehensive plan" and a fairly detailed and specific safety plan was developed and signed by the parents of all four children. The paramour's children were not included on the SAW, but included in the safety plan as described. On 02/28/2015, the victim child was [REDACTED] to his paternal aunt as agreed upon in the safety plan.

The ongoing worker continued to visit with the children in their respective safety plan homes and on 03/11/2015 made a visit to the father's home to ensure they took necessary steps to keep the children from accessing [REDACTED] in the future. During the March 11th visit, the father showed the worker that an alarm was put on the laundry room door, which is off of the kitchen, and the [REDACTED] will be kept in a keyed lock box, with the key being kept in a separate location. There is now a safety gate blocking off the kitchen as well. The father inquired when the children could return but the worker did not provide a timeframe at that moment.

[REDACTED]

On 03/20/2015 the father's paramour advised the agency that she and the father would be taking a [REDACTED] safety course being offered in April 2015. Also on this day, the paramour explained that she had started to attend [REDACTED]. She was also going to inquire about [REDACTED]. In another phone call on 03/31/2015 the paramour said that she registered for a parenting class called "Raising Youth in the 21st Century."

A new SAW was completed on 04/01/2015 due to "New Information," however, the case notes were unclear as to what exactly the information was that generated this worksheet. This safety assessment continued to list the children as "Safe with a comprehensive plan" [REDACTED]. The plan that had the children residing with family members remained in effect.

The agency continued remained open with the family and maintained contact with the parents and children through April 2015. The children remained on a safety plan throughout that time period. It should be noted that on five separate occasions between 03/24/2015 and 04/15/2015 the father's paramour contacted the agency and inquired when her children were going to be returned to her care and actually asked for their return at least twice. [REDACTED]

[REDACTED] The children remained in the care of the informal caregivers as described in the safety plan. This is also the last safety assessment completed on the family according to CAPS.

On 04/24/2015, the agency completed the CPS investigation for this incident by submitting and "Indicated" status determination [REDACTED] that listed both father and his paramour as the perpetrators. The ongoing worker for the family was also the worker to complete the CPS investigation. The narrative stated that the victim child was able to open the child proof bottle on his own. Although this was not included in a case note, this writer was made aware of this information at the Act 33 meeting. The lack of detail in this narrative will be reviewed in a later section of this document.

Also on 04/24/2015 father's paramour contacted the agency and informed them that she and the father were no longer together and that she was going to continue to have her children reside with her mother because the paramour's electric was shut off. She also reported that the father's children were going to continue to live at the paternal aunt's as per the safety plan.

Post-Incident Status:

The agency continued working with the family to help resolve the issues in the home and those that came up after their determination (i.e., mother's lack of housing, utility issues, etc.) and the ongoing disputes between the biological parents and, later, the father and his paramour.

Although there is no dictation entry showing a safety plan was lifted, the paramour's mother contacted the agency on 06/01/2015 and informed the caseworker that her daughter removed the children from her care that day and she was unsure where she was going to stay with them. The caseworker attempted to contact the paramour via her cell phone but was told that it was "disconnected." The paramour called the agency the next day (June 2nd) and gave the worker an address where she and the children were residing.

On June 6th, the paramour contacted the agency to inquire about taking the children to [REDACTED] and told the caseworker that fielded the call, not the assigned worker, that the safety plan was "lifted" on 04/27/2015. A supervisor advised the worker that the children could leave the state with their mother [REDACTED]

On 06/15/2015, the Family Service Plan was reviewed with both parents. Attempts to see the father's and paramour's children at their respective residences were made on 07/07/2015 but these attempts were unsuccessful. According to the documentation contained in CAPS, the last contact with the victim child and his sibling occurred on 06/10/2015 and the last contact with the paramour's children took place on 04/09/2015. The dictation is deficient in the fact that it does not give the status of any safety plan (if any), the current location of the children and their respective caregivers, etc. Any and all of the deficiencies will be outlined in the appropriate section of this document.

