



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/18/2013
Date of Incident: 03/30/2016
Date of Report to ChildLine: 03/30/2016
CWIS Referral ID: [REDACTED]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Armstrong County Children and Youth Services

REPORT FINALIZED ON:
08/28/2016

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.

Armstrong 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 04/27/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	07/18/2013
[REDACTED]	Biological Mother	[REDACTED] 1995
[REDACTED]	Mother's Paramour	[REDACTED] 1991
* [REDACTED]	Victim Child's Caregiver (Step-Mother of Mother's Paramour)	[REDACTED] 1978
* [REDACTED]	Caregiver's Daughter	[REDACTED] 2000
* [REDACTED]	Caregiver's Daughter	[REDACTED] 2002
* [REDACTED]	Caregiver's Husband	[REDACTED] 1966

*Denotes this individual was not a household member of the victim child's residence.

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) obtained and reviewed all current records pertaining to the [REDACTED] family. WRO staff conducted an interview with the Armstrong County Children and Youth Services intake supervisor on 04/12/2016 and 04/25/2016. WRO staff also attended and participated in the Multi-Disciplinary Investigation Team (MDIT) meeting that occurred on 04/27/2016, in which medical professionals and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

The agency received a report on the mother's family in 2011 when she was 15-years-old that she had gotten a tattoo and tried to run away from home. The agency did not accept the referral for investigation as there were no allegations of abuse or neglect. There has been no previous involvement with the victim child.

Circumstances of Child Near Fatality and Related Case Activity:

Armstrong County Children and Youth Services received a Child Protective Services (CPS) report on 03/30/2016. This CPS was reported [REDACTED] [REDACTED] stating the victim child was a 2-year-old previously healthy child who was transferred to CHP from Armstrong Hospital on 03/28/2016. She presented at Armstrong Hospital due to a change in mental status after ingesting [REDACTED] at the mother's boyfriend's step mother's (caregiver) home. The victim child [REDACTED] after ingesting [REDACTED] at the caretaker's home. The physician certified the victim child to be in serious condition; hence, the report is an Act 33 near fatality investigation.

Armstrong County contacted the victim child's mother within 2 hours of receiving the report and the mother reported that the victim child [REDACTED] to her care. The caseworker made arrangements to meet the family at their home at 7:00 PM that evening. [REDACTED] accompanied the caseworker to the visit and joint interviews were conducted to gather information surrounding the incident.

The mother stated she left for work on 03/28/2016 at 7:15 AM and left the victim child with her paramour. The paramour received a call from his boss asking him to come into work early. At approximately 8:10 AM, the paramour put the victim child in her car seat and drove her to his step-mother's residence and dropped her off around 8:30 AM. The paramour stated he arrived at his step-mother's home at 5:13 PM to pick up the victim child. He reported that the victim child appeared to look really tired and was lying on the couch. The step-mother reported that the victim child had not taken a nap, so the paramour stated that he initially thought that she was tired. He reported that she slept in the car seat on the way home. He explained that she was acting "sluggish" and she laid on the couch when they got home.

The mother reported that when she arrived home around 6:00 PM, the victim child was asleep on the recliner; further, she tried to wake her up because she did not want her to sleep too long or she would not want to go to sleep at bedtime. The mother described that the victim child was "limp and lethargic" and she could not wake her up so she put her in the bathtub and the child could not open her eyes the entire way. This is when the mother knew something was wrong and she and the paramour transported the victim child via car to Armstrong Hospital around 6:30 PM. The mother reported that while in the car, the victim child's breathing became "difficult and irregular" and she became "unresponsive". When they arrived at the Emergency Room (ER), the mother carried the victim child into the waiting room and told the medical staff that she needed immediate attention. At this point, the victim child was [REDACTED]. The victim child was then transported by life flight to CHP at which time she was admitted [REDACTED].

The mother and her paramour were asked if they were aware of any medications that the caregiver takes. They were not aware of specific medications, but stated that they were aware that she had medications that were typically lying on the table. The mother's paramour also reported that his two half-sisters ages 14 and 16 were at home on spring break when the caregiver was watching the victim child. The mother reported that the victim child has no pre-existing medical conditions and that the only recommendation made by CHP was for the child to follow-up with her Primary Care Physician (PCP). The mother also reported that she is no longer planning to allow the caretaker to babysit the child. The caregiver's home was described as "cluttered" and "abnormally messy". This caregiver was only watching the victim child every other Monday as the child attends day care on Wednesday and Friday and stays with a great-aunt on Tuesdays and Thursdays. On the opposite Mondays, the paternal great-grand mother watches the child.

The mother signed Releases of Information (ROI) for the agency to obtain the medical records for the victim child. A photo of the victim child was taken and the agency deemed that there were no health or safety concerns related to the mother's care and home environment. The caseworker attempted to gather information on the biological father, and the mother refused to provide the information, reporting that she does not know who the biological father is.

