



## **REPORT ON THE FATALITY:**

Niccolo Varner

**Date of Birth: 7/30/2011**

**Date of Death: 7/15/2012**

**Date of Oral Report: 7/16/2012**

### **FAMILY KNOWN TO:**

Delaware County Children and Youth Agency

### **REPORT FINALIZED ON:**

**04/24/2013**

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))

**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. Delaware County has convened a review team in accordance with Act 33 of 2008 related to this report on 8/1/2012

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Father	[REDACTED]/1964
[REDACTED]	Mother	[REDACTED]/1983
* [REDACTED]	Sibling (Half)	[REDACTED]/1997
[REDACTED]	Sibling	[REDACTED] 2007
Niccolo Varner	Victim Child	07/30/2011

\*Note: [REDACTED] is the child of Mr. [REDACTED] & [REDACTED] (Biological Mother). The child resides with his mother at [REDACTED] in [REDACTED], Ohio [REDACTED]. However the child has resided at times within the father's household.

**Notification of Child Fatality:**

On 07/15/2012, this report was called into Delaware County Children & Youth as a [REDACTED] [REDACTED] investigation because the cause of death was unknown. The parents called 911 on this date due to baby Niccolo Varner not breathing. The child was transported to Fitzgerald Mercy Hospital via an ambulance. The child was reported as dead on arrival, as his body was cold, pupils dilated, and rigor mortis had set in. The parents escorted the child to the emergency room area then left the hospital without speaking to hospital officials. Ms. [REDACTED] was later arrested for possession of drug paraphernalia (a crack pipe) and incarcerated. The death of Niccolo Varner was reported to the County as suspicious on July 16, 2012 and [REDACTED] [REDACTED] Report naming the mother, [REDACTED], as the [REDACTED]. The child death was also certified as a Child Fatality due to allegations of being caused by abuse.

### **Summary of DPW Child Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and completed an extensive review of all current and past County case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworkers [REDACTED] and Supervisor [REDACTED]. The regional office also participated in the County's Act 33 Review Meeting held at Delaware County Children & Youth (Upper Darby, PA.) office on August 1, 2012.

### **Summary of Services to Family:**

#### **Children and Youth Involvement prior to Incident:**

The [REDACTED] family was referred to Delaware County Children, Youth and Families in July 2011. It was reported Ms. [REDACTED] stated that she did not know she was pregnant while in the emergency room at Mercy Fitzgerald Hospital complaining of stomach pain. The report indicated that she was 9 months pregnant and transferred to Delaware County Memorial Hospital where she gave birth to Niccolo (July 30, 2011) without the benefits of prenatal care. Ms. [REDACTED] and Niccolo both tested positive for [REDACTED] at delivery according to the referral, and Niccolo was placed in the [REDACTED]. Niccolo was hospitalized from his birth until September 24, 2011. This case was accepted for services on August 01, 2011 to ensure that Ms. [REDACTED] attended and completed [REDACTED]. On August 4, 2011, Ms. [REDACTED] admitted to be actively using heroin and tested positive for [REDACTED]. Ms. [REDACTED] agreed to begin [REDACTED] at [REDACTED] (at one time) as well as at the [REDACTED] only to find reasons why she could not complete the program. Mr. [REDACTED] agreed to participate in a drug screening initiated by the County and his results were negative for any illicit substances. Mr. [REDACTED] was the safety plan for the children in the home by not allowing Ms. [REDACTED] to be left alone with the children. This family received intake services from August 1, 2011 to October 6, 2011 at which time this family was transferred to the County's Services to Children in their Own Home Department (SCOH). During the family's participation in SCOH, the family began to stabilize. Ms. [REDACTED] began [REDACTED] with [REDACTED] for [REDACTED] [REDACTED] as well as her [REDACTED] stability. Ms. [REDACTED] has exhibited a commitment to addressing her issues. The County received verbal confirmation from [REDACTED] office in reference to Ms. [REDACTED] participation in [REDACTED]. During this period, both parents were committed to providing safety and security for their children. So much so that [REDACTED] (residing with his biological mother in Ohio) was given permission to visit his father [REDACTED] for periods at a time. The County closed this case on May 4, 2012.

