



REPORT ON THE NEAR FATALITY OF:



BORN: 09/29/2011
DATE OF INCIDENT: 08/11/2012
DATE OF ORAL REPORT: 08/11/2012

FAMILY NOT KNOWN TO:
Erie County Office of Children and Youth

REPORT FINALIZED ON:

May 22, 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. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report.

Summary of Review

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	victim child	09/29/2011
[REDACTED]	mother	[REDACTED] 1977
[REDACTED]	victim child's father	[REDACTED] 1978

Non-Household members:

[REDACTED]	half-sibling	[REDACTED] 1996
[REDACTED]	half-sibling	[REDACTED] 1997
[REDACTED]	father of [REDACTED]	[REDACTED] 1976
[REDACTED]	half-sibling	[REDACTED] 2007
[REDACTED]	father of [REDACTED]	[REDACTED] 1971
[REDACTED]	maternal aunt	[REDACTED] 1970

It should be noted that [REDACTED] reside with their fathers during the school-year weeks, and visit with mother on weekends and for longer periods in the summer.

Notification of Child (Near) Fatality:

Erie County Office of Children and Youth (ECOCY) received a report on August 11, 2012 at 4:33 am regarding the victim child who was brought to [REDACTED] in Erie via ambulance unresponsive, and in [REDACTED]. After [REDACTED] for the child, it was discovered that the child had abrasions on her nose, [REDACTED] on her neck, a [REDACTED] on her forehead and it appeared as though she had been smothered. The child was certified to be in

critical condition by the treating physician but it was probable that she would survive. The child's condition was deemed suspicious due to the inability to dictate how the child's injuries occurred. The report was numbered for investigation of physical abuse. The child was transported to [REDACTED] via helicopter.

A supplemental report was received at 6:00 am on the same date reporting that the child arrived at [REDACTED] and the mother reported that the child was lying down to sleep and when checked on the child was face down gasping for air with her face in the pillow. Per the EMT that treated the child, the mother kept changing her story as to why the child was face down in the crib. The injuries could be consistent with trauma, according to the physician, and the treating physician also certified the child to be in critical condition due to the suspicion of abuse. It was also reported that the child may be [REDACTED] and it was unknown if she would survive.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families reviewed the ECOCY file regarding this family's previous involvement and the near fatality incident, including the safety assessments, risk assessments, on-going documentation, medical records, FSP and CPP's, court materials, and correspondences. The Department participated in the Internal Child Near Death Review meeting facilitated by Erie County on September 12, 2012 via teleconference. The Department also spoke directly to the intake supervisor regarding the CPS investigation findings.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

ECOCY received a GPS report on October 13, 2011 stating that at the time of [REDACTED] birth, the mother [REDACTED]. She had been [REDACTED] on 10/02/2011 and the chart reflects that she is not in a [REDACTED]. The case was accepted for assessment and given a 24 hour response time. The caseworker attempted a home visit on 10/13 and 10/14, but no one was home. Contact with the family was made on 10/25/11 at which time the conditions of the home were deemed safe and [REDACTED] needs were being met. The mother stated that she may have accidentally taken one of the father's prescription [REDACTED] pills by mixing up the bottles, as she had awakened in pain and thought she had taken an ibuprofen. The mother stated that she would take a drug test, but the dictation does not reflect that this occurred. The caseworker obtained [REDACTED] medical records and made collateral contact with her primary care physician (PCP) who stated there were no concerns. The mother's other children resided with their fathers, and visited with the mother on weekends. ECOCY closed the case on December 8, 2011.

ECOYC received a GPS report on June 11, 2012 which stated that the mother brought [REDACTED] to Hamot Hospital ER due to the concern that he had [REDACTED], but she left prior to the child being seen. It was reported that the child resides with his father but was at the time visiting with his mother. The case was accepted for a GPS assessment on 6/20/12; assigned on 6/21/12 with a 5 day response time.

The caseworker made unannounced home visits to the father's home on 6/25 and 6/26/12 but no one was home. An appointment letter was sent to the [REDACTED] father on 6/28/12. Collateral calls were made to the reporting source on 6/29/12 and 7/12/12, with messages left to call if there were any additional concerns.

On 7/12/12, the caseworker made an unannounced home visit to the mother's residence. [REDACTED] were present for the visit. The mother stated that she waited several hours for [REDACTED] to be seen in the ER when she decided to leave and see the PCP the next day, June 12th. The mother reported that she obtained a topical medication from the PCP which she had been applying; the caseworker saw the medication and noted that it was almost empty. The caseworker stated in the documentation that [REDACTED] was observed to have no [REDACTED]. [REDACTED] appeared to be of normal development and there were no safety concerns noted in the home.

