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



**Date of Birth: January 8, 2009**  
**Date of Near Fatality Incident: June 20, 2011**

**The family was known to**  
**Allegheny County Office of Children, Youth & Families**

**Date of Report: August 15, 2012**

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, went into effect on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.<sup>1</sup>

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

**Family Constellation**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/08/2009
[REDACTED]	Mother	[REDACTED] 1964
[REDACTED]	Father	[REDACTED] 1956
[REDACTED]	Alleged Father of [REDACTED] (Per Mother)	Deceased
[REDACTED]	Brother	[REDACTED] 1998

**Notification Of Near Fatality**

Circumstances related to the near fatality of the victim child were reported to ChildLine on June 20, 2011. According to the referent, the mother reported that on the morning of June 20, 2011 she noticed that her [REDACTED] bottle was empty and the victim child was increasingly drowsy and then eventually became limp. The mother called 911 and the child was transported via ambulance to [REDACTED]. At the time of admission the child presented limp and "filthy" from head to toe. The mother was unable to report how much [REDACTED] was ingested by the victim child. [REDACTED] stated that the child was in critical condition and was taken to [REDACTED]. Upon receipt of the report, Allegheny County Office of Children, Youth and Families was notified of the near fatality and immediately commenced an investigation. The victim child was [REDACTED] two days later to the care of his mother. The examining physician stated that the victim child will make a full recovery and does not suspect any neurological damage. The only follow-up recommendation from the hospital is well child check-ups at this time.

**Summary of DPW Near Fatality Review Activities**

The assigned Western Regional Office Program Representative reviewed the case file and had frequent contact with Allegheny County caseworkers and supervisors assigned

<sup>1</sup> 23 Pa, C.S, § 6343(c)1,2.

to this case related to the child near fatality as well as subsequent activity with the family. The regional program representative also attended the Allegheny County Multi-Disciplinary Team (MDT) meeting pertaining to the case on August 11, 2011.

### **Summary of Services to the Family**

#### Children and Youth Services Prior to Incident

The mother was initially referred to Allegheny County in 1980 as a child because of neglect by her mother. Subsequent to that referral she was placed in foster and congregate care. After her release from care the family case was closed.

Following the birth of her oldest child in 1987, mother was referred to Allegheny County because of neglect related to [REDACTED]. The county assessment revealed that the mother was intellectually limited, [REDACTED]. Between 1987 and 1996 the agency extended in-home services to the mother for that child as well as five other children she subsequently gave birth to in 1990, 1991, 1992, 1994 and 1996. The mother was unresponsive to services directed at maintaining the children in her home. Consequently, those six children were removed from her care and subsequently adopted.

In October 2002 the mother was re-referred for services because she had been a victim of violence and was in need of help in caring for her seventh child, a son who was four years old at that time. The case was accepted and brief services extended; the case was closed in January 2003. Additional referrals were received pertaining to neglect and truancy of this child in 2004 and 2005. Again brief services were extended and the case was closed. In December 2008 an anonymous referral was received alleging that the mother, who was eight months pregnant, was unable to adequately care for her son now 10 years of age, let alone a newborn. The case was accepted; sporadic services extended to the mother, the brother of the victim child and the victim child, who was born in January of 2009. The case was then closed in October of 2009.

During the course of the above interventions there appears to have been little attention paid to the fathers of any of the children who had received agency services. Agency activity was focused almost entirely on the mother. According to the mother, the victim child's father is deceased and his brother's father is incarcerated.

On April 7, 2011 the agency received a General Protective Services report. According to the referral the brother had been excessively truant from school, he has reported he hates his life and adds that his life "sucks." The brother said that he has no bed at home and that there is not much furniture in the home. He said that "everything is getting turned off" most likely related to utility service in the home but has not been more specific than that. He also indicated that his mother hits him with a plastic bat on his legs and knees. He states that he has never had any injuries or marks from those situations. Per the referral source, he has borderline intellectual functioning and "behavioral issues". The brother has had 60 absences this school year but many of those are excused as mother writes excuses for the days he misses. The reporter stated there have been some illegal absences this year and the brother was charged with truancy at the local magisterial district office. The child was fined \$125 and the

mother paid the fine. The caller reported the school staff encouraged mother not to pay the fine so the matter would be referred to children and youth but the mother paid the truancy fine. The caller stated that the brother has "body odor", and his hygiene is poor. The caller had no information regarding the younger child (the victim child) at home.

