



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 05/08/2012**  
**Date of Incident: 11/17/2014**  
**Date of Report to ChildLine: 11/17/2014**  
**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Warren County Children and Youth Services

**REPORT FINALIZED ON:**  
**8/26/15**

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(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 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Warren County convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on December 15, 2014.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	05/08/2012
[REDACTED]	Biological Mother	[REDACTED] 1988
* [REDACTED]	Biological Father	[REDACTED] 1982
[REDACTED]	Half-Sibling	[REDACTED] 2007
[REDACTED]	Half-Sibling	[REDACTED] 2008
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Mother's Paramour	[REDACTED] 1976
[REDACTED]	Non-relative Household Member	[REDACTED] 1997
* [REDACTED]	Father's Paramour	Unknown

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

**Summary of OCYF Child Near Fatality Review Activities:**

The Department of Human Services Western Region Office of Children, Youth and Families received a copy of the case record and was provided access to the electronic file via the CAPS system. A review of the file was completed by the Department. The Department was a participant of the County Act 33 meeting on December 15, 2014.

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

On January 17, 2012 a General Protective Services Report (GPS) was received by Warren County Children and Youth Services (CYS). The report alleged that the

mother's husband (the father to some of the older siblings) had a legal history of sexual assault. The paramour had been charged with indecent exposure, but no report of child sexual abuse was made. The report was screened out and closed. (Victim child was not born at this time.)

On January 20, 2012 a GPS report was received that the mother's husband at the time (the father to some of the older children) smoked and sold marijuana. The mother's home allegedly smelled of marijuana. The referral was accepted and investigated. Warren County CYS was not able to validate the concerns and the case was closed on January 31, 2012. (Victim child was not born at this time.)

On June 18, 2013 a GPS report was received that the children were at the maternal grandmother's home. The allegations stated that the home smelled of urine and the mother had "promised" not to take the children to the home. The report indicated that there was an active Protection from Abuse order filed on the victim child's father, which the father alleged was obtained through the mother lying about the father. The report was screened out and closed at intake due to a lack of concerns for abuse or neglect.

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

On November 17, 2014, Warren County CYS received a report that a 2 ½ year old child was admitted to the local hospital [REDACTED] after ingesting [REDACTED] medication at his father's home. The examining physician reported that the medication was believed to be [REDACTED] and was at a significant level, resulting in overdose symptoms. The victim child [REDACTED] upon arrival at a local hospital, Warren General Hospital, and it was unknown if he would survive. The victim child was transported to Children's Hospital in Pittsburgh (CHP) [REDACTED]

The victim child was in the home of his father at the time of the incident. It had been reported to the attending physician that a party had taken place at the father's home the previous evening and the medication was left out, beside the freezer. Due to this information, the report was certified as a near fatality and the father was listed as the alleged perpetrator on the Child Protective Services (CPS) investigation.

A courtesy request was sent to Allegheny County Office of Children, Youth and Families seeking a 24 hour visual of the victim child. The request was completed on November 18, 2014 and an interview occurred with the victim child's mother at that time. The mother reported that she received a phone call from the father's paramour reporting that she and the victim child's father were on the way to the hospital and that the victim child had ingested pills [REDACTED]. The mother reportedly did not know who [REDACTED] medication [REDACTED] in the father's home.

The mother reported having four children living in her home, the victim child being the youngest. The older two siblings were with their father (not the victim child's

father) and the third was with the grandparent. [REDACTED]

[REDACTED] She admitted that, while in the relationship with the victim child's father, [REDACTED]

Warren County CYS contacted the Warren General Hospital [REDACTED] and requested additional information upon the victim child arriving at CHP. [REDACTED] reported the father found the victim child with the pills in his mouth. The father took the pills out of his mouth and transported him to the hospital.

Warren County did complete an assessment on the siblings and found them to be safe with the other caregivers. The mother reported she had primary custody of the victim child and the father had the child ten days a month when his work schedule allowed.

Further communication with CHP confirmed that there were multiple different medications in the victim child's system. The reports indicated that the victim child had [REDACTED] in his system. [REDACTED]

[REDACTED] The mother reported that the father stated he walked away for a few minutes and then returned to find the victim child eating pills.

Further communication with the father by CHP reported that the father was attempting to clean up the house for a Thanksgiving gathering and brought an old box up from the basement. The box contained [REDACTED]. The father stated that he heard the victim child shaking a pill bottle and returned to find the child playing with medications. He noticed at this time that the victim child had eaten some of the medications. The father tried to induce vomiting of the victim child and then transported him to Warren General Hospital.