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

Although the county conducted an Act 33 meeting as required, this did not occur in the required timeframes. In addition, the meeting did not contain the necessary participants to have a true multidisciplinary approach. In attendance were the agency director, the assigned ongoing caseworker, the supervisor for the case, Western Regional staff, a staff member from [REDACTED], and the director of [REDACTED]. The director acknowledged that there were obviously deficiencies with how this case was handled; however, no report has been submitted to the Department to this date.

Department Review of County Internal Report:

As stated above, the Greene County CYS just conducted their Act 33 meeting on 07/14/2015, which was well outside the required timeframe. To this date, no report has been provided to the Department for review.

The Western Region staff contacted the director that as a result of the deficiencies found and noted with this investigation, the agency would be receiving citations in a Licensing Inspection Summary (LIS) and they would be required to complete a Plan of Correction.

Department of Human Services Findings:

• County Strengths:

- The county responded immediately to the report of suspected child abuse and notified the police of the incident. The workers went to the hospital to interview the father and his paramour and also visited the homes of the informal caregivers in the middle of the night to ensure they were safe and appropriate homes.

- The agency identified a need to protect the children in this home [REDACTED]

- The agency verified what pill bottles were given to the family and also verified that the child could actually open a safety cap by asking him to do so.

- The agency identified a need for General Protective Services with this family and accepted them for service prior to this incident. FSPs were completed with the family on a timely basis.
- The staff in the agency maintained open communication, which included caseworkers, supervisors, the director, and solicitor.
- The agency used safety planning for all four children in this home.
- County Weaknesses:
 - On 03/28/2014, the agency received a report of the children sexually acting out with one another and it was screened out by the intake supervisor with no explanation. This should have been assessed to explore what behaviors the children were displaying, if those behaviors were abnormal for their age, and where they learned those behaviors. With reports such as this, children are often victimized and act out what has happened to them. An assessment of these behaviors would have been beneficial to assess and ensure safety.
 - On 04/30/2014, the agency received a report that the children had "MRSA" and the mother was not providing them [REDACTED]. The first documented contact with the family was 06/02/2014 (32 days after the report was received). In addition, this report was not entered as a new referral in CAPS even though the agency closed the family at intake on 03/17/2014.
 - Although the family was accepted for service on 07/28/2014, according to the documentation contained in CAPS there was no contact with the victim child and his brother between 11/06/2014 and 01/08/2015. This is a 62 day span of no contact with children ages 2 and 4. During this time period, the boys were residing with their biological mother.

In addition to this, according to the documentation contained in CAPS the paramour's children also have gaps in when contact was made with them. It appears as though these two children (ages 6 and 12) were seen on 07/26/2014, but not again until 02/26/2015. The children were again seen on 04/09/2015 but not again until 06/01/2015. The case notes end on 07/07/2015 and there are no contacts documented with these two children since June 1st.

 - The two children referenced above also did not appear on any safety assessments or risk assessments until April 2015. This includes the safety assessment that placed all four children on a safety plan with respective

informal kinship caregivers. The paramour's children were deemed safe with a comprehensive plan and put on a safety plan, but there is no SAW to document the threats to them.

- The four children in this case were all placed on a safety plan dated 02/27/2015. As per the safety plan, the victim child and his brother stayed in one informal kinship home and the paramour's two children in another kinship arrangement. [REDACTED] at that time as the parents were in agreement with the arrangements.

However, between 03/24/2015 and 04/15/2015 the father's paramour contacted CYS and requested her children be returned to her care. The county never returned the children to her care, [REDACTED]

- The agency did not complete risk and safety assessments on the children when they were returned to their respective homes. Whether planned or unplanned, assessments must be completed in certain timeframes (each with different timeframes). The case notes never really document whether it was planned or not, nor is there an exact entry as to when any children were returned to their parent.
- Although initial attempts to involve law enforcement in this investigation were made, it does not appear that any follow-up occurred to inquire if they received the report of suspected abuse and whether or not they were investigating. According to the case notes, it does not appear that anyone contacted PSP after those initial days.
- The agency submitted the investigation with an "indicated" status on 04/24/2015 listing both the father and his paramour as the perpetrators. There are two issues with the determination:
 1. The "Category of Abuse/Neglect" states that it is Causing Bodily Injury To Child Through Recent Act/Failure To Act. The "outcome explanation" states that "the agency finds this case meets the CPSL requirements regarding Physical Abuse (Causing Bodily Injury To Child Through Recent Act/Failure To Act). This appears to be the incorrect form of abuse. Causing bodily injury means that the parents knowingly, recklessly, or intentionally gave the child enough medication to cause him to overdose on it. This should have been categorized as "Serious Physical Neglect."

