



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF

[REDACTED]

BORN: March 17, 2008
NEAR DEATH: April 26, 2009

The family was not known to Children and Youth Services
The family was not known to other public/private social service agencies

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 by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, January 4, 2009. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.¹

Circumstances of Child's Near Fatality:

According to the [REDACTED] dated 04/26/2009, child was found chewing on [REDACTED] belonging to mother who has an extensive history of drug abuse. There is an inconsistent history as to the source of the medication. At one point, the family reported the pills were prescribed but that they could not remember the name of the prescribing doctor. A short time after, the father said he gets the pills for the mother.

The mother found the child with the pill in his mouth and brought the child to the hospital. Child was sedated upon arrival and had to be given [REDACTED] as an antidote. Case was [REDACTED] with both parents as [REDACTED]. Child is being transferred to Children's Hospital of Pittsburgh and is expected to be [REDACTED] overnight.

A [REDACTED] report was received on the same date which stated the child was brought to hospital in ambulance. Parents found child drowsy and lethargic. Child ingested a [REDACTED]. Parents could not give a consistent explanation for why they had [REDACTED] or how the child got the pill. Father told the doctor that he gets them for the mother so she won't do drugs. Mother told the doctor that she gets the pills from [REDACTED]. Mother could not give the name of the person who prescribed the [REDACTED]. Child was given an [REDACTED] and transferred to Children's Hospital of Pittsburgh. Child is in serious condition as certified by [REDACTED].

Summary of Review**1. Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Child	03/17/2008
[REDACTED]	Mother	[REDACTED]1983
[REDACTED]	Father	[REDACTED]1971

2. Documents Reviewed and Individuals Interviewed:

The OCYF Program Representative reviewed the case file provided by Allegheny County CYF for the [REDACTED] on this family. The file included the investigation summary, demographic information, risk/safety assessment and safety plan, and progress notes. Interviews were conducted with Allegheny County CYF staff, including the former caseworker, the current intake caseworker and the current intake supervisor, as well as the caseworker from Armstrong County who had knowledge of the case. Also reviewed were the medical records provided by the Children's Hospital of Pittsburgh.

Case Chronology

[REDACTED], age thirteen months at the time of the near death event, was in the care of his mother and father when he ingested what the parents believed to be [REDACTED], a drug that father admittedly obtained illegally to assist mother with her [REDACTED]. Mother discovered [REDACTED] with the [REDACTED] tablet in his mouth and removed it. The parents then noted [REDACTED] appearance as listless, with dilated pupils, so they transported him to the hospital. Allegheny Valley Hospital (AVH) administered [REDACTED] to counter the effects of the substance, and a [REDACTED] determined that [REDACTED] had in fact ingested cocaine. Neither parent had an explanation for the baby's ingestion of that substance. AVH made a report of [REDACTED] and arranged for [REDACTED] transport to Children's Hospital of Pittsburgh (CHP) for further evaluation, as [REDACTED] was [REDACTED] to be in critical condition while at AVH. CHP Emergency Department provided no further treatment, and he was [REDACTED] to a foster home that same evening. Shawn required no medical follow-up for the incident.

[REDACTED] birth father has another child from a previous marriage and claims a third child as his own but is not the child's birth father. These children are in the care of other relatives.

OCYF placed [REDACTED] in a foster home after the Court granted an Emergency Custody Authorization. [REDACTED] was later placed with his maternal aunt and uncle, where he remains to date. This kinship placement is certified as A Second Chance, Inc. foster home.

[REDACTED] mother died in July 2009 after an accidental heroin overdose. [REDACTED] father remains involved through visitation but is not receiving [REDACTED]. According to documentation reviewed, he has not complied with other requirements of the Court and of the Family Service Plan. Shawn's maternal aunt and uncle state their willingness to become a permanent placement for [REDACTED].

Previous CY involvement

The family has been known to Allegheny County CYF since 2008 when [REDACTED] and mother [REDACTED] at the time of his birth (March 21, 2008). Both parents have had longstanding addiction - mother to heroin, and father to crack cocaine.

Shortly after his birth (May 16, 2008), [REDACTED] received burns to his thumb and chin after a lit cigarette allegedly fell from the back of a couch. Allegheny County CYF instituted in-home services to address safety issues for [REDACTED] and [REDACTED] for parents. The family relocated to Armstrong County, and a referral was made to this county. The case was closed on August 4, 2008.

Allegheny County opened the family's case on two occasions in 2008 and also referred the family to Armstrong County when mother and [REDACTED] resided with maternal grandmother in that county. Armstrong County did not open a case on the family, as the family's residence in Armstrong County was never confirmed.

Compliance with Statutes and Regulations

As was noted in the MDT meeting, the family frequently moved between Allegheny and Armstrong Counties during the course of their child welfare involvement. Allegheny and Armstrong Counties documented three referrals between the counties to assist the mother with housing and substance abuse treatment, but neither county opened a case or provided services because of an inability to confirm the mother's residency. It is critical that counties' coordinate service delivery to any shared family, particularly for those families with high degrees of mobility.

This review noted incomplete communication between Allegheny and Armstrong Counties prior to decisions related to case acceptance for services and case closure. Each county agency appeared to defer to the other county to serve the family. The case record documentation that detailed communication between the agencies, including sharing of information related to assessment of the baby and caregivers and the agreed upon agency that assumed responsibility to serve the family were not complete.

The children of highly mobile clients are vulnerable to safety and risk factors when their parents or caretakers move about for very short periods of time or move frequently, and particularly when those moves involve crossing county boundaries or shared custody across county boundaries.

Both child welfare agencies shared responsibility for this case and were charged with ensuring that the family's needs were addressed in a comprehensive, coordinated and timely manner prior to decisions of case transfer or closure.

Findings and Recommendations

The family was highly mobile between Allegheny and Armstrong Counties, and the agencies were not able to confirm residency despite diligent searched by the agencies. Despite this fact, the agencies lacked sufficient communication, and detailed communication between the agencies, including sharing of information related to assessment of the baby and caregivers and the agreed upon agency that assumed responsibility to serve the family were not complete.

The following is recommended to improve practice within the Counties:

- 1) To ensure County child welfare agencies are able to effectively share information statewide, it is imperative that a SACWIS system be created for use across all counties.
- 2) To ensure that families who are highly mobile and who cross county boundaries receive timely and appropriate responses to identified or suspected risk to their children, the Counties should review all policies and practices, including case record documentation, related to:
 - Case Acceptance for Services
 - Case Closure
 - Coordination of Services for Shared Clients between county agencies
 - Internal review of inter-county transfer cases by administration
- 3) Review of Inter- county Case Transfer Policy as it related to CPSL, 3490.401
- 4) Review of case closure criteria and procedures.

