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**REPORT ON THE NEAR FATALITY OF:**



**BORN: July 27, 2007**

**FAMILY KNOWN TO:**  
*Beaver County Children and Youth Services*

**REPORT FINALIZED ON:**  
*October 21, 2011*

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 [REDACTED]. 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. Beaver County has not convened a review team in accordance with Act 33 of 2008 related to this report.

The rationale provided by Beaver County CYS staff is that the investigating worker had already completed all of the necessary interviews and obtained all of the pertinent medical documentation to support an [REDACTED] determination. This was all done prior to the time the review was to take place.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	07/27/2007

[REDACTED]

**Notification of Child (Near) Fatality:**

On December 17, 2010, Beaver County CYS [REDACTED] a case they had initially received on December 15, 2010 as a [REDACTED] report as a [REDACTED] report after contacting the treating physician at Children's Hospital of Pittsburgh to inquire whether the report would be considered a near fatality. The physician confirmed that due to the child's condition upon arrival, the report should be considered a near fatality. The [REDACTED] report was regarding the child, [REDACTED], as the [REDACTED] and [REDACTED] as the [REDACTED]. The [REDACTED] in the report were that the [REDACTED] child, [REDACTED], had possibly ingested four Trazodone tablets, which she found in her grandmother's room.

The child was initially treated at Heritage Valley Medical Center in Beaver, but later transported to Children's Hospital of Pittsburgh and admitted into the [REDACTED]

██████████. Due to the child's condition upon arrival, the treating physician certified the report as a near fatality.

### **Summary of DPW Child (Near) Fatality Review Activities:**

As part of this near fatality review, the Western Region Office of Children, Youth and Families requested a complete copy of the family's record, including the ██████████ and medical documentation used to support the agency's finding. The family's case file was reviewed and follow-up conversations took place between the regional office staff and the investigating caseworker.

As stated previously, Beaver Co. CYs did not convene a near-fatality review for this incident, as the agency had already determined based on the information they obtained that the incident was accidental in nature.

### **Summary of Services to Family:**

#### Children and Youth Involvement prior to Incident:

Prior to becoming involved with the agency, ██████████ and the children were not living together. The children were residing in Illinois with a great aunt and uncle, while ██████████ was living with ██████████ father, ██████████, in Aliquippa, Beaver County. It is unknown why the children were residing with relatives. At some point, ██████████ was arrested for theft charges, leaving ██████████ with no income and no supports. As a result, ██████████ went to live with her mother, ██████████ and her two children ██████████ (half-siblings) (ages 3 and 1.5 years of age) in Ohio. In early November 2008, ██████████ relocated to Aliquippa with her mother and half-siblings. Once arriving in Aliquippa, ██████████ children came to live with her as well.

The family was initially referred for assessment services on November 18, 2008 due to housing conditions, such as overcrowding and "below minimal standards of living." There were also concerns that the mother, ██████████ was incapable of parenting her children. The household composition at the time of the report was ██████████ and her four children, as well as ██████████ and her two children.

Beaver County CYs assisted ██████████ in applying for and obtaining necessary services for the children, such as ██████████ and concrete goods. The caseworker was concerned for the family because they were new to the area, had no transportation, and seemed overwhelmed. The worker made the decision that intensive services could be beneficial for the family and made a referral for services which began immediately following the referral.

On November 26, 2008, a second report was made regarding the family. According to the reporting source, one of the children placed a plastic utensil on the stove and it started a fire. When the fire department and police responded to the home, they found it

"cluttered and overcrowded." The worker visited the home on the day of the second referral and found minimal damage caused by the fire.

The intake worker completed an assessment of the family and as a result of the findings, accepted the family for services on December 17, 2008. The Risk Assessment that was completed at the conclusion of the intake assessment and acceptance for service rated the Overall Risk as "High." The rating was due to six young children living in a small apartment, both mothers having [REDACTED] and issues supervising the children. [REDACTED] children were referred for [REDACTED] services and the family began working with the Parenting Wisely program.

