pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: January 30, 2012
Date of Incident: December 18, 2012
Date of Oral Report: December 18, 2012

FAMILY KNOWN TO:

Lycoming County Children & Youth Services

REPORT FINALIZED ON:
May 6, 2013

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. 6349 (b))

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Reason for Review

Senate Bill No. 1147, now known as Act 33 went into effect 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. Lycoming County has convened a review team in accordance with Act 33 of 2008 related to this report. The team meeting was held on January 18, 2013.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim child	01/30/2012
	Mother	[redacted]/1977
	Father	[redacted]/1986
	Half-Brother	[redacted]/1995
	Half-Sister	[redacted]/1999
	Half-Sister	[redacted]/2004
	Maternal grandmother	55 years old

Notification of Near Fatality

A [redacted] referral was received on December 18, 2012. On that evening, mother called 911 because the victim child was unresponsive. Mother then took the child to the Williamsport Hospital ER before paramedics arrived. Victim child was taken by ambulance to Geisinger Medical Center in Danville. Child was found to have PCP in her system. Mother initially denied there was any PCP in the home, stating child could have been exposed to prescription medication. Father [redacted] has many prescribed medications. Mother later stated that she had cigarette laced with PCP and it was left on the coffee table in the living room. While she was in the kitchen, the child had the cigarette in her mouth. There was some suspicion that mother may have been covering for her 17-year-old son, but there was no evidence to support this belief.

Dr. [redacted] certified the victim child to be in serious condition and admitted her to the [redacted]. The child responded to medication and regained consciousness. Her condition was stable at the time of the report.

Summary of DPW Child Near Fatality Review Activities:

Reviewed entire case file
Reviewed medical records
Interviewed CPS caseworker, supervisor, social services director
Attended Act 33 Near-fatality team meeting

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[1] 23 Pa, C,S, § 6343(c)1,2.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

Lycoming County CYS received an anonymous report in 2007 alleging drug activity at the address where the family lived. The referral source could not provide names, accurate gender or ages for the children in the household. CYS was unable to substantiate the complaint and the household members denied drug use or drug dealing. At the time the children were honor roll students and the oldest child was active in extracurricular athletics. Following one assessment visit, the case was closed.

Circumstances of Child's Near Fatality and Related Case Activity:

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Dr. [redacted] certified the victim child to be in serious condition and admitted her to the [redacted]. The child responded to medication and regained consciousness. Her condition was stable at the time of the report.

Lycoming County CYS investigated the report, initially interviewing [redacted]. The caseworker called the family home but no one answered. Following a call from the OCYF Central Region Office, who had been notified of the near-fatality report, a home visit was made on December 18, 2012 at about 11:00 p.m. in order to assure the safety of the other children in the home. Maternal grandmother was at the home and planned to remain there with the children. Because of the late hour, the children were not interviewed at this time. The following day, Lycoming County CYS met with mother, maternal grandmother and the victim child at the hospital. Victim child [redacted] on December 20, 2012, with a safety plan in place stating that maternal grandmother would supervise all of mother's contact with the victim child.

Police searched the home and found marijuana residue in the oldest child's bedroom. He admitted to having smoked marijuana on the day of the incident but insisted that he used marijuana recreationally only on occasion. Mother denied having knowledge of her son's marijuana use, although [redacted] stated that she has smelled marijuana on this young man often.

Lycoming County CYS made frequent home visits to monitor compliance with the safety plan, continue the assessment and discuss services with mother, who admitted to using PCP for some years as a means to deal with stress. Mother voiced her willingness to cooperate with services, expressed remorse for what had happened and began attending [redacted]. A referral was made to the agency's Outreach Services as well as [redacted]. The Multi-Disciplinary

Meeting was held January 18, 2013 in compliance with Act 33. The team made a number of recommendations regarding specific services and referrals for the family, including offering a [redacted] for mother, referrals for the oldest child, nearly 18 years old, who was known to be using marijuana, and maintaining the safety plan for the immediate future. An internal clinical team meeting was held on January 23, 2013 at which time the agency decided to open the family for voluntary in-home services and to offer a Family Group Decision-Making conference.

On January 25, 2012, the [redacted] assessment was completed for the victim child, as required. The Family Service Plan (FSP) was discussed on this date and again on February 2, 2012. The FSP was signed by all parties on February 21, 2013. Mother declined the offer of a Family Group Conference. Father participated in the casework visits but, due to [redacted], was unable to take an active role. He can listen and understand but is unable to speak intelligibly. He does not provide any of the child care or household management, being restricted to a wheelchair and requiring assistance for all of his activities of daily living.

The child abuse investigation was concluded and the CY48 was filed on January 24, 2013 indicating mother as the perpetrator due to lack of supervision. Mother stated that [redacted] Mother was charged by police with three misdemeanors, Endangering the Welfare of Children, Recklessly Endangering Another Person, and Possession of a Controlled Substance. The charges have not yet been adjudicated.

Current/Most Recent Status of Case:

After her initial display of responsibility and cooperation, mother began resisting services [redacted]. She refused to submit to random urine screens, stopped attending [redacted] and the agency received an anonymous referral alleging that mother was using illegal drugs. On April 3, 2013, [redacted] mother had been using PCP throughout the Easter weekend. There was also an allegation that mother had physically assaulted her [redacted] paramour, but he refused to file any charges.

The agency responded immediately and met with maternal grandmother and the children, then with mother. An out-of-home safety assessment was completed and the safety plan was changed to include the stipulation that none of the children were to be alone with mother. At the time of this writing, the children remain in informal out-of-home placement with maternal grandmother.

County strengths and deficiencies as identified by the County's near-fatality report:

County Strengths:

The Agency's family engagement and positive working relationships between CYS and community resources

The review team determined that the near-fatality could not have been prevented by CYS.

County Weaknesses:

None identified

County Recommendations for Changes at the Local (County or State) Levels as Identified in County's Near Fatality Report:

CYS, law enforcement and hospital staff should partner to review and update abuse protocols.

Department Review of County Internal Report:

The Department concurred with the County's report in a letter to the county dated April 15, 2013.

Department of Public Welfare Findings:

County Strengths:

The County responded immediately to the hospital and coordinated the CPS investigation with law enforcement.

The County made frequent in-person contacts with all family members during the assessment period and thereafter to assure compliance with the safety plan.

Timely [redacted] to address issues identified in the family, along with a referral to the agency's own Outreach Services.

The family was fully engaged in the development of the service plan.

Documentation of the county's activities is detailed and kept current.

County Weaknesses:

At the time the report was made, the County did not make an immediate home visit to assure the safety of the older children until directed by the Regional Office to do so.

Statutory and Regulatory Compliance Issues:

None identified

Department of Public Welfare Recommendations:

Encourage close monitoring of agency practice regarding the assurance of safety of all children in the household when a referral is accepted for assessment and potential safety threats are identified.