**Circumstances of Child Fatality and Related Case Activity:**

The County received a referral on July 15, 2012 [REDACTED] indicating that Ms. [REDACTED] and Mr. [REDACTED] (parents) called 911 because their child, Niccolo, was not breathing that morning. The child was then transported to the hospital where it was reported that the child was dead on arrival. The parents were with the child's body in the emergency room for a short period and then left without speaking to any hospital staff. The death of the child was determined to be suspicious on July 16, 2012. Niccolo Varner's death was investigated by the Children and Youth Services, Collingdale Police Department and the Criminal Investigation Unit. Ms. [REDACTED] was arrested for possession of a crack pipe shortly after leaving the emergency room. The agency took [REDACTED] of Niccolo's sibling, [REDACTED]; on July 16, 2012, after both Ms. [REDACTED] and Mr. [REDACTED] refused to sign a safety plan that would allow the child to reside with his maternal grandmother while the [REDACTED] investigation ensued. On July 20, 2012, [REDACTED]

[REDACTED] On 9/13/2012 the County " [REDACTED] awaiting the determination from the District Attorney's Office. In November 2012, the County " [REDACTED] on this [REDACTED] Investigation [REDACTED]

**Current Case Status:**

The [REDACTED] family has been receiving services from Delaware County Children and Youth Services since July 15, 2012, as a result of Niccolo Varner's suspicious death. A medical examination was completed on the child and the cause of death was determined to be Acute Heroin Intoxication. [REDACTED] (mother) was arrested on November 9, 2012 on the charges of Murder of the Third Degree, Criminal Homicide, Involuntary Manslaughter, Aggravated Assault, and Endangering the Welfare of Children. She remains incarcerated at George W. Hill Correctional Facility and is awaiting trial. Ms [REDACTED] was also placed on the [REDACTED]

Delaware County Children and Youth Services is currently providing SCOH case management to this family. On August 24, 2012, [REDACTED]. The County has provided supervised visitation between Ms. [REDACTED] during the months from August through November leading up to her arrest.

[REDACTED] participated in a [REDACTED], conducted by [REDACTED] on September 13, 2012. This was recommended to assist the child with the loss of his brother and separation from his mother. The child also participated in an assessment at [REDACTED] and will be involved in [REDACTED] sessions.

**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. Delaware County has convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 Meeting was scheduled on August 1, 2012. .

- Strengths: Delaware County Children & Youth Services completed a thorough investigation
- Deficiencies: The County had its struggles with receiving [REDACTED] records/information [REDACTED] from a health professional provider that was working with the family.
- Recommendations for Change at the Local Level: No recommendations at this time
- Recommendations for Change at the State Level: A recommendation from MDT that a more efficient collaboration between Delaware County Children & Youth Services and the Office of Behavioral Health is pursued to assist with identifying licensed treatment professionals.

**Department Review of County Internal Report:**

Overall, the county did an acceptable job with the provision of services and supervision to the [REDACTED] family. The review of the county's family record illustrated that the county continuously assessed the safety of this family prior to the case final closure on May 15, 2012. However, the SERO did have a concern with the county's inability to file a complaint against Dr. [REDACTED] office for failing to share documented information that the county had appropriate consent to obtain. It was reported that [REDACTED] had begun [REDACTED] with Dr. [REDACTED] on January 20, 2012 when she began to refuse drug testing from the county. The county reported attempting to get the [REDACTED] plan as well as testing result from the doctor's office via faxes dated 02/16/12, 02/28/12, 03/29/12 and 04/17/12. The county did receive a verbal confirmation (04/17/12) from a staff person from the doctor's office indicating [REDACTED] was in compliance with attending [REDACTED] and submitted negative drug testing results for controlled substances over the telephone. However, the county was not successful in getting documentation to support the doctor's office findings. The County accepted verbal confirmation and decided to accept the verbal confirmation from the doctor's office that the mother had been in compliance with her [REDACTED]. They subsequently closed the case.

**Department of Public Welfare Findings:**

- County Strengths: Delaware County has demonstrated a strong collaboration with their partnering systems, i.e. the Police Department, Medical Examiner's Office, and Mercy Fitzgerald Hospital personnel.
- County Weaknesses: The county decision not to pursue Dr. [REDACTED] office for the requested treatment information to a formal complaint.
- Statutory and Regulatory Areas of Non-Compliance:  
Delaware County Children & Youth services was in compliance with all statutory and regulatory areas

**Department of Public Welfare Recommendations:**

Delaware County is advised to develop a protocol to file a formal complaint against any medical or mental health provider that continuously refuses or fail to respond to the agency's concerns as it relates to requested information that the county has a legal right (appropriate consents) to obtain.