The victim child eventually [REDACTED] became responsive. He was moved to a regular room for monitoring and was [REDACTED] on November 21, 2014 to the care of his mother. The child was seen by his pediatrician and appeared to be doing well with no indication of long term effects from the overdose.

The father was interviewed on December 3, 2014 and admitted to bringing a box of [REDACTED] from the basement. The box had sat around the house for several days untouched on a counter. On the date of incident, the father was packaging food with the victim child and sibling in the kitchen. The father made himself a sandwich and sat down in the living room to eat. The children were still in the kitchen. The father admitted he could not see the children in the kitchen from the living room. The father reported hearing the pill bottle shaking and went into the kitchen to find the victim child with the pills. The father noticed pills on the floor that had bite marks in them. The father reported that he called his girlfriend, got the boys dressed and waited for his girlfriend to come home. It was approximately

20-30 minutes from the time he found the victim child with the pills before the girlfriend came home and they transported the child to the emergency room.

Warren County CYS completed the abuse investigation with an indicated status determination on December 15, 2014. The basis was due to evidence supporting the lack of supervision by the father that resulted in a serious medical condition of the victim child. No criminal charges have been filed.

The victim child appeared to be recovering well and was showing no side effects from the incident. The case was accepted for services due to the indicated status and in order to monitor the victim child in the father's home during visitations. The mother was not recommended any in-home services. The father was recommended to complete parenting class [REDACTED]. The father has complied with the recommended goals.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:**

- Strengths in compliance with statutes, regulations and services to children and families:
  - The collaboration within the county from the onset of the investigation was commendable. The investigation was able to be completed within the 30 day time frame.
- Deficiencies in compliance with statutes, regulations and services to children and families:
  - Although done on the date of incident, the time for the hospital to make the report [REDACTED] and police was delayed; sooner would have been beneficial.
  - The lack of a protocol within the hospital reporting system resulted in the pill bottles being returned to the father instead of being handed over to law enforcement.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  - Establish a practice and protocol at Warren General Hospital for the circumstances and time frames when notifying CYS and Law Enforcement of cases involving child welfare.
  - Establish appropriate policy at the local hospital for chain of command regarding custody of possible evidence in child welfare situations.
  - Recommendation for CYS to include as part of a home safety inspection where and how to store medication safely.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  - No recommendations given.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:
  - Public service announcements offered regarding safety of home medication, including immediate tips for ingestion and direction to Poison Control Center.
  - Inclusion of drug and alcohol prevention, as well as safe medication usage and storage when offering parenting classes (including foster parent information.)

**Department Review of County Internal Report:**

The Department received the County Act 33 Internal Report on January 26, 2015. The report was reviewed and found to be concise and organized to meet the requirements of Act 33. The Department does respectfully agree with the findings of the team and the recommendations made on the internal report.

**Department of Human Services Findings:**

- County Strengths: Warren County CYs responded timely and with commendable resourcefulness in order to gather details and facts associated with the allegations. A courtesy request was sent to Allegheny County for a visual assessment of the victim child and fact finding interview with the custodial parent. Collaboration between Warren County, the local law enforcement and medical providers involved in the management of this case was exemplary. Documentation of all imperative medical records was received and accessible in the record.
- County Weaknesses: The home visit to the father's home was not completed by the county agency until December 3, 2014, two weeks following the report. The Act 33 Team recommendation of a hospital policy to secure potential evidence also appears to directly relate to the need of the county to complete a timely assessment. An assessment of the father's home and identification of all [REDACTED] in the home would prove more beneficial when done more timely following the receipt of the referral.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. No areas of statutory or regulatory non-compliance.

**Department of Human Services Recommendations:**

The Department respectfully recognizes and agrees with the above stated recommendations identified in the Act 33 Team Meeting. In addition, the following recommendations are submitted by the Department:

- Education for local hospital emergency rooms in regards to the need for established protocols when dealing with potential drug overdoses of young

children. Timely reporting to law enforcement and CYS is crucial when securing evidence and gathering information. Child arrived in emergency room at approximately 3:30pm and the report was not made until 10:00pm that night.

- o In addition, it would be recommended that the County assess the physical location where the alleged abuse occurred in a timelier manner in order to identify any potential evidence to support the investigation. The assessment of the father's home, where the incident occurred, was not completed until two weeks following the incident.