pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Emily Dodson

Date of Birth: 07/13/2016
Date of Death: 12/02/2017
Date of Report to ChildLine: 12/28/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:
08/31/2018

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Westmoreland County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 01/17/2018 and 2/21/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Emily Dodson	Victim Child	07/13/2016
[redacted]	[redacted]	1988
		1975
		2005
		2006
		2009
		2012
		2016
		2015
		1976

*Denotes a person related to the case but not a household member

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) attended the initial local county review meeting on 01/17/2018 via conference call due to late notification. WERO attended in person at Westmoreland County Children's Bureau (WCCB) for the follow-up meeting on 02/21/2018. The Region reviewed case notes, requested pertinent documentation and reviewed casework activities to the current and prior referrals.

Children and Youth Involvement prior to Incident:

WCCB received four previous [redacted] reports for the family, three of which were [redacted] by the county.
On 01/19/2015 the county received a [redacted] referral from Fayette County Children and Youth Services (FFCYS) to inform WCCB that Fayette County had been involved

with [redacted] due to [redacted]. They also had been informed [redacted] was allegedly moving back in with [redacted] and there were previous concerns of domestic violence. The [redacted] and [redacted] on 01/22/2015 as [redacted]

On 07/13/2016 WCCB received a [redacted] referral stating [redacted]. were not [redacted]. The referral noted [redacted] denied using [redacted]. The initial referral stated [redacted] provided a possible reason for [redacted] was that [redacted] worked with college kids. [redacted] later admitted to using illegal substances prior to finding out [redacted] and provided a possible reason [redacted] was due to being around people who were smoking marijuana. A nurse at the hospital reported to the caseworker [redacted] provided three to four "stories" as to how [redacted]. [redacted] born prematurely at 37 weeks gestation. [redacted] reported [redacted] had not [redacted] due to recently moving to the area and owing money to a previous [redacted] office and they would not release [redacted] records. [redacted] stated [redacted] did not know [redacted]. A referral for a bed at a [redacted] was made and records indicate the family was utilizing community resources however none were noted in case documentation. One follow up was noted that [redacted] had been seen for [redacted]. This referral was [redacted] on 07/25/2016 noting [redacted] were safe and basic needs were being provided.

A [redacted] referral was received on 11/21/2016 and [redacted] on 11/22/2016. The referral stated that [redacted] had received very limited [redacted] for [redacted]. [redacted] had scheduled an appointment for [redacted] on 10/24/2016 but failed to show for the appointment. The reporting source made calls to [redacted] and sent a letter, including a registered letter, but could not make contact. The reporting source noted a check of insurance indicated [redacted] had activated insurance on 10/13/2016. The reporting source was concerned due to [redacted] not being seen by a doctor since leaving the hospital after [redacted]. This referral was [redacted] with the reason being the [redacted]. The [redacted] stated, "well checks are not medically necessary".

On 12/05/2017 WCCB received a [redacted] referral stating the [redacted] had responded to the family home on 12/02/2017 due to the victim child being found unresponsive. It was reported to the police the victim child had been put to bed at 9:00 p.m. on 12/01/2017. The victim child [redacted] slept in [redacted] cribs in the living room with [redacted], who slept on a mattress on the floor. [redacted] reportedly checked on the victim child around 7:00-8:00 a.m. on 12/02/2017 and thought she saw the victim child move under her blanket but remained asleep. At 9:00 a.m. [redacted] again checked on the victim child and found her to be "purple and unresponsive". A call to 911 was made at 9:30 a.m. The reporting source noted [redacted] did not accompany the victim child to the hospital and declined the opportunity to say goodbye when the coroner called [redacted] The coroner noted the victim child probably died sometime before on 12/01/2017; however it was not [redacted] and interview notes indicate the

death may have occurred between the night of 12/01/2017 and morning of 12/02/2107. The autopsy results were pending at the time of the report. This referral was [redacted] the reason stating [redacted] section noted [redacted] reported. Coroner to call back if CAN suspected as result of autopsy". This referral directly relates to the registered fatality report and [redacted] report which is addressed in the next section.

FCCYS had two prior reports on the family. FCCYS received a prior [redacted] report on the family on 04/11/2011. The child identified on the [redacted] report was [redacted] was [redacted] on 05/04/2011 for [redacted] after [redacted] slapped [redacted] in the face, causing swelling, pain and redness. [redacted] was also reportedly living in the household at the time, however was not registered or investigated for the abuse.

FCCYS received a [redacted] report on 04/25/2011 regarding allegations [redacted] was not being followed and [redacted] on this date. The case was [redacted] on 05/04/2011 and [redacted] on 11/02/2011. The electronic record does not specify what services were offered to the family during the six months the family [redacted].