On 7/12/12, the caseworker made a collateral call to the PCP to verify that [REDACTED] had been seen. On 7/26/12, the caseworker visited [REDACTED] father's home. The father reported that the child had [REDACTED] a year ago, but he was not aware of the child currently having it. He reported that [REDACTED] stays with him during the week of the school-year, and stays with his mother on the week-ends and for longer periods in the summer which is an informal arrangement between the parents.

On 8/06/12, the caseworker provided documentation regarding the above case activities and the GPS assessment was closed.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 8/11/12 at 1:55am, the agency received a CPS report concerning [REDACTED] as she had been seen at [REDACTED] in Erie and then transported via helicopter to [REDACTED]. She was deemed to be in critical condition as the result of suspected abuse. She had to be [REDACTED] and there were numerous injuries, including a [REDACTED] on and about her nose, on her forehead, and [REDACTED] around the neck. The mother had reported to the [REDACTED] staff that her daughter, [REDACTED] was babysitting [REDACTED] and she received a call from [REDACTED] saying that [REDACTED] was in the crib and making whistling noises. The mother stated that when she arrived at the home, [REDACTED] was face down in the crib with her eyes rolled back in her head. The mother provide conflicting information which included that the child was crying and her father was yelling at her to shut-up;

then she stated that a ghost did something to the child. The police had been notified.

At 4:42am, the caseworker spoke to the [REDACTED] social worker who reported that [REDACTED] continued to be in the [REDACTED] but the tests completed determined there was no injury to her brain or her eyes. The parents were reported to be at the hospital.

At 10:02 am, the caseworker spoke to the detective assigned the law enforcement investigation. The detective reported that he had interviewed the parents. At 10:47 the caseworker contacted Allegheny County Office of Children Youth and Family Services to request a courtesy visit with [REDACTED] who was at [REDACTED] in Pittsburgh. There was also a request for Allegheny County to obtain a medical update regarding the child's condition, and they were informed that law enforcement was assigned and the parents can provide an account of the incident to the caseworker if they chose.

At 12:05pm the [REDACTED] social worker called to report that [REDACTED] medical condition had improved as she is awake and responding. The physician believed that she was stable so the [REDACTED] was to be removed at some point that day.

On 8/12/12 at 2:51pm, the agency received information from [REDACTED] unit that the [REDACTED] was doing well. [REDACTED] she was deemed to be normal but sleepy. The skeletal ex-rays were normal but [REDACTED] toxicology screen came back positive for [REDACTED]. The physicians intended to complete additional testing to rule out a medical cause for this, but it is suspected that she was given the medication.

On 8/13/12, the caseworker contacted [REDACTED] father explaining the CPS report and the agency's need to assure [REDACTED] safety by making direct contact with him. A home visit was scheduled for 8/14/12 and the father was instructed to not allow the mother to have unsupervised contact with [REDACTED] until there is more information gathered.

At 11:10am on 8/13/12, the caseworker spoke to a pediatric nurse who reported that [REDACTED] was doing very well without the [REDACTED] and she is getting ready to be transferred [REDACTED]. If the child continues to progress, she will be discharged in the next 48 hours. At 11:24am the caseworker made contact with the Allegheny County supervisor who confirmed that two caseworkers responded to the hospital, and that she would have them return a call to the ECOCY caseworker.

At 11:42am the caseworker spoke directly to the child's treating physician at [REDACTED] who confirmed that the child tested positive for [REDACTED] with no associated medical reason for doing so. The physician reported that [REDACTED] is a sedative and could have caused the child's breathing to have slowed down.

There was no medical reason for [REDACTED] to stop breathing; however when she arrived at [REDACTED] she was barely breathing and had to be [REDACTED] [REDACTED] was reported to be doing much better; however there remains a concern for [REDACTED]. The physician was concerned that the child had [REDACTED] on and around her nose and that no one could account for the cause.

The caseworker also spoke to the [REDACTED] physician who stated that she met the parents on the day the child arrived at the hospital, but at that time, was not aware of the [REDACTED]. This physician also corroborated that the [REDACTED] could have caused the child's breathing to be slowed down to the point of needing [REDACTED]. She reiterated her concern for the fact that the child's nose is scraped up the bridge of the nose and on each side of the nostrils and nobody can provide an explanation. The mother reported to this physician that her 16 year old [REDACTED], who was visiting at the time, put [REDACTED] to bed at 7:00pm. The mother reported checking on the child at 10:15pm at which time she found her on her belly with her head up at the corner of the crib. The mother reported laying her hand on the child's back and realizing that she was breathing slowly so she turned her over and the child started gagging so the mother told [REDACTED] to call 911. The physician reported that it does not appear to be abuse, but more of a concern as to how the child got the [REDACTED] in her system and how she got the abrasions around her nose.