In April of 2009, [REDACTED] and her children moved out of the family home and in with a paramour. After moving out, [REDACTED] began having issues that affected the safety of her children, including [REDACTED], and medical issues that included two accidental overdoses on prescription medication. As a result of these issues, Beaver Co. CYS received referrals on [REDACTED] and her children. [REDACTED] voluntarily put her children in the care of family members, with Beaver Co. CYS formalizing the placement by obtaining custody of [REDACTED] children and certifying the kinship parents as foster parents in August 2009.

In August of 2009, the family was transferred from the Intensive Services unit to Protective Care ongoing services unit, with the risk remaining "High." Due to the High Risk rating, the agency had contact with the family at least once per week, which they had been doing since accepting the case in December or 2008.

In January 2010, [REDACTED] father, [REDACTED], moved back into the home, as he and [REDACTED] began a relationship again. [REDACTED] reported that while in jail, he completed [REDACTED] and parenting classes. He advised the worker that he was on parole and provided the name of his Parole Officer. The agency completed a Safety Assessment and Plan for the family, as [REDACTED] was a new household member and had issues that could be a threat to the children's safety, such as [REDACTED], violence and criminal activity. The plan put in place and agreed upon by [REDACTED] was that he would not be unsupervised with the children pending Beaver County completing clearances on him. The [REDACTED] caseworker verified current and prior treatment history on both [REDACTED]. After reviewing the background information on both parents, the agency deemed the children safe in his and [REDACTED] care and terminated the safety plan.

According to case dictation, the family had been having ongoing issues with their apartment, many of which were due to the condition of the building and the landlord's refusal / inability to maintain it properly. As a result, the building was condemned and the family had to be out of the building by February 4, 2010. The family found a new apartment and moved in on February 3, 2010. The caseworker maintained contact with the children and parents throughout this process and visited the new apartment, ensuring it was a safe environment. Although the residence itself was appropriate, the parents found it difficult to afford and began to fall behind in rent and utilities.

In May of 2010, the family received an eviction notice due to inability to pay rent. The caseworker discussed finances with the mother and was assisting her in locating a new residence for her and her children. Emergency housing was located and the family moved into their new residence on or about June 16, 2010. During this whole process, the caseworker was having regular visits and contact with the family, including the children, and noted no concerns. The worker used the words "active, cheerful, playful, and talkative" to describe the children while the housing transition took place.

The family had approximately 60 days to stay in the current emergency housing. As a result, the family and the caseworker diligently researched possible apartments for the family. While in emergency housing, the agency had minor issues with the condition of the residence, specifically cleanliness and the odor of cat urine. There were no concerns noted regarding supervision of the children. The worker had regular contact to monitor the condition of the home, both announced and unannounced. On September 11, 2010, the parents signed a new lease for a residence in Aliquippa, Beaver County. The family moved into this new residence over the weekend of September 18, 2010. When the family moved into this apartment, [REDACTED] moved back into the residence with them, with her children remaining in foster care. It was determined that a safety plan was not required upon [REDACTED] moving back into the home, as she would not be the sole caretaker and the safety assessments determined the children to be safe.

At this point in time, the family was addressing their [REDACTED] and had not displayed any issues with [REDACTED]. The structured case notes report that both parents "work together to supervise the children," have "adequate" parenting skills, and are protective of their children.

The family's new residence, in which they still currently reside, is a three bedroom home. When the family moved into the home in September, the two boys shared a bedroom, the two girls shared a bedroom and [REDACTED] had her own bedroom, all three located on the second floor. [REDACTED] converted the dining room on the first floor of the home into their bedroom. These were the sleeping arrangements at the time of the incident on December 15, 2011.

The caseworker determined that the children were safe in their parents' care, as the parents were not displaying any concerning behaviors that would affect their children's safety. The two younger children were enrolled in daycare, while the two older children attended kindergarten. On October 12, 2010, the overall risk was rated "Moderate" due to housing instability. As with previous practice with this case, the worker continued to have contact with the family at least once per week with the children and family to ensure housing was being maintained appropriately.