Circumstances of Child Fatality and Related Case Activity:

On 12/28/2017 WCCB received a [redacted] referral stating the sixteen-month-old victim child had passed away between the night of 12/01/2017 and 12/02/2017 as a result of a [redacted] overdose. The [redacted] referral was made as a result of the findings from the initial autopsy completed after the [redacted] referral from 12/05/2017. The referral was reported to ChildLine for [redacted] and named [redacted].

The [redacted] referral was received and responded to by WCCB on 12/28/2017. The preliminary autopsy report indicated the victim child had 1100ng/ml of [redacted] in her system. A [redacted] disclosed the victim child died as a result of an inappropriately high dose of the drug [redacted], which is contained in [redacted] and the victim child's death was consistent with a fatal dose. WCCB was informed law enforcement had obtained a warrant on 12/28/2017 to search the family residence for over the counter medications. The caseworker interviewed the family and was informed [redacted] had been at work during the evening of 12/01/2017, [redacted]. [redacted] initially denied any medications were ever provided to [redacted]. The caseworker was informed by law enforcement that when [redacted] were informed as to the details of the search warrant [redacted] stated, "this is on you", referring to [redacted] and informed the detective [redacted] had previously given [redacted] medications to sleep. During the 12/28/2017 interview with [redacted], [redacted] denied administering [redacted] but stated the victim child was teething and crying and [redacted] had attempted to give her [redacted]. The victim child allegedly spit these out and did not ingest them. The caseworker indicated during the Act 33 follow up meeting [redacted]

[redacted] provided four to five statements regarding the incident and use of [redacted] or other sleep aid medications and providing them to [redacted].

During an interview with law enforcement [redacted] stated on the date of the incident [redacted] may have had the [redacted] in the kitchen due to [redacted] having troubles with [redacted] allergies because of problems with the furnace. [redacted] stated she left [redacted] in charge of [redacted] for approximately twenty minutes while [redacted] took a shower. [redacted] stated [redacted] could not locate a sippy cup after the incident and eluded that [redacted] may have given the victim child the [redacted] by using the sippy cup. [redacted] stated [redacted] had been told by a primary care physician a dose of up to 5mg within a twenty-four hour time frame would be acceptable for the victim child. [redacted] went on to state the victim child, as noted, was not feeling well. The victim child was clingy and did not want [redacted] to put her down. [redacted] stated the victim child had [redacted], was teething, coughing, had a runny nose and did not have an appetite. [redacted] tried to give her the [redacted] around 5:00-6:00 p.m. but the victim child spit it out. [redacted] said later, at approximately 7:15 p.m., [redacted] attempted to give the victim child [redacted] chewable tablet but she pulled it out of her mouth. [redacted] then went to take a shower around 7:20 p.m. Before [redacted] went to shower [redacted] said to [redacted] "go take a shower I got this". While [redacted] showered [redacted] was left downstairs with [redacted] while [redacted] were upstairs in [redacted] rooms. When [redacted] came down from the shower [redacted] made a motion to [redacted] to be quiet as the victim child was in her crib sleeping. The victim child then woke up screaming around 8:30-8:45p.m. [redacted] attempted to soothe her. [redacted] reported [redacted] got home around 9:20 p.m. and [redacted] was holding the victim child; she had fallen back asleep. [redacted] reported the only other medication [redacted] may have been giving [redacted] for their illness was [redacted], which is an all-natural medication for children. [redacted] stated [redacted] does not remember if [redacted] gave the victim child any of it on the date of incident. [redacted] said [redacted] had not given the victim child any [redacted]. She said the liquid [redacted] was purple in color and the dose was 2-3 ml.

On 01/02/2018 WCCB [redacted] noting that [redacted] would not be unsupervised with [redacted]. [redacted] was to be reauthorized on 02/28/2018 however a supervisor dictation at the time of case transfer noted [redacted] was not reauthorized.

On 01/16/2018 forensic interviews were completed on [redacted]. [redacted] disclosed remembering [redacted] being sick but was not aware of any medication administered. [redacted] stated [redacted] has given [redacted] "stuff" to help [redacted] sleep and it was a liquid, dark blue/purple in color. [redacted] disclosed [redacted] has been given round green pills although it is unknown what these pills were. [redacted] said [redacted] told [redacted] that [redacted], who was in charge while [redacted] showered, gave medicine to [redacted], or at least the victim child. On 01/22/2018 [redacted] completed a forensic interview and disclosed [redacted] had helped [redacted] with care of [redacted] but had never given [redacted] any medication. [redacted] said on the day of the victim child's death

[redacted] was upstairs and came down and found out the victim child had died so [redacted] went back upstairs to watch television. [redacted] stated that [redacted] tried to give something to the victim child the night prior for a cold. It was pink in color.

