

Office of Children, Youth and Families

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REPORT ON THE NEAR DEATH OF

[REDACTED]

**DOB: [REDACTED]/2009
Date of Incident: 04/26/2012**

**FAMILY KNOWN TO:
York County Children, Youth and Family Services**

Report Finalized 03/28/13

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. Section 6349 (b)).

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.¹

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. York County has convened a review team in accordance with Act 33 of 2008 related to this report.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED]/2009
[REDACTED]	Sibling	[REDACTED]/2003
[REDACTED]	Sibling	[REDACTED]/2011
[REDACTED]	Father	[REDACTED]/1984
[REDACTED]	Mother	[REDACTED]/1983

Notification of Fatality/Near Fatality:

On April 26, 2012 mother was checking [REDACTED] of another child, who required diabetic testing, when the victim child ingested the medication. The medications did not have child proof caps on them. The child ingested [REDACTED]. Child was brought into [REDACTED] by mother and then was transferred to [REDACTED] by life flight. The father was at work during the incident.

Documentation Reviewed and Individuals Interviewed:

For this review Central Region interviewed:

- [REDACTED], Child Protective Services (CPS) Supervisor at York County Children & Youth Services
- [REDACTED], CPS Case Worker at York County Children & Youth Services

Central Region reviewed:

- Child Death Data Tool
- Medical records
- Case file

¹ 23 Pa, C,S, § 6343(c)1,2.

Case Chronology:

Previous CYS involvement:

Family was known to the agency in 2004 for two environmental referrals. There was previous involvement with the family and the older sibling. In June of 2004 the agency received a referral regarding the environmental concerns in the home with mother listed as the [REDACTED]. Allegations included: home was cluttered and messy and infested with roaches. Boxes of food and junk were on the floor. The referral was not substantiated.

Then in December of 2004 the agency received another referral with environmental concerns and mother as the [REDACTED]. The child tripped over junk on the floor of the trailer and hit his mouth. The child was living with mother at the time and received [REDACTED]. This referral was substantiated and the agency provided [REDACTED] to the family. In January 2005 the agency discharged services and closed the case.

Circumstances of Child's near fatality:

On April 26, 2012 the mother was checking [REDACTED] of another child, who required diabetic testing, when the victim child ingested the medication. The medications did not have child proof caps on them. The child ingested [REDACTED].

Child was brought into [REDACTED] by his mother due to his lethargic behavior. The admitting diagnosis at [REDACTED] was [REDACTED] with concern that the child was [REDACTED]. The referral source had a concern for lack of supervision due to this being the second time the child ingested an inappropriate substance in less than a week. He was then transferred to [REDACTED] by life flight in [REDACTED]. The child was certified as being in [REDACTED] by a physician at [REDACTED] because of the child being not easily roused and the uncertainty of how his body would react to the medication in his system. The father was at work during the incident.

Current/Most Recent Status of Case:

While the victim child was hospitalized, the agency developed a safety plan for the two siblings with the father and grandmother for supervision with the mother. The victim child was [REDACTED] on 04/27/2012 and an action plan was established and the safety plan was lifted on 05/01/2012.

The action plan is that the family will lock up all medications at all times except when needed. All potential harmful substances will be locked away so that the

children have no access to them. When mother is administering medication for [REDACTED] the victim child will be gated in the same room or will be restricted to within viewing distance of his mother.

The agency will monitor the action plan with unannounced visits to the home. The case was open for services. The child is currently receiving [REDACTED]

[REDACTED]. He has received [REDACTED] through [REDACTED]. He had follow up appointments scheduled with his family doctor and [REDACTED] York at [REDACTED] to monitor his health.

The case was unfounded by York County Children, Youth and Family Services on 6/15/2012. The incident was accidental in nature. The mother had stored the pills in a place that the child could access. The child was not in danger of dying according to the medical review at the Act 33 meeting held on Friday, May 18, 2012 at 1:00 pm at the York Hospital.

Services to Children and Families:

The victim child has a medical history that includes a [REDACTED] [REDACTED]. In the later part of April 2012, he was seen for an [REDACTED] and developed a [REDACTED] from the [REDACTED]. He is currently receiving [REDACTED]. He has received [REDACTED] and routine appointments through [REDACTED]. He had follow up appointments scheduled with his family doctor and [REDACTED] at [REDACTED] to monitor his health.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

A near fatality review team meeting was held on May 18, 2012 in conjunction with the Act 33 requirements. The Central Region Program Representative assigned to York County Children, Youth and Families attended the meeting.

County Strengths: County strengths include the agency's collaboration with the law enforcement officials, and the safety planning completed in a timely manner.

County weaknesses: There were no deficiencies noted.

County Recommendations for Changes at the Local /State Levels as identified by Fatality Report:

None identified at this time.

Central Region Findings:

County Strengths: The investigation completed by York County Children, Youth and Families was conducted in a timely fashion and in collaboration with the York Police Department. The case was unfounded by York County Children, Youth and Family Services on 6/15/2012. The incident was accidental in nature. The agency provided necessary services to all family members and was able to keep all the children safe during the investigation.

The safety plans were timely, inclusive of family and care providers input and signatures. Referrals for services were completed and necessary services were coordinated. The police are no longer involved and no criminal charges are being pressed.

County weaknesses: There were no deficiencies noted.

Statutory and Regulatory Compliance Issues:

York County Children, Youth and Family Services conducted a timely investigation in conjunction with the law enforcement officials. Safety assessments were completed and the siblings were able to remain in their home during and after the investigation. Referrals for services were completed and necessary services were coordinated for the family.