



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**Trenton R. Finnegan**

**Date of Birth: February 24, 2010**

**Date of Death: October 23, 2010**

**FAMILY KNOWN TO:  
Washington County CYS**

**REPORT FINALIZED ON: 7/19/2011**

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 by Governor Edward G. Rendell. 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. Washington County 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>
Trenton R. Finnegan	victim child	February 24, 2010
[REDACTED]		

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

The Western Regional Office of Children, Youth, and Families (WROCYF) received the preliminary notification of the death of Trenton Finnegan on October 25, 2010. The notification revealed that the child had been found dead at the family home on October 23, 2010. Washington County Children and Youth Services (CYS) received the initial report of the child's death from [REDACTED] on October 23, 2010. The reporting source was a nurse at Washington Hospital Emergency Room. The reporting source indicated the story told to her was that the child was put to bed at 12:30 a.m. on October 23rd and was not checked on until 1:00 p.m. later that day. It was also reported that there was an article of material (sheet or blanket) wrapped around the child's neck. Paramedics had been called to the family home by the child's parents, when they arrived child appeared to be deceased, but they continued attempts to revive the child enroute to the hospital. The reporting source indicated the child was dead on arrival at the hospital. [REDACTED] asked reporting source if the cause of death was due [REDACTED] and reporting source replied "it could be anything at this point". The report was identified as a child death as the cause of death was suspicious.

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

The assigned Western Regional Office program representative interviewed, and has had frequent telephone contact with the Washington County CYS caseworkers and supervisors assigned to this case, related to the child fatality and subsequent follow up with the family. WROCYF also had phone contact with Greene County CYS pertaining to a report regarding the victim child's three year old sister, who was residing with the maternal grandfather in Greene County at the time of the child fatality. WROCYF also attended a Washington County CYS internal fatality review team meeting on November 18, 2010. Prior to the review team meeting, the WROCYF program representative reviewed the family case file.

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

Prior to the child death there had been previous brief services extended to the family by both Washington and Greene County Children and Youth Services.

### **Case Chronology**

August 19, 2008

█████ referral made to Washington County CYS. The referral was based on a custodial dispute between the parents of their then five month old child. The case was opened for assessment.

August 2, 2008

The assigned caseworker visited the family home to address the allegations in the report.

September 8, 2008

Case closed following intake assessment; as the assigned worker determined there was no evidence of ██████████

September 6, 2010

The family was referred to Greene County CYS. The reporting source, maternal grandfather, reported he was temporarily caring for his then two year old granddaughter who was covered with flea bites she had reportedly received while residing with her parents in Washington County; the grandfather believed that the family home was not fit for habitation.

September 6, 2010

A referral was made from Greene County CYS to Washington County CYS; as the child's parents were residents of Washington County. This referral was based on the report the grandfather had made to Greene County in which he alleged that his granddaughter, the subject child's two year old sibling, who was

visiting with him, was covered with flea bites. The referral indicated that her 7 month old brother (Trenton) may also have flea bites.

September 7, 2010

The case was screened out by Washington County CYS because the intake worker believed that both children were in Greene County with relatives.

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

This family was initially referred to Washington County CYS on August 19, 2008. The referral was a [REDACTED] regarding [REDACTED], an older sibling of Trenton. The basis for the report was that the sibling's father, [REDACTED] had taken the sibling from her mother, [REDACTED], and would not return the sibling back to the mother. The report stipulated that the mother did not believe the sibling was safe with her father, although no allegations of [REDACTED] were made. The case was initially opened for assessment on August 19, 2008. Following an investigation of the allegations, it was determined there was no need to open the family for ongoing services and the case was closed on September 8, 2008. The case was closed within the 60 day assessment period. At the point of case closure the sibling was residing with her mother and maternal grandparents; and the family agreed to resolve the custody issue through family court.

There was no subsequent activity on this family until September 6, 2010 when Greene County CYS was contacted by the maternal grandfather who expressed concerns regarding his granddaughter, [REDACTED] (age 2). The maternal grandfather advised Greene County CYS that he had Kristen for the weekend and she was covered in flea bites. He also stated that when visiting with him a few weeks ago, [REDACTED] also had so many flea bites, and he convinced the mother to take her to the hospital for treatment. The grandfather also expressed concern for the other child in the family, Trenton (age seven months) whom he believed also had flea bites.

On September 6,, 2010 Greene County CYS referred case to Washington County CYS where the parents of the children resided. On September 7, 2010, Washington County CYS screened the case out as an Information and Referral Report since they believed both of the children were currently residing with the grandfather in Greene County and therefore an assessment was not needed.

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

Washington County CYF received a report [REDACTED] related to Trenton's death, from ChildLine on October 23, 2010. The report had been generated by a nurse at Washington Hospital, where the child had been transported to by paramedics, and had been declared dead on arrival. The

cause of death was considered to be suspicious. Washington County CYS commenced an investigation immediately. The assigned worker visited the family home and interviewed the child's parents, and other family members. During the assessment the worker determined that the physical environment of the home presented risks to the safety and well being of ██████████ Trenton's two year old half sibling, The worker also believed that both parents had drug and alcohol issues which required assessment and treatment. As part of a safety plan, arrangements were made for ██████████ to remain with her maternal grandfather, a resident of Greene County.

During the course of the investigation into the child death report the agency worked collaboratively with Pennsylvania State Police and the Washington County Coroner who were also investigating the circumstances of the death. The agency determined that the status of the initial fatality report would be ██████████ based on information received from the police, who concluded there was insufficient evidence to pursue criminal charges against the parents, and the coroner who concluded the manner of death was inconclusive but consistent with Sudden Infant Death Syndrome. The agency submitted a report ██████████ on November 30, 2010.

