pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/05/2012
Date of Date of Incident: 02/16/2016
Date of Report to ChildLine: 02/17/2016
CWIS Referral ID: [redacted]

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

Franklin County Children and Youth

REPORT FINALIZED ON:
8/25/2016

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.

Franklin County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/17/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	victim child	06/05/2012
	sister	[redacted]2013
	mother	[redacted]1994
*	father	[redacted]1990
*	friend of mother	17
*	friend of 17 year old	19

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children Youth and Families participated in the County Internal Fatality Review Team on 03/17/2016. Prior case history, medical reports were obtained and meetings with staff were held.

Children and Youth Involvement prior to Incident:

On 05/30/2015 Franklin County Children and Youth received a General Protective Services (GPS) referral regarding the living conditions of the mother and 2 children. The referral was in regard to the home being trashy, no food in the home, [redacted] needles are lying around. The agency conducted an unannounced home visit of the mother on 06/02/2015 and found clothes on the couch, food in the home and no needles lying around. The agency conducted another unannounced

home visit on 06/11/2015 and found no issues other than the home still being messy. The mother explained that she tries to stay on top of cleaning but the children are active. The agency conducted a 3rd unannounced visit on 06/18/2015. The home was cleaner and there were no other environmental issues and therefore the case was closed on the same date.

The agency received another General Protective Services referral on 09/18/2015 regarding the children not being cared for by mom and mom not taking the children to the doctors as needed. An unannounced home visit occurred on 09/22/2015 as the mother was leaving and could not speak to the worker. Another visit was scheduled for 10/07/2015. The mother admitted to being behind on immunizations due to not having a car but recently purchased one. She did obtain an appointment at the doctors to get the needed immunizations. She signed releases of information for the worker to obtain the children's medical records. The home was messy and mom was requesting help in obtaining a bed for the victim child as he broke his. Mom received information on who to contact in the community for a bed. Caseworker followed up with doctor's office who confirmed that the children did receive their immunization, there are no other medical concerns and the case was closed on 10/20/2015.

On 10/23/2015, there was a General Protective Services (GPS) referral naming the paternal grandfather as the alleged perpetrator for injuring the victim child's sister. The alleged perpetrator was attempting to pull the child away from the mother during an argument. The child had no injuries and the case was closed on 10/30/2015.

On 02/03/2016 the agency receive a General Protective Services referral regarding unstable housing of the mother and children. The mother dropped the children off at their paternal grandmother's home as she often cares for the children, while the mother left for New Jersey. The mother had not returned and the paternal grandmother called the agency to inform them that she will keep the children until a plan is developed. The caseworker called the mother and left a message to call her back. On 02/12/2016 the mother called the caseworker to inform her that her fine was paid in New Jersey (unknown what fine was for) and that she will get the children on 02/13/2016. The children returned home with the mother on 02/13/2016. On 02/15/2016, the caseworker contacted the mother to schedule a visit and the mother agreed for some time during the week. On 02/17/2016 the agency receive the near fatality report.

Circumstances of Child (Near) Fatality and Related Case Activity:

The agency received the referral on 02/17/2016 from [redacted] The date of incident was 02/16/2016. At approximately 7:30-8:00 pm, the victim child's mother was giving him and his 2 year old sister a bath. There was about 6 inches of water in the bath tub. The mother left the bathroom to get more soap and was gone, according to her, for about 10 to 15 seconds. During that time a 17 year old friend of the mother, who was visiting her, went into the bathroom to check on the children. At that time she found the victim child under water. The other child was

upright and fine. The victim child was unconscious. The male 19 year old friend attempted CPR while the mother called 911 for an ambulance. The child was [redacted] and transported by ambulance to Hershey Medical Center where he was [redacted] The child made a full recovery and [redacted] on 02/22/2016 to the maternal grandfather. The child will be seen periodically by his pediatrician to assess any possible complication. There would be no further follow up with Hershey Medical Center unless unforeseen problems occurred.

Law Enforcement and Children and Youth staff interviewed all parties present in the home at the time of the incident. Based on those interviews, it was determined that the child may have been left alone for less than 1 minute and that the incident could have occurred within 15 seconds. The CY 48 was submitted on 03/29/2016 with a status of unfounded.

Upon receipt of the report, a safety plan was put into place for the victim child's sibling with a family friend who was assuring no unsupervised contact between the children and their mother. This safety plan was updated as time progressed to include a maternal aunt and maternal grandfather as supervisors of contact between mother and child.

Shortly after [redacted] the hospital, the child's father picked up the kids for a visit and never returned the children as there was no custody order. The father obtained an emergency protective custody order and then a custody arrangement was made via civil court. The father obtained full custody and mother was awarded supervised visitation. The father lives with his mother and father; the home is stable and free of safety threats.

The agency opened the family for General Protective Services. [redacted] began in the home shortly after the father obtained custody. [redacted] The agency is currently seeing the children at least once monthly to assess their safety and well-being. The victim child has not had any medical concerns as a result of this incident since he [redacted] the hospital.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

  The county agency investigation complied with regulations and response times as required.

- Deficiencies in compliance with statutes, regulations and services to children and families;

  The county agency report did not reference any deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

  The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  The county agency report did not mention any recommendations for change at the state or county level.

Department Review of County Internal Report:

The county report was received on 05/19/2016. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

  Upon review of the documents associated with this case, it would appear there is a positive working collaboration between law enforcement, medical facilities and the county agency.

- County Weaknesses:

  The circumstances of this case and the review of the county's work did not identify any systemic weaknesses.

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

  There were no areas of non-compliance found during the review of this case.

Department of Human Services Recommendations:

The Department concurs with the findings from the Franklin County Children and Youth's Act 33 meeting and the case determination.