On 8/13/12, the agency obtained [REDACTED]

[REDACTED]. The mother reported that the only way [REDACTED] could have gotten the [REDACTED] in her system is if she accidentally found one of her father's pills on the floor. The mother reported that he [REDACTED] 2 weeks ago; that the father receives [REDACTED] from his PCP and when he was [REDACTED], he threw some of the pills on the floor. The caseworker informed mother that she was going to contact the child's father [REDACTED].

On 8/14/12, the caseworker visited with [REDACTED] at his father's home. [REDACTED] had told his father and paternal grandmother a few weeks ago that his mom and [REDACTED] father had gotten into a fight and her father took a bunch of pills. The father stated that he will assure [REDACTED] safety and that while he works the paternal grandmother will watch [REDACTED]. He agreed to supervise the mother's contact with [REDACTED].

At 12:17 pm on 8/14/12, the caseworker was notified that [REDACTED] was ready [REDACTED]. The mother was contacted regarding the fact that the agency case-

aid would be picking the child up from the hospital. The mother supported the plan to place [redacted] with her sister, at the maternal aunt's home who was already an approved kinship caregiver for other children.

The mother was contacted at 9:40 am on 8/15/12 to report that the case-aid was on her way to pick [redacted] up and take her to her maternal aunt's home. There was a discussion of child's feeding habits, allergies, or required special care. At 4:30, the caseworker visited [redacted] in her kinship caregiver's home. [redacted] was observed to be playing in a bouncer and smiling. The caseworker provided [redacted].

[redacted]. The caseworker scheduled a home visit with the parents for later in the morning that day. Contact was made with [redacted] father on 8/16/12 to ensure that the children were remaining in his care.

The caseworker completed a home visit with [redacted] mother and father at 11:00 am on 8/16/12. The mother reported the following information regarding details leading to the near fatality incident:

- Her 15 year old daughter and her friend along with her 16-year old son came to visit for the day.
- [redacted] had been fussy for the last week which was attributed to teething.
- That she placed [redacted] in her crib between 8:15-8:30pm.
- That she entered [redacted] bedroom between 10:15-10:30pm and found her lying face down in the crib at which time she turned her over and tried to wake her up. [redacted] opened her eyes, but she appeared to not be awake; and observed her having difficulty breathing.
- Her son brought her a wet cloth to wipe off the child's face and after a few minutes she had her daughter contact 911.

The father reported that he was not home at the time of incident as he had left the home to work as a DJ around 8:10pm. He came home as soon as he was contacted and drove the older children to the hospital. The father also brought a lock box from his bedroom that contained his prescription medication, which contained the following prescription bottles: [redacted]

[redacted]. The father also reported that he had a prescription for [redacted] but was not reportedly taking it. The caseworker noted that the prescriptions were from two doctors. The father also reported that when he [redacted] that additional prescriptions were given to him. The father reported that a few weeks prior to the incident, he attempted suicide on some of his pills including the [redacted] and that he was [redacted]. He reported that the police came to the home and searched his belongings and he believed that the police spilled pills on the floor, resulting in the child taking one of the [redacted] pills.

The mother reported that she was prescribed [REDACTED] as the result of having [REDACTED] and [REDACTED]. The parents agreed to have a urinalysis the next morning. At this point the father also admitted that he smoked marijuana but denied doing this while in the caretaker role. The father also reported that he has given the mother some of his medications if she does not have hers with her.

The safety assessment worksheet was completed for all of the children which resulted in the need for a safety plan. The parents agreed to only have supervised contact with the victim child. The mother agreed that her other children would remain in their father's care and that her contact with them be supervised.

On 8/17/12, the caseworker visited with [REDACTED] at his father's home. His father agreed to the safety plan and planned to utilize the paternal-grandmother as [REDACTED] caregiver in his absence. The agency also provided the kinship caregiver [REDACTED] on that day. There was a supervised visit at the agency at which time the parents and 15 year old sister visited with the victim child. It was noted in the dictation that 45 minutes into the visit, the father made a phone call to get a refill for his [REDACTED] and that he appeared to be more anxious and fidgety than normal. The mother reported after the visit that she and the father were not able to have the urine screen earlier in the am. The parents agreed to have a urine screen on Monday, 8/20/12.

The caseworker made a visit to [REDACTED] father's home on 8/20/12 and interviewed the children independently regarding the events leading up to the incident. [REDACTED] reported that her sister appeared to be fine all day on 8/11/12 except for being a little fussy. Her mother got up about 10:15pm to take her medication and to check on her sister and found her in the corner of the crib barely breathing. She reported that her mother was trying to wake her up and that she kept opening and closing her eyes. [REDACTED] called 911 and the ambulance came and took her sister and mother to the hospital. [REDACTED] also reported that her mother and step-father keep some of the medications on their headboard and others in the bathroom cabinet. She also reported that after the police interviewed her, she went to her mother's home and found a pill lying on the floor, but she was not sure what it was.