According to the case dictation, the caseworker's last contact with the family prior to the incident was on December 14, 2010. The visit was announced and the caseworker made contact with all household members. Again, no concerns with supervision or housing conditions were noted for this visit.

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

On December 15, 2010, a [REDACTED] report was made to Beaver Co. CYS as a result of the incident. The assigned caseworker made contact with the [REDACTED] victim and parents at Children's Hospital of Pittsburgh on December 16, 2010.

In the interview on December 16, 2010 the parents reported that [REDACTED] were upstairs in their rooms taking a nap before dinner, which is their usual routine. While the children were napping, [REDACTED] was in her room but did not come downstairs for a short period of time. [REDACTED] was making dinner and [REDACTED] was cleaning their bedroom. Reportedly, [REDACTED] heard [REDACTED] crying "as if she were hurt" so he ran upstairs and found her on the landing of the steps. [REDACTED] reported that when he found [REDACTED] her head was down, she was crying, and shaking very badly. He thought she was having a "low blood sugar episode" so he took her downstairs and gave her Kool Aid and candy to raise her sugar level. [REDACTED] stated he is [REDACTED], so he is aware of symptoms.) After five to ten minutes, [REDACTED] did not improve, so they called 911. When the EMTs arrived, they asked to go upstairs "where the event occurred." The caseworker documented that the father told her that when they went upstairs, they went into [REDACTED] bedroom. The door was open and they saw pill bottles on the floor, with the bottle of Trazodone open. Initially, [REDACTED] denied that [REDACTED] could have gotten into the pills, but after they counted them they found four missing. [REDACTED] was taken via ambulance to Heritage Valley Medical Center where a toxicology test was done. [REDACTED] accompanied [REDACTED] to the hospital and was present throughout her stay. The results of the test confirmed that [REDACTED] had ingested Trazodone and she was later transferred to Children's Hospital of Pittsburgh.

After reviewing the events with the caseworker, a safety plan was developed that required [REDACTED] leaving the home, as the parents did not want to lose custody of their children and would do anything asked by the agency to keep them. While at the hospital, the other children were in the care of their paternal uncle. [REDACTED], although initially reluctant, agreed that it would be safer for the children if [REDACTED] was not in the home.

Also on December 16, 2010, the caseworker interviewed [REDACTED]. While she reported that she felt terrible that [REDACTED] had gotten into her medication, she felt it was [REDACTED] and [REDACTED] job to supervise the children, not hers. [REDACTED] denied using any illegal drugs. The caseworker walked through the home and observed some over-the-counter medication sitting on a mantle and there was a bottle of antibiotics in refrigerator, which was not secured from the children. After meeting with the parents and [REDACTED], the caseworker completed a Safety Assessment and determined the children were safe with a comprehensive safety plan stating [REDACTED] would not be unsupervised with the children.

On December 17, 2010 the caseworker assigned to complete the [REDACTED] investigation contacted the treating physician at Children's Hospital of Pittsburgh to inquire whether the report would be considered a near fatality. The physician confirmed that due to the child's condition upon arrival, the report should be considered a near fatality. The caseworker discussed this conversation with agency supervisors and as a result, registered the report as a near fatality on this same date. The worker went back to the

home to develop a new safety plan with the family. The plan that was developed with and signed by the parents and [REDACTED], involved [REDACTED] leaving the home. Although there were other actions listed in the plan, the only actions that could have an immediate impact on safety and agreed upon were [REDACTED] not being allowed to have contact with any of the children in the home unless approved by Beaver County CYS and assurances the parents would properly supervise the children while in the home. On December 19, 2010, the caseworker went back to the home to confirm [REDACTED] moved out.

On December 20, 2010, the investigating worker interviewed [REDACTED] regarding her involvement in the incident. At this time, [REDACTED] was residing at the [REDACTED]. The caseworker asked where she kept her medication and [REDACTED] described keeping it in a tote, which she used as a night stand next to her bed. [REDACTED] reported that there were six bottles of medication in the tote. All of the medication except for the Trazodone had child safety caps, for which she had no explanation. Her bedroom door did have locks on it, both inside and out, to keep the children out of her room. Earlier on the day of the incident, she reported that she had gone downstairs and must have forgotten to lock her door because she found her purse dumped onto the floor, chocolates that were in her room had been eaten, and the children were in her lotion. Although she said she must not have locked the door, she was sure that she closed it. She also believed that [REDACTED] must have gotten into the medication earlier in the day than what [REDACTED] believed, because she said it "takes a while for that medication to kick in."

