



REPORT ON THE FATALITY OF:

Dean Pugliese Jr.

Date of Birth: 10/25/2003
Date of Incident: 07/03/2019
Date of Death: 07/03/2019
Date of Report to ChildLine: 07/08/2019
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Dauphin County Children and Youth Services

REPORT FINALIZED ON:

January 9, 2020

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.

Dauphin County did convene a review team in accordance with the Child Protective Services Law related to this report. The agency facilitated the Act 33 review on 07/26/2019.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Dean Pugliese Jr.	Victim Child	10/25/2003
[REDACTED]	Mother	[REDACTED] 1971
[REDACTED]	Father	[REDACTED] 1959
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Paternal Cousin	[REDACTED] 1994

* 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 Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged Dauphin County Children and Youth Services personnel to discuss the incident and subsequent findings. CROCYF attended the CYC agency's Act 33 meeting on 07/26/2019.

Summary of circumstances prior to Incident:

Representatives of Dauphin County CYC informed CROCYF that the family was not known to the agency.

Circumstances of Child Fatality and Related Case Activity:

Dauphin County CYC received [REDACTED] on 07/08/2019 indicating that a 15-year-old child died of a drug overdose. [REDACTED] initiated the report when it was identified [REDACTED] that [REDACTED] with [REDACTED] and that [REDACTED] failed

to seek medical care for [REDACTED] during his overdose. The victim child died at [REDACTED] residence. An autopsy was completed on 07/04/2019 and the findings indicated that the youth died due to lethal amounts of heroin and Kratom in his system. (The United States Drug Enforcement Administrator states that Kratom comes from the leaves from the tropical tree Kratom in Southeast Asia which causes stimulant and sedative effects in different doses.)

At the onset of the [REDACTED] investigation, CY5 personnel assured safety of [REDACTED] who was in the home at the time of the incident. A safety plan was not developed as [REDACTED] outlined that [REDACTED] would reside with [REDACTED] and that the child would not be left alone with [REDACTED]. The CY5 agency completed [REDACTED]. It was noted that the victim child resided with [REDACTED] but that the youth had been spending more time with [REDACTED]. Law Enforcement informed the CY5 agency that they performed a search of [REDACTED] residence which resulted in finding [REDACTED] who was also residing in [REDACTED]. [REDACTED] reported to CY5 personnel that [REDACTED] was not aware of [REDACTED] drug use. As part of the CY5 investigation, interviews were conducted with [REDACTED]. [REDACTED] reported that [REDACTED] was playing video games with [REDACTED] home on 07/02/2019 and described [REDACTED] talking slowly and that [REDACTED] appeared tired. [REDACTED] informed CY5 personnel that [REDACTED] observed the youth was acting "weird" and asked the youth why he was acting they way he was. [REDACTED] stated that the victim child told [REDACTED] that he was on heroin, but then later said he was on Kratom. Later that evening, [REDACTED] arrived that [REDACTED] house and [REDACTED] picked up both [REDACTED] and transported [REDACTED] to [REDACTED] home where the victim child later overdosed and died.

CY5 personnel interviewed [REDACTED] who denied purchasing heroin but admitted purchasing Kratom and that [REDACTED] mutually shared the drug with [REDACTED]. [REDACTED] reported that [REDACTED] was unaware that [REDACTED] was under the influence of drugs when [REDACTED] picked him up at [REDACTED] home on 07/02/2019. [REDACTED] also admitted that [REDACTED] knew [REDACTED] was in distress later in the evening and that [REDACTED] could hear [REDACTED] "snoring, snorting and gasping" but failed to obtain medical care for him because according to [REDACTED] the youth never requested assistance. [REDACTED]

Dauphin County CY5 offered the family services which included parenting classes, [REDACTED]

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

The agency's Act 33 team identified effective collaboration and communication between law enforcement, medical staff, the coroner's office, and the CYS personnel.

During the [REDACTED] investigation it was noted that [REDACTED] was very cooperative.

[REDACTED]

The agency offered services for [REDACTED]

The Act 33 team noted that the CYS agency promptly requested and attained the victim child's medical records which allowed [REDACTED] time to review.

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

Due to the cause of death as a drug overdose, the Child Death Joint Investigation Team was not initiated immediately.

The Act 33 team noted that the CYS agency did not receive a referral on the child's death until death until five days later.

During the review, the Act 33 team noted that the Coroner's office was not aware the drug in question was Kratom.

During the meeting, it was reported that Law Enforcement officials have been unable to unlock the youth's cell phone to assist in their respective investigation of where the youth may have purchased drugs and from whom.

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

The CYS agency's Act 33 team will review protocols to ensure that the agency is notified all child deaths even if they initially fall under "the category of drug overdose, shootings, etc." The Leadership of Dauphin County CYS will communicate this recommendation to the District Attorney.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies

NA

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

NA

Department Review of County Internal Report:

The CROCYF received Dauphin County CYS' Child Fatality Report on 09/25/2019. Upon review of the documentation, CROCYF assessed that the information efficiently described the incident, the actions taken by the agencies involved, and the status of the case. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

During the Act 33 meeting, it was evident that CYS personnel were prepared to present the case.

The CYS agency has developed an Act 33 team where members represent a wide variety of disciplines.

- County Weaknesses:

At the time of this report, the CROCYF has not identified areas of weakness.

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

At the time of this report, the CROCYF has not identified areas of regulatory non-compliance.

Department of Human Services Recommendations:

From the information gained from fatality, The CROCYF has developed the following recommendations:

The Department recommends that OCYF take the lead in requesting data from Children and Youth Agencies and from OCYF Regional Offices of incidents where the substance, Kratom, was a factor. If the Department is successful in gaining the data over two calendar years, 2018 and 2019, the information will be shared with the State's Department of Drug and Alcohol Programs (BDAP).

The Department also recommends that, in collaboration with BDAP, educational material should be distributed to local and State entities about the origin of Kratom and the potential health risks to children and adults.