2. The "Outcome Explanation" does not explain exactly why they believe it meets the criteria. From all accounts, the parents had the [REDACTED] up on a counter or microwave and the [REDACTED] was in a childproof container. Although it was never documented in the case record, the caseworker informed this writer that she provided the child with a childproof medication bottle and the child was able to open the bottle on his own. According to the case record, the parents were not asleep, nor were they under the influence of any substances when the incident occurred. The father was in the bathroom and the paramour was in another room when the child walked out of that room and into the kitchen where the medication was kept.

- The agency did not have an Act 33 meeting in a timely manner and it seems as though they were not aware of the process when they were contacted for an update on their report. In addition, agency staff was unable to answer specific questions regarding the incident and investigation, such as how they felt it met the criteria for the report, was the paramour aware that the father was in the bathroom, how long was he in there, etc. The agency staff also seemed to be unclear as to why the assigned ongoing worker completed the investigation instead of an intake worker and was not exactly sure if there was a policy in place for such circumstances and what the policy stated.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency
The agency was found to have violated the following statutes and regulations with this family's case, all of which will be outlined in a Licensing Inspection Summary (LIS):

- 3130.21 (b) related to the Safety Assessment and Management Process (SAMP) and Act 33
- 3490.232 related to Receiving reports and assessing the need for services
- 3490.321 (e), (f), (h), and (j) related to Risk Assessment
- 3490.55 (e) related to written documentation of all of the facts obtained from interviews
- 3490.235 (g)(2) related to contacts with the children
- 6324 (1) of the Juvenile Act related to Taking Into Custody
- 6351 (a) and (b) of the Juvenile Act related to Disposition of dependent child

Department of Human Services Recommendations:

- Greene County CYs should continue the practice of prompt responses to any CPS report received by their agency. In addition, attempts to involve law enforcement from the onset of an investigation should still occur.
- Based on what is contained in this case record, closer supervision of what is occurring in cases is needed. There are extensive gaps in contacts with children,

SAWs and Risk Assessments that were improperly completed yet approved by supervisors, and case notes incomplete or missing from the record. Supervisors must be comfortable enough in their role as teachers to provide constructive criticism, set deadlines for work to be completed, and not accept work that is not done correctly or is done inadequately.

- Greene County CYS, as well as other county Children and Youth agencies, need to become familiar with the policies and procedures as they relate to Act 33. This includes knowing what is required to happen and when it is required to take place, and who must be part of the process. As the process has just been officially finalized, now is an appropriate time to ensure this happens.
- Greene County CYS could benefit from some form of refresher for Safety and Risk Assessments, as there were multiple errors in both of these processes. The refresher should cover who is to be assessed, when assessments are done, etc.

In addition, the safety planning process needs to be reviewed as well. Although the plan put in place was appropriate, it is no longer applicable when a parent requests a change in the developed plan. At that time, other arrangements must be made. When a parent demands their children be returned while a safety plan is in place, the agency only has two options available to them: Return the children or obtain protective custody.

- Greene County CYS should work collaboratively with their court system to develop a protocol for seeking emergency protective custody after hours, on weekends, holidays, and in the event a Judge is unavailable.
- Closer attention should be paid to all reports that are made to the agency. One report of the two youngest children sexually acting out was "screened out" by the intake supervisor with no justification entered into CAPS. In addition, another call to the agency was made alleging the children had [REDACTED] but it was not entered as an intake or new information. It was added to the case notes and as a result, the children went over 30 days before anyone made contact.