



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 12/12/2014
Date of Death or Date of Incident: 09/14/2015
Date of Report to ChildLine: 09/14/2015
CWIS Referral ID: [REDACTED]

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

Westmoreland County Children's Bureau

REPORT FINALIZED ON:
02/04/2016

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.

Westmoreland County Children’s Bureau (WCCB) was not required to convene a review team in accordance with the Child Protective Services Law related to this report. The county unfounded the report within 30 days and was not required to convene a meeting.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	12/12/2014
[REDACTED]	Sibling	[REDACTED] 2013
[REDACTED]	Cousin	[REDACTED] 1998
[REDACTED]	Cousin	[REDACTED] 2000
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Father	[REDACTED] 1986
[REDACTED]	Cousin	[REDACTED] 1995
[REDACTED]	Aunt	[REDACTED] 1978

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children Youth and Families (WRO) reviewed the case record. A review team meeting was not held due to the report of alleged abuse being unfounded by the agency within 30 days of the date of the oral report.

Children and Youth Involvement prior to Incident:

WCCB did not have involvement with the family prior to this incident. WCCB also contacted Allegheny County Children, Youth, and Families (ACCYF) to inquire if they had prior history with the family. ACCYF did not have a prior history with the family.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/15/2015, WCCB received a report from [REDACTED] that the victim child had been transported to [REDACTED] hospital. The victim child had been admitted to a local community hospital on 09/13/2015 after he stopped

breathing. The victim child was found to have [REDACTED] is his system. He was transported by medical helicopter to CHP. At the time the report was made the victim child [REDACTED] It was unknown how the victim child ingested the [REDACTED].

WCCB contacted the local police department and alerted them to the incident. The officer was aware of the family and assumed it was "all drug related". The local police department made a referral to the county detective. The caseworker contacted [REDACTED] for background information on the victim child and incident. [REDACTED] relayed to them the family is questioning the aunt. The aunt who is a household member has a [REDACTED] since she [REDACTED] [REDACTED] The Aunt admitted to the hospital staff that she did drop a pill that morning. She did look for the pill but could not find it. She assumed the dog ate it.

The caseworker from WCCB and the county detective did a joint hospital visit that same day. Both the caseworker and detective interviewed the [REDACTED] physician. [REDACTED] stated that she did believe the family's story but still felt compelled to report the incident as a precaution. The victim child was [REDACTED] [REDACTED] The victim child was also [REDACTED]

Mother reported that the victim child was fine the morning of the incident. He went with the father while she fed the sibling. After the children were done eating, the mother allowed them to play on the floor in an empty room until they were ready to go shopping. The mother and father took the victim child and the father's niece shopping. The victim child fell asleep on the way to the store. While in the store, mother noticed the victim child was waking up and moving around. She took the pacifier out of the victim child's mouth and noticed his lips and mouth were blue, then the child's eyes rolled into the back of his head, and he made a "seizure type face". Mother grabbed the victim child and began to run to the front of the store. Someone then called 911. There was a nurse in the store and assisted [REDACTED] [REDACTED] The victim child was taken by ambulance to the local hospital [REDACTED] He was then taken via medical helicopter to the regional [REDACTED] hospital. The hospital ran tests and the results were positive for [REDACTED] According to the mother, when the victim child recovers from [REDACTED] there should not be any long term effects to him. The family questioned the aunt who admitted to dropping the pill that morning.

Father confirmed that his sister and her children were living with the family. The aunt keeps her medication on the third floor of the house. She does take the medication in other rooms of the house. [REDACTED] comes to the home to provide services to the aunt. The father said that when he left the home at 9:00 AM that the victim child was perfectly fine. The father reported that both he and the mother work. The mother works at a [REDACTED] where the victim child and his sibling attend. The victim's child's sibling was at the day care center at the time the interview took place. Father stated that the children have a pediatrician and receive regular medical care. This information was confirmed by the pediatrician.

The WCCB completed a home visit to the family on 09/23/2015. Present for the caseworker's visit to the family home were the mother, the victim child and his sibling, the aunt and her daughter. The mother reported that the victim child was doing well and he had not been [REDACTED]. The victim child was acting like his old self. The aunt reported during her interview that she has a [REDACTED]

She has been [REDACTED]. She was keeping the medication in her purse since she did not know where she was going to be in the house. She did not want to keep going up to the third floor for her medication. [REDACTED]

[REDACTED] The aunt reported that she usually takes her medication over the sink in the bathroom. She said that when she was taking her medication she did not know what happened to a pill. She and her daughter looked for the pill and could not find it. She did not tell her brother and sister-in-law that she dropped a pill. [REDACTED] comes to the home twice a week to work with her. She is never in the home by herself and she will have someone in the home watch her take the pill.

Due to the incident being determined an accident the WCCB filed the Child Protective Service Report with an "unfounded" finding on 09/28/15. The case was closed by WCCB. No charges were to be filed by the local police department or the county detectives.

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

WCCB was not required to submit a report.

- Strengths in compliance with statutes, regulations and services to children and families; Not Applicable
- Deficiencies in compliance with statutes, regulations and services to children and families; Not Applicable
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; Not Applicable
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; Not applicable
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse; Not Applicable

Department Review of County Internal Report:

WCCB was not required to submit a report since the case was unfounded the e within 30 days of the oral report to ChildLine.

Department of Human Services Findings:

- County Strengths:
 - WCCB worked with the local law enforcement office on this case. The caseworker and the county detective went to the regional [REDACTED] hospital on the day of the report to see the victim child. Interviews were conducted with the treating physician, the mother, and the father.
 - WCCB contacted neighboring counties to determine if they had any active/inactive cases with the family.
 - WCCB made a collateral contact with the children's pediatrician.
- County Weaknesses: and
 - No areas of weakness noted
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - No areas on non-compliance

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings in this review:

- Communication is needed between the drug vending companies, prescribing physicians and the public about the distribution and safe keeping of medications.