[REDACTED] believed that it was possible that [REDACTED] took the medication as there were four pills missing. However, she was not present when the EMTs found the medication spilled on the floor in her room. [REDACTED] expressed frustration with the pharmacy for not putting a safety cap on the prescription bottle. She also reiterated that she did not feel it was her job to supervise the children at all times and they shouldn't have been in her room. The caseworker discussed getting a lockbox for the medication, which [REDACTED] felt was a good idea. She could not recall specific details when the children may have been upstairs unsupervised in order to narrow down any timeframe. She also understood that as per the safety plan, she was to have no unsupervised contact with [REDACTED] until further notice.

Later on December 20, 2010, the investigating worker interviewed the parents regarding what took place on December 15<sup>th</sup>. [REDACTED] had already been discharged from the hospital and was present during this visit. According to the parents account of what happened, they had gotten up approximately 7:30 to get the two older children ready for school. After getting the two older children off to school, the parents woke [REDACTED] and [REDACTED] up, gave them breakfast and played with them. [REDACTED] reported that her mother had been in her room most of the day, but was "up and down the stairs to roll cigarettes" at times. At some point during the day, [REDACTED] left the home to get prescriptions filled, although [REDACTED] was unsure exactly what medications were being filled. Also around this time, [REDACTED] left the home to meet with his probation officer and run errands. [REDACTED] arrived home prior to [REDACTED]. When [REDACTED] came home, [REDACTED] came downstairs to inquire if he had purchased any cigarettes while he was out. At this point in time, all of the children were home and the parents reported that the children were upstairs cleaning their rooms and making their beds.

██████████ stated that he was preparing dinner and while doing so, checked on the children at least once. He said that approximately 30 minutes prior to dinner being ready, he called for ██████████ to come downstairs. ██████████ reported that ██████████ had gone to the bathroom and needed cleaned, so ██████████ took him to the bathroom. ██████████ said that when he returned to the kitchen, he heard ██████████ crying and screaming. As described earlier, ██████████ thought the child was having a ██████████ episode so he gave her Kool Aid and Hershey's kisses. Afterwards, ██████████ contacted 911 to request assistance.

The father reported that when the EMTs arrived, they processed with him the events that transpired during the day. After reviewing events in the day, the EMTs took the father upstairs to search for a possible cause, where they found the maternal grandmother's bedroom door open and medication spilled on the floor. The EMTs counted the spilled medication and determined that the child may have ingested 400mg of Trazodone. ██████████ could not remember if ██████████ bedroom door had been open or shut throughout the entire day, but does remember it was open when he heard ██████████ crying and went to her.

The parents claimed that they check on the children at least every five or ten minutes and were aware that the children got into ██████████ purse, chocolates, and lotion. They do feel as though it was ██████████ responsibility to help supervise the children, as it was a condition of her moving into their home. The caseworker advised the parents that ██████████ is not the parent of the children and she was not responsible for supervising them just because she was living in the home. The caseworker verified that the parents keep their medication in a locked briefcase, which is kept in a locked cabinet in the kitchen. The caseworker also ensured there were no other safety concerns in the home. The safety plan described earlier in this document remained in place.

On December 22, 2010 the caseworker had one last follow-up interview with ██████████ ██████████ to confirm a few aspects of the investigation. ██████████ said that when she left the home that day, it was to pick up her prescription for Klonopin. She recalled closing her door, but was unable to lock it because ██████████ removed the lock at some point and had yet to put it back on the door. The caseworker also viewed all of her prescription bottles and confirmed that all bottles but the Trazodone had child safety caps.

