



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Anthony Thompson

BORN: August 6, 1992
DIED: July 14, 2010

**FAMILY NOT KNOWN TO GREENE COUNTY CHILDREN AND YOUTH
SERVICES (CYS)**

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 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 near child 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

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	[REDACTED]	[REDACTED]
Anthony Thompson	Victim Child	08/06/1992
[REDACTED]	[REDACTED]	[REDACTED]

Notification of Fatality / Near Fatality:

During a County Child Fatality Review Meeting held 9/19/2011 regarding an unrelated incident and child, Greene County CYC became aware of the passing of [REDACTED] on 07/14/2010. The child passed away at his father's residence. It was initially reported that when [REDACTED] bedroom was seen, numerous beer bottles, some empty and some half emptied were found. It was reported by the same individual who viewed [REDACTED] room that there were numerous beer bottles in a computer room off of the child's bedroom. It was then reported that this individual asked the father if he knew that his son had been drinking alcohol and allegedly the father admitted that he had supplied the alcohol to his son.

When the police and Greene County Child Protective Services investigators interviewed the father, he denied giving his child alcohol. Being that the fatality had occurred one year prior to the report, both the police and Green County CYC were unable to determine if there were, in fact, beer bottles in the child's room. The autopsy of the child did not reveal the presence of alcohol.

It was later determined that the child died of a non-alcohol related death, and that he had [REDACTED].

Documents Reviewed and Individuals Interviewed:

For this review, the Western Regional Office of Children, Youth and Families reviewed the Greene County CYC family record, the death certificate, and the Pathological Diagnoses Report provided by [REDACTED] Pathology Associates of Pittsburgh, PA. The Western Regional Office of Children, Youth and Families also attended the Child Fatality Review Team Meeting held regarding this report.

¹ 23 Pa. C.S. 6343 (c) (1)-(2).

Case Chronology:

As stated, this case was brought to the attention of Green County CYC during a child fatality review meeting on 09/19/2011 regarding an unrelated incident and child. This incident was reported to [REDACTED] and an investigation occurred. The county caseworker went to the home on October 4, 2011 and completed a safety assessment. There were no safety threats present in the home. The county also requested the death certificate and pathology report which was received and reviewed. After reviewing the reports, and consulting with legal and medical experts, CYC determined that the father did not provide the child with alcohol, and that the child had died from a [REDACTED].

Previous Children and Youth involvement:

Greene County CYC did not have any involvement with the family prior to the fatality.

Circumstances of Child's Fatality or Near Fatality:

During a County Child Fatality Review Meeting held 9/19/2011 regarding an unrelated incident and child, Greene County CYC became aware of the passing of [REDACTED] on 07/14/2010. The child passed away at his father's residence. It was initially reported that when [REDACTED] bedroom was seen, numerous beer bottles, some empty and some half emptied were found. It was reported by the same individual who viewed [REDACTED] room that there were numerous beer bottles in a computer room off of the child's bedroom. It was then reported that this individual asked the father if he knew that his son had been drinking alcohol and allegedly the father admitted that he had supplied the alcohol to his son.

When the police and Greene County Child Protective Services investigators interviewed the father, he denied giving his child alcohol. Being that the fatality had occurred one year prior to the report, both the police and Green County CYC were unable to determine if there were, in fact, beer bottles in the child's room. The autopsy of the child did not reveal the presence of alcohol.

It was later determined that the child died of a non-alcohol related death, he over [REDACTED]. It is believed the child [REDACTED]. Police continue to investigate the child's death.

Greene County CYC determined the report to be [REDACTED] on November 1, 2011, after reviewing the medical documentation, meeting with the investigating police officials, and interviewing the mother and father.

A safety assessment was completed, and determined there were no safety threats present in the home with respect to the victim child's niece, who also resided in the home.

Greene County CYC assisted the family in locating a [REDACTED] for the victim child's niece, as she was close to the deceased child and subsequently closed the case.

Current Status of Case:

Green County CYC determined the report to be [REDACTED] on November 1, 2011, after reviewing the medical documentation, meeting with the investigating police officials, and interviewing the mother and father.

A safety assessment was completed, and determined there were no safety threats present in the home with respect to the victim child's niece, who also resided in the home.

Greene County CYC assisted the family in locating a [REDACTED] for the victim child's niece, as she was close to the deceased child and subsequently closed the case.

Services to children and families:

None

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

Strengths - The County responded appropriately once they were informed of the child's death.

Deficiencies - A system is being worked on to ensure when a child dies that the county is notified within a reasonable timeframe, not a year later. Open communication is necessary in order for this to occur.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

It is recommended that the county establish a protocol to be notified of all near fatalities and fatalities that occur in the County.

Statutory and Regulatory Compliance issues:

None

Western Region Office of Children, Youth and Families Findings:

County Strengths - The County conducted the investigation in a timely manner, once they were informed of the fatality. The safety assessment process was completed timely and accurately, and all parties involved in this case were interviewed.

County Deficiencies - The County may consider establishing a protocol with local hospitals, law enforcement, and the Coroner's office to be notified of all fatalities that involve children in the County. Additionally, the County may consider providing training to these same entities regarding Act 33.