Concurrently, however, while investigating the child death, Washington County CYS obtained information from the Pennsylvania State Police which suggested that Trenton had been severely neglected by his parents. According to the officer assigned to the case, the conditions of the home that Trenton had been residing in were deplorable. The officer also reported that at the time of his death, Trenton had a severe diaper rash which was blistered and bleeding. Based on this information the agency registered a second report ██████████ on November 12, 2010. The report identified the parents as ██████████ because of ██████████ of the child's well being. The agency determined the ██████████ a report to ██████████ on November 30, 2010.

#### **Current Case Status:**

Based on the investigation into Trenton's death and subsequent evaluation of the family home, Washington County CYS filed a dependency petition on behalf of Trenton's half sibling, ██████████. A hearing in regards to the dependency petition was held on January 18, 2011. The sibling was adjudicated dependent and placed in the care of a family member. As noted above, the agency had, at the time of Trenton's death, allowed ██████████ to remain with her grandfather, on an informal basis. The grandfather later advised the agency he could not continue to care for her. Subsequently, the agency obtained protective custody of ██████████, identified another family as a resource, and placed her in their care. The agency had completed a home study of this family and approved it as a kinship care resource.

The case has been transferred from the intake to the ongoing unit for services. At this point the plan for [REDACTED] is reunification with her parents. Goals have been established for mother and father to achieve reunification with [REDACTED]. The mother is required to attend parenting classes, have a psychological assessment, and complete a drug and alcohol assessment. The biological father is also required to attend parenting classes, receive a psychological assessment, and complete a drug and alcohol assessment.

The family's case will continue to be monitored and served by Washington County CYF as determined appropriate in order to ensure the safety and well being of [REDACTED]

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

Washington County convened a Child Death Review Team to discuss the fatality of Trenton Finnegan on November 18, 2010. The review team submitted a 90 day report to the WROCYF on February 24, 2011. The conclusion of the review team was that Washington County CYF was in compliance with statutes, regulations, and services provided to the Finnegan family.

It was also the determination of the review team that there were no deficiencies in the manner by which Washington County CYF handled the case.

Based on the above information, the review team did not make any recommendations for changes at either the state or local level on reducing the likelihood of future child fatalities or near fatalities directly related to child abuse and neglect, the monitoring and inspection of county agencies, or on collaboration of community agencies and service providers to prevent child abuse and neglect related to this case.

**Department Review of County Internal Report:**

The Department does not believe that the county internal report provides sufficient information to justify the conclusions reached by members of the team. The report did not examine the agency's decision to process the referral it had received from Greene County CYF on September 6, 2010 as an Information and Referral Services Report. Instead it simply notes that the agency had received an Information and Referral report approximately one month before Trenton's death. It is conceivable that had the agency scrutinized the referral it received from Greene County carefully, Trenton's death may not have occurred. For the county to submit an internal report without examining the agency's decision screen the case out as an Information and Referral Report is not acceptable.

**Department of Public Welfare Finding:**

Washington County CYS has been cooperative with the department in its investigation into the death of Trenton Finnegan. Washington County caseworkers and supervisors followed up with all requests made by the Department in obtaining relevant information into the scenario surrounding the child's death, as well as services being provided to the parents and their two year old daughter. The Department also recognizes that the agency arranged an internal Child Death Review Team on November 18, 2010 in accordance with Act 33.

A major concern of the Department pertains to the communications between Washington County CYS and Greene County CYS on September 6 2010, approximately six weeks prior to the death of Trenton. On September 6<sup>th</sup> Greene County CYS had communicated, both verbally and in writing, to Washington County CYS information it had received from the child's maternal grandfather, a resident of Greene County who had Trenton's older 2 year old half sister with him at the time. As per the report, the 2 year old sister had an issue with flea bites, apparently received while residing with her mother and stepfather in Washington County. The grandfather also stated that Trenton might also have flea bites. When this information was communicated from Greene County CYS to Washington County CYS it was not, according to Washington County CYS, clear that Trenton was actually residing with his parents at their home in Washington County; so Washington County CYS did not accept the case for assessment but chose to process it as an Information and Referral Report and closed it effective September 7, 2010.

It is the Department's belief that Washington County CYS did not effectively collaborate or communicate with Greene County CYS, prior to disposing of the Greene County referral as an Information and Referral report. It is the Department's position that Washington County CYS should have followed up verbally with Greene County CYS in an attempt to identify the exact location of the family home, confirm the whereabouts of Trenton, and subsequently visit the family home to determine if the child was at risk.

As noted above, the Department also believes that the County's Internal Review Report lacks clarity; team members should have examined the agency's decision making related to receipt of the Greene County CYS referral of September 6<sup>th</sup> in greater detail and not simply have endorsed its decision to dispose of it as an Information and Referral Report.

**Department of Public Welfare Recommendations:**

Because of the concerns specified above it is the Department's recommendation that Washington County develop procedures ensuring that when it receives a referral from another county regarding any health and safety issues that involve a child it, as the he receiving county, should make every effort to verify the information received from the referring county. Once the information is verified, the receiving county should follow up and assure the safety of the child. This did not occur in this case.

Additionally the Department recommends that the agency review the format it has adopted for completing Internal Review Reports relating to child deaths. The report it submitted pertaining to Trenton is superficial and does not provide sufficient information to justify its findings that services it extended to Trenton and his family were in regulatory compliance.