On 04/01/2016, the agency received the CHP medical records regarding the victim child's

[REDACTED]

At 11:00 AM on 04/01/2016, the caseworker and [REDACTED] Trooper conducted a joint interview with the alleged perpetrator who was in the caregiver role at the time the victim child ingested [REDACTED]. The alleged perpetrator reported that the victim child arrived at her house around 8:30 AM on 03/28/2016 at which time the child reportedly played with her toy kitchen and the alleged perpetrator read books to her until around 10:00 AM at which time the alleged perpetrator put on a movie for the child to watch. The alleged perpetrator reported that her 16-year-old daughter left the home around 11:00 AM. Prior to leaving the home, the 16-year-old put make-up on the victim child. The alleged perpetrator's husband left for work between 11:00 AM-12:00 PM. She then fed the victim child pancakes for lunch and the 14-year-old ate lunch with them. The alleged perpetrator reported that the victim child fell off of a sit and spin around 1:00 PM, but reported she seemed fine and did not cry. At this point, the 14-year-old went to her room for the afternoon. The alleged perpetrator stated she and the victim child played most of the afternoon and watched another movie around 3:30 PM. Around 4:00 PM, the victim child ate pierogis and had a juice box. The victim child then climbed up on her lap in her chair around 4:30 PM. She reported that she and the victim child talked and she remembers having a conversation with the mother's paramour when he picked the child up related to the child being tired because she did not take a nap.

The alleged perpetrator reported that the mother's paramour contacted her around 6:00 PM to tell her that the child was acting abnormally tired and asked if anything happened during the day that would have caused this. The alleged perpetrator told him about the child falling off the sit and spin and the child was complaining of her ear hurting earlier in the day. The alleged perpetrator stated she got a call around 6:30 PM that the victim child was being taken to the Emergency Room. At 7:47 PM, the alleged perpetrator reported getting a call from the Armstrong Hospital asking her what medications were in her home and around 10:50 PM a call from the mother's paramour requesting more information related to the child's fall off the sit and spin.

The alleged perpetrator provided the caseworker with a list of medications [REDACTED]. The alleged perpetrator also reported that her daughter [REDACTED]. The alleged perpetrator reported that her child [REDACTED]. Her daughter will take her own [REDACTED], but the alleged perpetrator stated that she sometimes needs to remind her to do so. The alleged perpetrator reported that she and her daughter have [REDACTED] and that [REDACTED] were stored in a bag pushed back on the table with figurines in front of it. The alleged perpetrator denied that the child left the first floor as she was contained to the kitchen, living room and kitchen and that the child was never alone with her daughter.

On 04/11/2016, the caseworker went to the alleged perpetrator's home to speak to her and her daughter regarding [REDACTED]. The daughter denied giving the victim child [REDACTED] but stated that she may have dropped one on the floor as she reported that she takes [REDACTED] in the living room. The caseworker took photos of the home which was cluttered and appeared to be in disarray. The alleged perpetrator showed the caseworker where the bag [REDACTED] had been kept and the caseworker noted there was a Ziploc bag [REDACTED] on the back of the end table in the corner of the living room. There was a large wolf statue and a snow globe in front of the bag which was there to keep the victim child out [REDACTED]. Since the incident, the alleged perpetrator keeps all [REDACTED] in a lock box. [REDACTED]

This incident happened on a Monday. The caseworker observed [REDACTED] bottle [REDACTED].

The caseworker conducted another home visit to see the victim child on 04/13/2016 and the child was deemed safe at that time.

On 04/27/2016, the agency held a Multi-Disciplinary Investigative Team (MDIT) related to this case. The interview information was presented as well as the medical information related to the investigation. After the facts were presented there was a discussion related to the CPS outcome. It was determined that the child did ingest [REDACTED], but there was no evidence to support that the incident occurred

intentionally. On 04/27/2016, the agency submitted the investigation summary with an unfounded determination due to the conclusion that the ingestion was accidental, and did not occur intentionally, knowingly or recklessly. It is believed that the victim child found the small pill on the floor and ingested it. The mother decided at this point that the child would no longer have contact with the alleged perpetrator or go to her home; therefore, the agency closed the case on 04/27/2016.

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

The agency did conduct a MDIT meeting on 04/27/2016, but the CPS report was unfounded prior to day 30 so the agency did not write an internal report related to strengths, deficiencies or recommendations for change at this time as it is not required under Act 33 given the above information.

Department of Human Services Findings:

County Strengths:

The agency responded to the report by seeing the victim child within 2 hours of receipt of the CPS report.

The agency collaborated with PSP by completing joint interviews with the mother and her paramour the evening the report was initiated as well as with the alleged perpetrator as part of the investigation.

The agency obtained and reviewed the victim child's medical records related to this incident. This was noted in the caseworker dictation as well as the supervisory logs.

The supervisory logs were maintained every 10 days as required during the investigation and the logs were detailed and contained information related to the safety of the child, the services provided, the interview details, review of medical information and next steps for the caseworker.

The agency completed the investigation within 30 days.

County Weaknesses:

No weaknesses were identified.

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

No statutory or regulatory areas of non-compliance were identified.

Department of Human Services Recommendations:

The Department recommends that there be public service announcements related to reminding those on medications to keep them stored in an area that is not accessible to small children. There has been an increase in the number of young children ingesting prescription medications that have resulted in many near fatalities and fatalities. It is also recommended that pharmacies be required to label the medications regarding safe storage when there are young children in the home.