pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 8/30/11
Date of Incident: 10/19/13
Date of Oral Report: 10/20/13

FAMILY NOT KNOWN TO:

Lancaster County Children and Youth Services

REPORT FINALIZED ON:

8/28/14

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, DPW 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. Lancaster County Children and Youth Services have convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	victim child	8/30/11
	biological mother	[redacted]/88
	maternal grandmother	[redacted]/61

Notification of Child (Near) Fatality:

On October 20th 2013, Lancaster County Children and Youth Services received a Child Protective Services (CPS) report on the child regarding lack of supervision. The child had ingested a combination of [redacted] medication at some point during the evening of October 19th 2013. At the time of incident the child was in the care of his maternal grandmother while his mother was at work. The child was able to get into the pill container, located in the grandmother's bedroom on top of a dresser. It was reported the child ingested four pills a combination of [redacted]. Upon notice of the incident the maternal grandmother contacted the victim child's mother at work. The child's mother works third shift hours. The victim child was taken by a family member to the mother's work. Maternal grandmother did not have transportation. The victim child's mother transported the child to Lancaster Regional Hospital on October 20th 2013. The child presented to be lethargic and non-responsive. The child was transferred to Lancaster General Hospital on the same date for further care and treatment [redacted] registered the report as a near fatality on October 20th 2013 due to the condition of the child. The hospital did not have concern of mother's care however, did have concern for the maternal grandmother's ability to provide adequate supervision of the child. There was conversation between the medical staff at Lancaster General Hospital and the mother regarding ensuring medication is locked and out of reach of the child. The child's mother understood however she had concern for grandmother's ability to follow through with the request as she can be stubborn. The county children and youth agency followed standard [redacted] regarding the investigation.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records pertaining to the [redacted] Family. Follow up interviews were conducted with the county agency caseworker [redacted], supervisor [redacted], intake director, [redacted] on October 20th 21st 23rd, November 4th 2013 and December 27th 2013. The Regional Office participated in the County Internal Fatality Review Team meeting on November 13th 2013.

Children and Youth Involvement prior to Incident:

N/A, the family was not known nor had involvement with the county agency prior to the county's investigation of the near fatality.

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

On October 20th 2013, Lancaster County Children and Youth Services received a [redacted] report on the child regarding lack of supervision. The child had ingested a combination of [redacted] medication at some point during the evening of October 19th 2013. At the time of incident the child was in the care of his maternal grandmother while his mother was at work. The child was able to get into the pill container box, located in the grandmother's bedroom on top of a dresser. The child was able to reach the pill container by climbing on the bed which placed the pills within reach. It was reported the child ingested four pills a combination of [redacted]. Upon notice of the incident the maternal grandmother contacted the victim child's mother at work. The initial report is that the maternal grandmother may have not been providing appropriate supervision or in particular was sleeping at the time of incident. The child's mother works third shift hours. The victim child was taken by a family member to the mother's work. Maternal grandmother did not have transportation. The victim child's mother transported the child to Lancaster Regional Hospital on October 20th 2013. The child presented to be lethargic and non-responsive. The child was transferred to Lancaster General Hospital on the same date for further care and treatment.

The child was treated for symptoms of poisoning. The child was unresponsive and difficult to arouse. The child was [redacted] The child initially was [redacted] on October 20th 2013; however the child's condition was still questionable. The child was still displaying lethargic responsiveness; [redacted] on October 22nd 2013. The child's mother was cooperative with county children and youth agency as well as law enforcement. Lancaster County Children and Youth Services developed a safety plan for the victim child. The plan was that the maternal grandmother would not have unsupervised contact with the child during the investigation. There was not concern for the child in the care of his mother as the reported incident took place when the child's mother was at work. The mother had issues with being able to find childcare for her child while she was at work due to her work schedule being in the

evening. The mother mentioned that she and her mother were not always in agreement with parenting or supervision practices however the mother did not have many choices for appropriate child care. During the investigation the victim child's mother took time off work and was with the child during his hospital stay. Upon discharge the child's mother remained at home with the child. The county children and youth agency and law enforcement conducted and completed the investigation. Law enforcement closed their investigation and determined the incident to be an accident. The county children and youth agency unfounded their investigation on December 17th 2013. The county agency did [redacted]

Current Case Status:

Lancaster County Children and Youth Services opened the mother and child for services in December of 2013 within the agency's Family Support Services Unit. The agency provided services for the child and his mother. The mother was cooperative and in agreement for services. The two main areas of focus was the county agency provided referral [redacted]. In addition the county assisted in helping to enroll the child into [redacted]. The county has continued to monitor the case. In a discussion with the county agency caseworker on 6/10/14 [redacted] The county agency has not had any concerns for the care of the child during agency involvement.

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

Strengths:

The county report identified the following strengths. The county requested medical records from Lancaster General and the child's primary care physician in a timely manner. The county children and youth agency informed DPW, OCYF Regional office of the report once received.

Deficiencies:

The county's report referenced issue with ability to obtain appropriate daycare for parents who may work non typical working hours. There was also mention of medicine not being in a locked container or stored out of child's ability to reach. The report also made reference that the county agency did not receive the report initially by the hospital. The child was seen by Lancaster Regional Hospital then transported to Lancaster General Hospital. The incident was reported to the county agency on October 20, 2013 by [redacted]. The report also referenced as precaution emergency services should have been contacted and the child should have been transported from the home to hospital via ambulance rather than having a relative drive the child to mother's work and subsequently having the mother transport the child to the hospital.

Recommendations for Change at the Local Level:

The report referenced a few options which could be utilized as a mechanism for change. The report referenced having a public service announcement in the area of disposal and storage of medicine. Inquire with pharmacies in the community if they would be willing to place pamphlets in medication bags on the subject of medication safety around children. In addition community outreach with local hospital Lancaster General Hospital to inquire if a representative might be interested in meeting with the county safety team to further discuss and provide information on medication safety.

Recommendations for Change at the State Level:

The report was nonspecific regarding this area; however some of the information referenced above in the local level section could easily cross over to the State Level especially public service announcements on the subject of children and medication safety.

Department Review of County Internal Report:

The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case. Due to the circumstances of this particular case there are no areas to dispute or concur with the identified report.

Department of Public Welfare Findings:

County Strengths:

The county children and youth agency and local law enforcement had good collaboration conducting the investigation. Post investigation the county agency was willing to assist the child's mother in finding and acquiring [redacted] for the child.

County Weaknesses:

The review of the case materials associated with this particular case did not substantiate any major weaknesses associated with the county children and youth agency.

Statutory and Regulatory Areas of Non-Compliance:

The review of the county case file notes and other pertinent records did not find any areas of noncompliance.

Department of Public Welfare Recommendations:

Follow up on the ability at the local level to inquire about bolstering community outreach and information to the public, in the area of medication safety especially around children and the potential health impacts which could occur. The county's implemented safety team may wish to explore if additional outreach would be beneficial in the area of mandated reporting to the members of the community health providers as circumstances in the CPSL have changed with various new legislation being passed over the past year.