[redacted] had been [redacted] a week prior to the incident. [redacted] was in part due to a report of [redacted] making statements of [redacted]. [redacted] allegedly made a comment after the victim child passed; "at least I have my favorite [redacted]". The family had been receiving [redacted] since November 2017 for [redacted]. WCCB offered [redacted] but the family declined these services.

At the follow-up MDT/Act 33 meeting on 02/21/2018 the recommendation was made to [redacted] due to the ongoing criminal investigation. [redacted] submitted to ChildLine on 02/23/2018. On 04/18/2018 [redacted] was charged with Involuntary Manslaughter (F2) and Endangering the Welfare of Children-Parent/Guardian/Other commits Offense (F3). [redacted] was released on $25,000 bond on 04/19/2018. [redacted] was rescheduled from 04/27/2018 to 05/18/2018. There is no documentation of [redacted] being reinstated given the charges. WCCB [redacted] on 02/28/2018.

Since [redacted], a subsequent [redacted] referral was received on 03/23/2018 alleging possible domestic violence [redacted], witnessed by [redacted] The report was [redacted] WCCB on 03/26/2018. The [redacted] at this time.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  - WCCB followed statutes and regulations by meeting an immediate response time, interviewing all household members regarding allegations and implementing [redacted] to ensure safety of [redacted] in the home.
  - A quick response occurred once the referral was received by WCCB.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The County did not note any deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  - Further investigate cases where [redacted] with other concerns present (i.e. no well checks).

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
    - The county did not note any recommendations at this level. The county did identify a concern with indicating a case with a pending criminal charge due to the appeal process. The county indicating these cases often need more than 60 days to fully assess the case.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - An increased knowledge given to [redacted] about medication management.

Department Review of County Internal Report:

The Department received the County Internal Report via email on 04/24/2018. The report lacked a thorough narrative of the history associated with the family involvement in Fayette County and gave limited detail to the prior reports received by Westmoreland County.

Department of Human Services Findings:

- County Strengths:
    - The county worked with law enforcement during the investigation and did offer services to the family.
    - The county met the response time as noted on the [redacted] referral.

- County Weaknesses:
    - In regards to the 07/13/2016 referral, the case record notes the family was utilizing community resources however does not provide documentation to support this statement. The county caseworker, as directed by a supervisor, provided no documentation regarding [redacted]. This is concerning given the fact [redacted]; and a previous [redacted] from 01/19/2015 noted [redacted] The first [redacted] dated 07/14/2016 noted [redacted] as not being seen. It was however noted on the 07/22/2016 [redacted] that [redacted] were seen and safe.
    - The 11/21/2016 [redacted] referral, which [redacted], noted that well-checks are not medically necessary; however given the lack of [redacted] and that only one follow-up weight check appointment was completed, a further assessment may have been warranted. This concern is further supported by a physician during the Child Advocacy Center assessment regarding the 2017 [redacted] on the victim child's death with the doctor noting, "The

child had not been seen by a physician consistently as infant. This brings up concerns that this was part of a bigger pattern of neglect".

- [redacted] was arrested on 04/18/2018 and case notes indicate when the police arrived the house smelled of [redacted]. There is no documentation of [redacted] follow up except that the caseworker had extensive conversations with [redacted] about not being under the influence while in the primary caretaker role.
- [redacted] was implemented by WCCB on 01/02/2018 and was due to be [redacted] on 02/28/2018. Supervisor notes indicate a discussion would occur to find out the reason for the lapse but there is no further documentation to address [redacted]. [redacted] arrest and continuing to reside in the family residence the record should provide documentation of a discussion as to implementing the plan again or what steps they have taken to assure safety.
- The County reported during the MDT/Act 33 they had become aware of another of [redacted] but had minimal information about the reason or the specifics to [redacted]. The caseworker noted on 01/22/2018 that [redacted] The family was living in Fayette County at the time. [redacted] had stated they were poor and could not afford [redacted] they used an [redacted] Fayette County. The Department would suggest a more detailed follow up regarding these details and [redacted] explanation as it appears unclear when [redacted] and what private agency was utilized to [redacted].

- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>
  - There were no statutory or regulatory areas of non-compliance noted.

<u>Department of Human Services Recommendations:</u>

The Department would recommend when [redacted], whether this includes or does not include [redacted], the family is at a minimum provided a follow up assessment and/or referral to a [redacted], parenting class, or referral to a community service that focuses [redacted]

The Department would recommend guidance to the county child welfare agencies regarding receipt of reports when [redacted] and the continual failure to complete follow-up pediatric visits. It would be

recommended that the county agencies should, at a minimum, complete collateral contacts with medical providers before making a decision to screen out the report.