pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Daniel Howarth

Date of Birth: 09/09/2021
Date of Death: 01/07/2022
Date of Report to ChildLine: 01/07/2022
CWIS Referral ID: [redacted]

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

Bucks County Children & Youth Social Services Agency

REPORT FINALIZED ON: 06/07/2022

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))

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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.

Bucks 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 April 04, 2022.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Daniel Howarth	Victim Child	09-09-2021
[redacted]	Sibling	[redacted]2018
[redacted]	Maternal grandmother	[redacted]1964
[redacted]	Mother	[redacted]1999
[redacted]	Father	[redacted]1996

* 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:

[redacted] and obtained verbal and written statements along with the autopsy report. [redacted] The Southeast Regional Office of Children Youth and Families (SERO) reviewed the historical documents from Bucks County Children & Youth Social Services. The SERO representative attended the Act 33 review. The Act 33 review took place on April 04, 2022, via SKYPE due to COVID-19.

Prior to the Act 33 review team meeting the members of the team reviewed the case summary, referral information, investigation materials and medical information. During the Act 33 review, the medical personnel described all tests and exams completed and responded to questions from the team. Law enforcement was present as well and responded to questions. The caseworker and supervisor were present and were available to be interviewed by the team.

Summary of circumstances prior to Incident:

The family has a history of involvement with child welfare since May 13, 2018. [redacted] for marijuana [redacted] has a long history of multiple drug use since [redacted] was an adolescent. [redacted] also has a criminal record. [redacted] was placed in kinship care with [redacted] The court ordered [redacted] to supervise [redacted] visits with [redacted] The agency had a written agreement regarding the order with the [redacted] for the child.

In 2021, [redacted] has a history of drug usage and a criminal history. [redacted] stated that [redacted] introduced [redacted] to methamphetamine and the two used drugs together. [redacted] The County was aware of the [redacted] however, [redacted] were difficult and uncooperative. [redacted] were homeless but were often found in [redacted] home. The county tried several times to assist [redacted] refused. The court placed [redacted] The court ordered that [redacted] is not to be unsupervised with [redacted] The County had a written agreement with [redacted]

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

[redacted] was home with [redacted] on 01/07/22 [redacted] also lives there with [redacted] is [redacted] comes to the house to visit [redacted] has a history with Bucks County C&Y. The County placed the children under [redacted] care. [redacted] was informed that [redacted] cannot stay overnight in the house and all visits must be supervised at all times [redacted] use drugs. On the date of 01/07/2022, the police and meds were called to assist with a 4-month-old Daniel Howarth. It was reported that the child was in cardiac arrest. When the police arrived [redacted] was performing CPR. The police and EMS attempted medical care to the child. The police reported that the VC was very pale. The child was taken to [redacted]

The police questioned the family. [redacted] stated that [redacted] was in [redacted] room and heard a commotion and then [redacted] came out. [redacted] was observed as being withdrawn. [redacted] gave a brief statement. [redacted] the VC was sleeping in [redacted] room around 11PM. [redacted] were not there. [redacted] goes to [redacted] room and hears the baby around 6AM-7AM and sees [redacted] in the room. [redacted] gives him the bottle and went back to [redacted] room until 8:30AM or 9AM. [redacted] starts work around 11AM.

11:30 [redacted] is screaming. [redacted] takes the baby and calls 911. The police spoke with the [redacted] and escorted [redacted] upstairs to [redacted] room where the child was found. Drugs and drug paraphernalia was seen around over the room. The police retrieved the bags of drugs. [redacted] was taken to the hospital. Shortly afterwards the child was pronounced deceased. [redacted] that the VC had been deceased for several hours prior to coming to the hospital. Childline was phoned and search warrants were obtained for the address. At the address, some of the items obtain by police were 3 unused heroin bags and a container of crack cocaine and 9 empty baggies, and syringes.