[REDACTED] reported that he was playing video games when he heard his mother calling for [REDACTED]; that they were trying to wake the victim child up; and, that he just stood back and waited for the ambulance.

[REDACTED]. Visitation with the parents was

established to be supervised twice weekly. The case was accepted for service on this date.

On 8/24/12 the father reported that he was prescribed the [REDACTED] for his [REDACTED] he contracted from his dog which creates joint pain.

O 8/30/12, the investigating Detective from Erie City Police Department contacted the caseworker to report that despite the discrepancies in the parents stories they passed the lie detector tests and there was no evidence or disclosure from the parents to suggest that they gave the [REDACTED] to the child purposefully. The detective stated that he had submitted the paperwork to the DA for review for a final decision whether to file criminal charges.

On 9/07/12, the on-going caseworker completed an initial home visit with the parents and gathered additional details regarding the father's [REDACTED] incident as well as more specific details regarding all of the medications the parents are taking. The father reported that on 7/27/12 he accidentally over dosed on [REDACTED] but stated that the overdose was related to the fact that the doctor told him to increase his dosage, which made him reportedly feel funny so he asked his wife to call 911. He also reported that he had been in a car accident in 2004 which resulted in his need for [REDACTED]. He was not seeing a pain specialist but reported that he has been given multiple prescriptions including [REDACTED]. He described that he had [REDACTED] if he did not take his medication. The caseworker gathered information on the parent's doctors

On 10/01/12, the intake caseworker spoke to the treating physician at [REDACTED]. The CY 48 report was submitted on that day to ChildLine resulting in an Indicated status against both parents for lack of supervision as the physician confirmed that [REDACTED] had [REDACTED] in her system which is believed to have caused her breathing to slow down resulting in the child being in critical condition. It was also determined that the abrasions to the child's neck and nose could have been caused at the time of [REDACTED] and did not appear to be the result of abuse or neglect.

Current Case Status:

On 01/28/13, [REDACTED]. The visits with [REDACTED] had gone well, and the parents demonstrated an ability to meet her needs. [REDACTED] She

remained placed in the kinship home of the maternal aunt. The visitation was gradually increased to overnights that were not supervised. The parents were attending all of [REDACTED] medical appointments, and her [REDACTED]

[REDACTED] The agency is continuing to monitor the child's return. The other children remain in the custody of their fathers and continue to visit at the mother's home.

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. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths:

- Very good communication between ECOCY, Allegheny County Office of Children Youth and Families, and the medical personnel at [REDACTED] at the onset of the investigation.
- The caseworkers and supervisors documented all of the information gathered during the CPS investigation process.

Deficiencies:

- The agency did not identify deficits.

Recommendations for Change at the Local Level:

- When completing a CPS investigation, the caseworkers need to be more diligent in questioning all of the doctors involved.
- The direct care staff needs to utilize the internet to research drug interaction.

Recommendations for Change at the State Level:

- There needs to be more training available to direct care staff regarding prescription drug usage and the effects and interactions of other prescription drugs

Department Review of County Internal Report:

The Department received the county report on September 17, 2012. The Department agrees with the recommendations established in the county's internal review process.

Department of Public Welfare Findings:

County Strengths:

- The agency responded to the near fatality report immediately and provided detailed documentation regarding all of the activities completed during the investigation.
- The supervisor provided oversight as documented in the supervisory logs, which included utilization of the critical thinking process.
- The agency maintained on-going communication with the Department throughout the investigation process.

County Weaknesses:

- The agency did not contact the physician regarding the medical findings until 10/01/2012 which is necessary information to gather in determining the outcome of the CPSL investigation. As the county stated the workers need to be more diligent in their efforts to gather the medical findings at the beginning of the investigation.
- When the initial GPS referral was made after [REDACTED] birth in which the mother [REDACTED], the assessment completed did not address the parent's [REDACTED] nor were releases obtained to speak to the prescribing physicians. This is a concern as the near fatality incident was related to [REDACTED] ingestion of [REDACTED]
- The second referral was made on 6/11/12 and the case was closed on 8/06/12. The previous history did not appear to have been reviewed as again there was no assessment of the parent's [REDACTED] needs. The father was hospitalized on 8/11/12 for overdosing on his medication.

Statutory and Regulatory Areas of Non-Compliance:

- There are no statutory or regulatory areas of non-compliance identified regarding the agency's response to this near fatality.

Department of Public Welfare Recommendations:

The Department recommends that the county continue its current practice regarding the internal reviews for Act 33 cases. The agency has identified a team of professionals that are committed to this process to ensure the agency continues to strive towards achievement of best practices consistently throughout the agency. The agency needs to expand its review of previous activity at the internal review meetings to include a discussion of strengths and weakness in agency practice during their involvement with the family.