Between April 7, 2011 and June 20, 2011 (the date of the victim child's near fatality) the agency made three attempts to interview the older brother, once at home and twice in school. None of these attempts were successful.

### Circumstances of Child's Near Fatality and Related Case Activity

According to the mother the victim child awoke about 7:45 am on June 20, 2011; at that point he seemed fine. Later, about 10:00 am, he climbed back into bed and tried to go to sleep. When she went to check on him he seemed strange and listless. At that point she found an empty bottle of [REDACTED] on the floor; not where she had left it in a locked box on top of a cabinet in the dining room. She guessed that he had somehow taken it off the cabinet and drank it. She immediately contacted paramedics who responded quickly.

When paramedics arrived they gave the victim child a [REDACTED] and transported him to the hospital. The victim child arrived at the hospital at about 10:45 am. Upon admission to the ER he was given another [REDACTED] and transferred to the [REDACTED] for observation. The victim child recovered from his [REDACTED] quickly and, according to hospital staff, did not have any medical complications.

On June 20, 2011, following receipt of the ChildLine report related to the near fatality, the agency engaged the family immediately and assumed protective custody of the victim child who was placed with an aunt on June 22, 2011. The victim child's older brother remained in the care of the mother with a comprehensive safety plan which included the implementation of intensive in-home services by two in-home providers, an adjustment in the mother's [REDACTED] requiring her to go to clinic for [REDACTED] [REDACTED] for the mother, weekly visitation by the agency, and an adjudication of dependency for both children with stipulation that the mother was to cooperate with service planning. The CPS investigation of the near fatality was completed on August 16, 2011 with a status of unfounded since substantial evidence did not exist to support a determination that the victim child was a victim of serious physical neglect. At the time the Near Fatality Report was generated the case was also referred to law enforcement officials; however on the basis of evidence obtained, no criminal proceedings were initiated.

### Current/Most Recent Status of the Case

The agency has been active with the family since the near fatality report. Both the victim child and his older half-brother were adjudicated dependent in August 2011. The mother's [REDACTED]

Allegheny County instituted in-home services for the family to support the older child's school attendance, the mother's recovery and parenting skill development. The brother

was referred to a community [REDACTED] for case management and intervention services, a truancy intervention provider and physical health provider, as well as for an assessment for presenting [REDACTED]. The victim child was referred to an [REDACTED] program.

The mother complied with Family Service Plan goals and court orders. In October 2011 the court ordered the victim child's return to the mother's care in response to a motion filed by her attorney. Since then the caseworker has had ongoing contact with the family. According to the casework supervisor, the victim child has made a satisfactory adjustment to his mother's care and has had no medical complications related to his accidental [REDACTED]. The casework supervisor reports that the primary focus of intervention with the family relates to the brother's school adjustment, for which he is still receiving support services.

### **County Strengths and Weaknesses as Identified by the County Near Fatality Report**

#### County Strengths

Allegheny County responded immediately to the near fatality report, conducted a thorough investigation and instituted a safety plan for both children.

#### County Weaknesses

None identified.

### **County Recommendations for Change at the County or State Level as Identified in the Near Fatality Report**

- Act 33 Review Team recommended communication with [REDACTED] that provide [REDACTED] to ensure that safety precautions for medication storage are shared with consumers, particularly those consumers with children in the home. A representative from the behavioral health Managed Care Organization (MCO) will facilitate discussions between the MCO and the provider community.
- Act 33 Review Team recommended Allegheny County staff training on use of data sources to better identify other systems that may be involved with consumers for family finding, case assessment and case planning purposes.

### **Department of Public Welfare Findings**

#### County Strengths

The Department concurs with the agency's findings that the investigation into this near fatality was timely and accepts the county's findings regarding the results of the investigation as well as the appropriateness of service planning for the family.

### County Weaknesses

The Department has concerns pertaining to the county's provision of services to this family prior to the Near Fatality Report; specifically related to its effort to engage the family in services upon the receipt of the GPS report made to the agency on April 7, 2011.

### Statutory and Regulatory Compliance Issues

None pertaining to the Near Fatality.