[redacted] gave a statement about getting to the house at 8AM after staying with the [redacted] address. [redacted] said stated that [redacted] Ubered to the house and went right to sleep cause the baby was sleep. [redacted] woke up to screaming. [redacted] admitted to using fentanyl. [redacted] used it two days ago at [redacted] house. [redacted] also said [redacted] uses syringes. [redacted] was in the bathroom and heard screaming. [redacted] ran downstairs because [redacted] thought someone was hurt. [redacted] came downstairs and saw that [redacted] was blue, and [redacted] were trying to bring him back. [redacted] didn't sleep at the house last night. [redacted] to the house around 9:30AM. [redacted] slept at [redacted] house. When [redacted] came to the house at 9:30AM [redacted] said the baby was sleeping so [redacted] let him sleep. [redacted] was just hanging out. [redacted] the last time [redacted] saw [redacted] son was last night and [redacted] was fine.

[redacted] gave the baby a bottle around 7AM. [redacted] agreed to come to police headquarters. At the police station, a search warrant was obtained to get blood from the [redacted] The blood was taken into evidence. [redacted] did sleep at the house the previous night. [redacted] was sleeping on the couch and was awaken by screams. [redacted] to submit blood. [redacted] did not agree to the draw. [redacted] did not obtain a search warrant for [redacted] blood because [redacted] did not appear to be under the influence. The next day, [redacted] attended the autopsy. [redacted] that there was no trauma to the baby. A urine tox screening revealed that the VC urine tested positive for the presence of fentanyl. The amount of fentanyl would not be available for up to 6 weeks and the official cause and manner of death would not be available for 12 weeks. [redacted] returned to the house 01/08/22 and conducted another search. [redacted] found more drug paraphernalia. On 01/13/22, [redacted] stated that [redacted] called. [redacted] returned to the house. [redacted] said I have to tell you a different story. [redacted] said that the VC was in her room, he was crying at 6AM. [redacted] goes to get the bottle, and [redacted] admitted to leaving the baby with [redacted]

[redacted] was removed from the home on 01/07/22 by Bucks Cty C&Y. [redacted] A safety plan was put in place. [redacted] was allowed to see the child for a supervised visit on 01/12. Bucks Cty was very concerned with [redacted] protective capacities. The county does not want to return the child to [redacted] On 01/18/22, a hearing was conducted, and the child was placed with [redacted] was contacted regarding the autopsy. I spoke with [redacted]

[redacted] that there were no signs of trauma to the VC and that [redacted] tested positive for methamphetamine, fentanyl, and amphetamines. [redacted] it will take approximately 12 weeks for the results of the cause and manner of death to be known. Next, [redacted] were contacted. I was informed that [redacted] were conducting the investigation into the incident. [redacted] spoke with the family on the day of the incident and obtained statements. [redacted] gave very minimal statements. [redacted] appeared high so a search warrant was obtained for [redacted] blood. Two vials were taken. [redacted] did not appear high; therefore, no search warrant could be obtained. The [redacted] did not volunteer [redacted] blood.

[redacted] have not been able to locate [redacted] after the incident for further questioning. [redacted] have looked for [redacted] address with no luck. [redacted] was interviewed three times. [redacted] reported that [redacted] has two stories. [redacted] original version is the truth. [redacted] that the statements and police report were sent to Bucks County C&Y. The information was obtained from the county. [redacted] also provided additional updates on the investigation. [redacted] bedroom was full of drugs and paraphernalia. Evidence was collected from the room. There were over 50 baggies of heroin and over 10 syringes that were easily accessible to [redacted] that it is unknown if the occurrence is an accident or if transference happen. [redacted] made a comment after the child death saying, "Do you believe it came from the Orajel." [redacted] could have placed it on [redacted] finger and rubbed the VC's gums for teething issues. [redacted] that at the time no arrests were made however [redacted] were being investigated.

