



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

**REPORT ON THE NEAR FATALITY OF:**



**BORN: 7/20/2010**  
**DATE OF INCIDENT: 10/11/13**  
**DATE OF ORAL REPORT: 10/11/13**

**FAMILY KNOWN TO:**

*Erie County Office of Children and Youth Services*

**REPORT FINALIZED ON:**

**2/12/14**

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))

**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. Erie County convened a review team on November 13, 2013 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victm Child	07/20/2010
[REDACTED]	Mother	[REDACTED] 1988
[REDACTED]	Biological Father	[REDACTED] 1985
[REDACTED]	Sibling	[REDACTED] 2009

**Notification of Child (Near) Fatality:**

On October 11, 2013, the Erie County Office of Children and Youth weekend caseworker received a call [REDACTED] reporting that the victim child was at UPMC Hamot Hospital allegedly due to taking 19 [REDACTED] pills. The alleged perpetrator was identified as the child's mother. A [REDACTED] performed at UPMC Hamot Hospital was negative; however the child was flown to Children's Hospital of Pittsburgh as a precaution. Allegheny County Office of Children, Youth and Family did a courtesy visit at Children's Hospital of Pittsburgh. The victim child [REDACTED] on October 12, 2013.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed the case record pertaining to the victim child's family, interviewed the assigned caseworker in the ChildLine investigation, and participated in the Child Near Death Review meeting on November 13, 2013.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

An Erie County Office of Children and Youth intake caseworker was assigned this case on January 27, 2013. It was alleged that the victim child's mother had been blowing marijuana smoke into her children's faces. The intake caseworker observed poor home conditions and the victim child's mother admitted to smoking marijuana, but not blowing smoke in her children's faces. The intake caseworker visited the home twice in the next week and the home conditions began to improve. The family moved to a new location and the issues were resolved. A referral was made to [REDACTED], but services were discontinued because the victim child's mother consistently maintained her home. The victim child's mother and father are married, but separated. The victim child's father was involved with the family, aware of the allegations, and helped the family move. The case was closed on March 7, 2013.

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

On October 11, 2013, the Erie County Office of Children and Youth weekend caseworker received a call [REDACTED] reporting that the victim child was at UPMC Hamot Hospital allegedly due to taking 19 [REDACTED] pills. A [REDACTED] performed at UPMC Hamot was negative; however, the child was flown to Children's Hospital of Pittsburgh as a precaution.

Allegheny County Office of Children, Youth and Family did a courtesy visit at Children's Hospital of Pittsburgh. According to Allegheny County Office of Children, Youth and Family, the child's mother stated that she was sleeping with the victim child in her bed while the victim child's sibling watched a movie. She woke up between 11:00 a.m. and 12:00 pm and was unable to wake the victim child. The victim child's sibling told the child's mother that he had seen the victim child taking pills. She found the cap on the floor and noticed that her [REDACTED] was missing. The child's mother reported she had lost the original child-proof cap that came with the container, and was using a cap from another container.

The victim child [REDACTED] on October 12, 2013 from Children's Hospital of Pittsburgh. On October 12, 2013, the Erie County Office of Children and Youth Services weekend caseworker met with the family upon their return to Erie to assess the home. The child's mother provided the same information that she had provided to the Allegheny County Children, Youth and Family Services caseworker at Children's Hospital of Pittsburgh. The victim child was in high spirits and was doing well. The home conditions were fine and no concerns were observed during this home visit. The caseworker discussed a plan for safety regarding the pills and a need for them to be locked up or kept in a location that the children could not reach them. The child's mother said she planned on keeping the pills in the car. The children were determined to be safe.

The case was assigned to an intake caseworker who visited the home on October 17, 2013. The caseworker met with the mother and children. The Erie County Office of Children and Youth Services supplied the victim child's mother with a lock box for her medication, which she reported she would utilize, but she still planned on keeping the pills in her car. The caseworker found both children to be clean, dressed appropriately and free from harm. The caseworker found the home to be clean and appeared to be safe for the children. There were no environmental concerns noted and the family had clothing, food and all utilities in the home at the time. The children were determined to be safe.

On October 22, 2013, the Erie County Office of Children and Youth caseworker met with the children and their father in their home. The children reported having fun at their father's home and appeared to be comfortable with him. The father reported that he is confident in his ability to care for the children and he reported no concerns for the children when they are in their mother's care. The children were determined to be safe.

On November 12, 2013, the Erie County Office of Children and Youth caseworker spoke with the Dr. Wolford from Children's Hospital of Pittsburgh who reported that the victim child's life was not "technically" in danger, but it could have been. [REDACTED] did not perform a toxicology screen on the victim child, but their toxicologist called this incident a [REDACTED] overdose. The hospital was unsure if the medications that the victim child took would have showed up in [REDACTED]. The victim child did not require [REDACTED]. The victim child received fluids, but no other treatment. The victim child was stable [REDACTED].

The Erie County Office of Children and Youth caseworker made a home visit on November 14, 2013. The caseworker met with both parents and both children. The caseworker spoke with the child's mother and suggested case opening. The parents reported that they were doing fine and meeting the children's basic needs as well as their own financial needs. The family was not interested in ongoing services from the agency. The children were determined to be safe at this time due to no safety threats being identified.

Erie County Office of Children and Youth completed the CY-48 on November 21, 2013. The report was unfounded as the agency had not been able to establish that the lack of supervision resulted in physical condition in the child. No drugs were present in the child's [REDACTED].

**Current Case Status:**

The case was closed as of November 25, 2013. Erie County Office of Children and Youth offered the family ongoing services and to work with a service provider to bolster their parenting abilities, but they declined such requests. The family's PCP reported that the children were up to date with their immunizations and had no concerns regarding the children. The family had no other service providers working with the family.

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

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. Erie County has convened a review team on November 13, 2013 in accordance with Act 33 of 2008 related to this report.

- **Strengths:** Allegheny County Office of Children, Youth and Family is to be commended for their promptness in interviewing the family and forwarding the information to Erie County Office of Children and Youth. Erie County Office of Children and Youth is to be commended for the way the referral was handled.
- **Deficiencies:** No deficiencies identified.
- **Recommendations for Change at the Local Level:** No recommendations for change at the local level.
- **Recommendations for Change at the State Level:** No recommendations for change at the state level.

**Department Review of County Internal Report:**

The Western Regional Office of Children, Youth and Families reviewed Erie County Office of Children and Youth's internal report on December 6, 2013, and agrees with their findings.

**Department of Public Welfare Findings:**

- **County Strengths:** The Erie County Office of Children and Youth responded immediately to the report and conducted a thorough investigation.
- **County Weaknesses:** No weaknesses were identified during the review.
- **Statutory and Regulatory Areas of Non-Compliance:** The review did not identify any compliance issues with statutes and regulations.

**Department of Public Welfare Recommendations:**

After reviewing the case record, interviewing the caseworker, and attending the Child Near Death Review on November 13, 2013 the Western Regional Office of Children, Youth and Families has concluded that the Erie County Office of Children and Youth in

collaboration with Allegheny County Office of Children, Youth and Family Services followed appropriate protocol in regards to the investigation of this referral.