After completing interviews of all parties involved, Beaver Co. CYs completed their ██████████ ██████████ on January 18, 2011 by submitting their ██████████ as ██████████. The agency determined that the incident was accidental and not due to a lack of supervision. The worker also took into account that the medication that the child ingested was the only medication kept in a bottle that did not have a child safety cap. The investigation was completed by a ██████████ worker and not by the ongoing services caseworker. After completing the investigation, the agency continued to provide services at the same level of intensity. At no time was a police report made regarding the incident.

**Current Case Status:**

This family has been open for services with Beaver County CYs since December 17, 2010. As per the current caseworker, the family has shown improvement in their supervision of the children and maintaining the residence so that there are no safety concerns. The children remain with their parents and were never removed from their care throughout the agency's involvement. At the time of this report, the grandmother was still residing in a woman's shelter.

The caseworker reported that the family has shown consistent care and protectiveness of the children. The parents completed their goals with the service providers and as a result, in-home services have ended. Due to the family's progress, the family's case was closed in early September 2011.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

Beaver County CYs completed their [REDACTED] investigation within thirty days with an [REDACTED] status. As such, the county was not required to convene a review.

**Department Review of County Internal Report:**

Not Applicable

**Department of Public Welfare Findings**

The Department received the complete case record the next business day. The record was well organized and thorough in content. Based on the documentation contained in the record, it is reasonable to conclude that Beaver Co. CYs's management of the case was appropriate. The workers had regular contact with the family, even providing intensive services for quite some time. In-home services were put in place, as well as parenting classes. The agency was thorough in obtaining medical records for the children, even before the near fatality incident.

Following the near fatality, the agency continued to address any concerns they had by maintaining regular, frequent contacts to assess safety, specifically supervision of the children. The agency also ensured that the grandmother, whose medication was left unsecured, was not residing back in the home with the children.

The agency documented the safety of and risk to the children by completing safety and risk assessments as needed, which were included in the file. Some of the safety assessments warranted safety plans and these were provided by CYs. Although completed, the safety plans revealed an area where the county could enhance their current practice. This will be described below.

- County Strengths:

The agency responded promptly to the initial referral, as well as all subsequent reports. The family was accepted for services as a result of the initial referral and the agency was having contact almost weekly, even when the risk was not rated high. Services to address the risk areas were put in place and monitored.

They also helped ensure the safety and wellbeing of the children, as they made regular visits to the home, assessed the living conditions, routinely asked about supervision, and verified that grandmother was no longer residing in the home or supervising the children. The caseworker involved in the near fatality also advised the parents that even though there may be another adult residing in the home with them, they are also responsible for supervision regardless of the situation.

Beaver Co. CY5 also made sure that the family had support services in place before closing the family's case.

- County Weaknesses:

No weaknesses were identified in this case; however, some best practice observations and recommendations are made below.

- Statutory and Regulatory Areas of Non-Compliance:

Based on a review of the agency's involvement with this family, no statutory or regulatory violations were noted. As such, an LIS is not warranted.

**Department of Public Welfare Recommendations:**

As stated previously, Beaver Co. CY5 was quite thorough when completing their safety assessments and accurate in identifying when a plan was necessary. However, there were five safety plans that contained safety actions that could be improved. Safety actions are intended to be immediate and able to be measured. Here are examples of statements found on these five safety plans:

1. "Parents will cooperate with intensive services" and "Parents will cooperate with CY5." In addition, there were statements regarding household members [REDACTED] and [REDACTED] classes. While these are necessary and beneficial to the family, change would take place over time. Safety actions need to have an immediate impact.
2. Mother "will not allow" father "unsupervised contact with children" and father "will not have unsupervised contact with children." These are considered to be promissory.
3. Words such as "appropriate" and "properly" are used regarding supervision and housing. These words are subjective, as they have different meanings to different persons. As such, they are not measurable.

While these issues are areas that can be enhanced, it is important to note that the assessments and necessary plans were completed and done timely. The issues outlined above represent "fine tuning" to further enhance safety of children. When a safety plan is clear and concise it is easier for all parties to understand their role in the process and to what standard they will be held accountable.