[redacted] medical evidence that the cause of death was ingestion of fentanyl. The police issued arrest warrants for [redacted] arrested on 3/16/2022. The police continued to search for [redacted] until [redacted] surrendered [redacted] on 03/23/2022. [redacted] charged with felony counts of involuntary manslaughter and endangering the welfare of a child. [redacted] has a felony charge of endangering the welfare of a child. At the time of the report, [redacted] were awaiting criminal hearings regarding the matter. [redacted] was moved from [redacted] and was placed with [redacted] did make bail however [redacted] has not been allowed any visits with [redacted] remain in prison. [redacted]

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;**

    - Collaboration and cooperation amongst Children and Youth, Local Police, and [redacted]
    - All parties were responsive relative to regulations regarding child abuse investigation and criminal investigation.
    - Child abuse and neglect response times were consistently met within state regulations.
    - [redacted] competently and quickly in securing evidence and taking statements from witnesses.
    - The Agency had consistently been clear and consistent with the [redacted] about the specific meaning of "supervised contact" between the child(ren) [redacted]
    - The local hospital acted competently in administering a drug test at the emergency room department.

- **Deficiencies in compliance with statutes, regulations, and services to children and families;**

    - If a child is currently under the custodial supervision of a county child welfare agency, all rooms should be thoroughly checked in the home at every home visit. Specific attention should also be given to kinship foster families where parental contact is to be supervised by the foster parent or extended kinship resources.

- **Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;**

    - Provide parental education resources, supportive services, and resource information to caregivers with diminished protective capacities or history of substance abuse.

    - Maintain communication with, and develop strategies with, the court system to maintain accountability with parents who do not make

progress in completing goals of their Family Service Plans. Move forward to promote timely goal change hearings and termination of parental rights when applicable.

- **Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and**
    - All rooms of the foster home should be thoroughly checked regularly, particularly in complicated kinship placements.
    - Services and medical testing should be mandated for sibling children of a victim child in cases of serious child abuse and/or neglect.

- **Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.**
    - None noted at this time.

Department Review of County Internal Report:

On June 10, 2022, the SERO received the county Internal Report. The report was reviewed and found to be a through review of the investigation and fatality of the child.

Department of Human Services Findings:

- **County Strengths:**

  The County made numerous visits to the home.

  [redacted]

  The county had an immediate response when the fatality was reported.

  The County worked well, closely, and swiftly with the police and district attorney to gather and share information.

  The County acted quickly to remove the sibling form the home. The police secured the home and interviewed [redacted] swiftly.

  The police had the [redacted] blood tested immediately.

The County assisted the State investigator by providing documentation, records, and other requested information.

- **County Weaknesses: and**

  The County did not do a complete inspection of the home prior to the incident. The County worker had an unannounced visit at the home the day before the fatality and would have seen the room where the VC was found. The room was filled with drugs and drug paraphernalia.

  The county did not report the sibling's welfare to Childline. The police reported that the sibling could have easily obtained the drugs and the drug paraphernalia.

- **Statutory and Regulatory Areas of Non-Compliance by the County Agency.**

  There were none noted.

Department of Human Services Recommendations:

The County must complete a total home inspection for all homes. A full inspection can reveal unknown circumstances in the home and allow the county to prevent and/or address unforeseen matters.

Licensing agency (SERO) can mandate the inspection of all rooms in a home and have a designated checklist that must meet a 100% compliance by the county. If the county/agency is non-compliant then high monitoring and/or revocation can be enforced.

There should be more accountability of the county when parents do not comply with referred services. Reports should be provided for 60 days on the status of the case to supervisors and management so that recommendations and adjustments can be taken to resolve the concerns.

A statewide hotline for substance abusing parents should be provided to those who need support and guidance regarding their addiction and parenting concerns. The hotline could provide verification to the county that the parents are compliant without being penalized.

Children under age 5 are extremely vulnerable. The county should provide a designated worker that is focused on the child's physical, emotional, and other needs to eliminate a substance born child barriers and concerns. The worker should have routine assessments of the child's progress and provide recommendations for concerns that need to be addressed.