



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**REPORT ON THE FATALITY OF:**

Wesley Ferra

**Date of Birth: 10/28/2014**  
**Date of Incident: 12/22/2014**  
**Date of Report to ChildLine: 12/22/2014**

**FAMILY KNOWN TO COUNTY CHILD WELFARE WITHIN THE  
PRECEDING 16 MONTHS:**

Indiana County Children and Youth

**REPORT FINALIZED ON:**

7/17/15

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, DHS 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. Indiana 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>
Wesley Ferra	Victim Child	10/28/2014
██████████	Sibling	██████████ 2012
██████████	Mother	██████████ 1988
██████████	Father	██████████ 1988

**Notification of Child Fatality:**

Indiana County Children and Youth received a ██████████ report ██████████ dated 12/22/2014 regarding the victim child. ██████████ notified ChildLine of the victim child's death ██████████

The father returned home from work during his lunch hour and found the victim child unresponsive. The victim child was not breathing and was found in the bed with the mother and sibling, who often slept together. Father performed CPR but advised that the victim child's color was gone.

Mother ██████████ while pregnant with the victim child and he ██████████ at birth. ██████████ Mother was also ██████████ and after pregnancy the mother continued ██████████ while breastfeeding the baby. The victim child had no outward signs of trauma. The victim child was pronounced dead at Indiana Medical Center.

**Summary of DHS Child Fatality Review Activities:**

The Western Regional Office of Children, Youth and Families obtained and reviewed all the current records pertaining to the [REDACTED] family. Follow up interviews were conducted on January 16, 2015 with the intake caseworker, ongoing caseworker and supervisor at Indiana County Children and Youth. The Regional Office also participated in the County Internal Fatality Review Team meeting on January 16, 2015 where the medical report was presented. The autopsy is not being released and could not be viewed.

**Summary of Services to Family:**

The [REDACTED] family is currently receiving [REDACTED] and the mother is receiving [REDACTED]. The Agency is doing monthly home visits and will continue to monitor the case until they feel they can safely close the case. The safety plan was lifted and there are no restrictions on the supervision of the parents with the nonvictim child.

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

On 10/29/14, Indiana County Children and Youth received a referral alleging that the mother had given birth to the victim child and was [REDACTED]. The victim child was experiencing [REDACTED] and was going to be transferred to Conemaugh Hospital in [REDACTED], Pennsylvania. [REDACTED] The victim child remained hospitalized at Conemaugh until November 4, 2014 when he [REDACTED] his parent's care.

Indiana County Children and Youth made home visits on October 31, 2014 and November 19, 2014. The intake was closed on November 19, 2014 after the agency completed a home visit, met with the parents and the two children. The mother expressed they were involved with [REDACTED] and the children get regular pediatric care.

**Circumstances of Child Fatality and Related Case Activity:**

On 12/22/2014, the father left for work around 6:45 a.m. Prior to his leaving the house for work, the victim child woke up at 4:30 a.m. and the mother breastfed him and went back to sleep. When the father left at 6:45 a.m. they were all still asleep. Father walked home from lunch and came home between 12:05 p.m. and 12:10 p.m. Father advised that Mother and victim child were still asleep on the pull out couch and the sibling was playing by herself. Father advised that the baby was asleep on his back and he noticed the change of color in the baby. He performed CPR and called 911.

The paramedics arrived and also performed CPR as did the physicians at Indiana Medical Center, but he was pronounced dead at around 1:30 p.m.

The father expressed that the victim slept on the pull out couch with a pillow, Mother, Father and sibling. The father disclosed to the County Coroner that the victim child was sleeping a lot lately and had funny looking bowel movements. The victim child had no outward signs of trauma and the victim child's body was cold upon arrival at the Indiana Medical Center.

Indiana County Children and Youth Services caseworker was notified on the evening of 12/22/2014 and conducted a home visit to ensure safety of the sibling. A plan of supervision was put into place by the county and the maternal grandparents agreed to supervise the mother's care of the non-victim child.

The Pennsylvania State Police were contacted on 12/22/2014 [REDACTED]  
[REDACTED] To  
date no criminal charges have been filed.

The non-victim child was participating [REDACTED]  
[REDACTED]  
The county assisted the family in getting involved [REDACTED]  
[REDACTED]. The caseworker made monthly visits to the home.

An Internal County Fatality meeting was held on January 16, 2015 at the Indiana County Children and Youth Services Office. Pennsylvania State Police, the Coroner, [REDACTED] and the Pediatrician were present. The Coroner advised that the autopsy showed no results and a toxicology report was pending

[REDACTED]

██████████ was also present at the meeting and discussed being in the home about once a week until victim child's death. They had no concerns for the victim child and last saw him on 12/17/14.

### **Current Case Status:**

The County submitted ██████████ on this case on February 19, 2015 as ██████████. They also closed ██████████ as of this date and opened ██████████ case for assessment to see if the family needed services. ██████████ case was closed on April 8, 2015 after two subsequent home visits as the family had community supports and the Agency determined that services were not warranted. These visits occurred on February 23 and April 1, 2015. To this date the family is still closed with the Agency and no further referrals have been received.

There are no pending criminal charges and the Coroner has ruled the victim child's death as undetermined and Sudden Unexplained Infant Death. ██████████

██████████ The Coroner's case was closed. The Coroner would not release his report to the County or DHS so these records were not viewed.

### **County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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. Indiana County has convened a review team in accordance with Act 33 of 2008 related to this report.

- **Strengths:** Family was engaged with ██████████, community resources and obtaining ██████████. Family also had family supports.
- **Deficiencies:** The OB/GYN and drug and alcohol treatment facility need to work more closely concerning prescriptions. An intensive case manager could have helped to coordinate drug and mental health treatment. ██████████ could have been potentially fatal, especially with a 2 year old in the home.
- **Recommendations for Change at the Local Level:** Collateral contacts need to be done to ensure compliance, particularly in this case that involved a newborn that was having ██████████. Also, coordination with mental health and drug and alcohol and the PCP/OB

would have been helpful given the fact that the mother had a history of drug abuse/addiction and the OB was unaware of this and [REDACTED]

- Recommendations for Change at the State Level: none noted

#### **Department Review of County Internal Report:**

The Department received the Internal Child Death Review report on February 25, 2015. The Department is in agreement with the internal report and with the areas of strengths and concerns that were noted in the internal report. These reflect the Department's concerns as well.

#### **Department of Human Services Findings:**

- County Strengths: When initial referral was received in regards to the child death, the county made immediate contact with the family.

County Weaknesses: When Indiana County Children and Youth Services initially received the referral upon the victim's child birth the case was closed with no collateral contacts. The family was allegedly involved with many different community resources and no calls were made to any of the agencies to ensure that family was complaint. No call was made to the pediatrician to ensure that follow up were being attended by the victim child and parents.

- Statutory and Regulatory Areas of Non-Compliance: A citation will be issued to the Agency under 3490.55 (d) as the Agency did not interview or gain information from collateral contacts that were vital to this case prior to the child's death. The [REDACTED] intake at the child's birth was closed and no collateral contacts were completed with any of the community resources that the family was active with.

#### **Department of Human Services Recommendations:**

The Department recommends that in the future, when a family is involved with community resources that the County CYS obtain releases and contact these agencies to ensure that the family is compliant and there is nothing concerning. This family was involved in many community resources and it appears that releases were signed however, none of the agencies were contacted and the case was initially closed with no collateral contacts.