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REPORT ON THE FATALITY OF

Kevin Boyle

Born: 8/3/95
DATE OF FATALITY: 4/1/09

FAMILY KNOWN TO:
MONROE COUNTY CHILDREN AND YOUTH SERVICES

DATE 4/12/11

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Mother	[redacted]
[redacted]	Father (deceased)	[redacted]
Kevin Boyle	deceased child	8/3/95
[redacted]	Sibling	[redacted]

Notification of Near Fatality

Child committed suicide, he wrote on his left leg with black marker "I love Angie and if I can't be with her I don't want to live anymore." Child overdosed on [redacted] methadone pills ([redacted]). On the evening of 3/31/09 [redacted] went to get [redacted] methadone and found only 3pills, 17 were missing. [redacted] asked Kevin if he knew where the missing pills were and he stated he did not. Kevin and [redacted] spent several hours [redacted] and [redacted] asked Kevin if he took them and he sarcastically stated he did. Kevin is known to joke around a lot and mother stated he appeared normal and not under the influence of the drug. He asked to go to bed and if they could [redacted] in the morning. On 4/1/09 mother found Kevin deceased. This was not reported to [redacted] until 4/3/09. [redacted] was not notified initially because child's death was a suicide and there was no suspicion of neglect. However mother kept giving different statements as to whether she knew Kevin took [redacted] medication. Children and Youth reported this to [redacted] because mother was inconsistent in her statements. It was [redacted] based on mother's failure to act which resulted in child's death.

Documents Reviewed and Individuals Interviewed:

NERO reviewed the CYS file containing the investigation including Safety Plan. All parties involved and all family members were interviewed by [redacted] County CYS. Interviews were documented in the file and reviewed by NERO. NERO interviewed the Caseworker and Supervisor of the case. NERO did not interview Kevin's [redacted] County CYS had numerous conversations and documentation of Kevin's visits to the [redacted]

Circumstances of Child's Fatality:

Child overdosed sometime during the night on 3/31/2009 and mother found child deceased in the morning.

Previous CY involvement:

On 10/25/1996 a baby sitter ([redacted]) was [redacted] for the [redacted] of Kevin Boyle. Kevin had bruises on his cheek, forehead, temple, chest, ear and both eyes. The family was not opened for services at this time because the [redacted] was not a household member On 6/9/2005 the family was opened due to allegations of domestic violence and [redacted]. The family service plan was achieved there were no incidents of domestic violence while the case was open. Father attended [redacted] for his [redacted] and both boys were receiving [redacted]. The closing risk was low and on 12/15/08 the case was closed.

Case Chronology:

On 2/21/08 the case was opened due to [redacted] and Kevin's truancy issues. The case remained open while the family received [redacted] for mother and Kevin. [redacted] attended [redacted] from 10/17/08 until 3/25/09 at which time he dropped out. He then returned to public school. Kevin was placed in an [redacted] On June 16, 2008 Kevin and a friend over dosed on [redacted]. This was mother's medication. Mother was prescribed this medication due to [redacted]. At this time a safety plan was put into place. Mother double locked all her medication and counted her pills. Mother followed the safety plan. Kevin was seen weekly by a [redacted] for [redacted] and suicide attempt.

4/1/09 Mother found child pale and not breathing. Mother called 911, an ambulance and the [redacted] arrived at the home. Kevin was taken to the Pocono Medical Center where had was pronounced dead. Children and Youth went to Pocono Medical Center. Mother and [redacted] were interviewed at the hospital. Children and Youth also spoke to Kevin's [redacted] and Dr [redacted] with concerns that mother may harm herself. [redacted] was taken into [redacted] and placed with a [redacted]. [redacted] had also interviewed mother and [redacted] at the hospital. [redacted] and Kevin's father died last year due to [redacted]

4/2/09 Mother, [redacted], and [redacted] had a visit. Mother presented 3 families as [redacted] for [redacted]

4/3/09 Case called into [redacted] and [redacted] based on mother's inconsistent statement to the Police and children and Youth. Mother told the Police that she knew Kevin took 2 pills and she asked Kevin for the bottle and he stated he would give it back to her in the morning. Mother told Children and Youth that she noticed the pills were missing at 5:15 AM and Kevin stated he did not know where the pills were and helped him look for them. Later he sarcastically stated "if I took 2 pills

where are the rest?" On this date a [redacted] for [redacted] was held and [redacted] of [redacted] was granted to Children and Youth. [redacted] was placed in an agency approved [redacted] and mother was asked to give family names for [redacted] placement of [redacted]. No dependency petition was filed.
4/4/09 [redacted] and [redacted] County Caseworker went to [redacted] home in [redacted] County for assessment. All Clearances had already been obtained and [redacted] was placed with his [redacted]

4/6/09 Mother was admitted to [redacted] unit of Pocono Mountain Center.

4/15/09 Caseworker goes to the hospital to see mother. Caseworker wanted to assess mother's [redacted] and assure she was receiving services. Mother was also interviewed regarding the incident. Mother appeared lethargic and highly medicated. She stated she would enter [redacted] for [redacted] on 4/21/09.

From 4/21/09 to 7/28/10 mother completed [redacted] and attends [redacted]

5/13/09 the case was [redacted] and closed. However it was understood if any new information was obtained the case would be [redacted]

7/28/10 Court Hearing was held and mother pled guilty to involuntary manslaughter for failure to act when child took an overdose of [redacted] methadone pills. It was determined mother knew child took the pills and failed to seek medical attention and as a result child died five hours later. [redacted] County called [redacted] and case was [redacted] for [redacted]

9/13/2010 case was [redacted] and based on mother's guilty plea, the case was [redacted]

Current/most recent status of case:

The mother acknowledges that the methadone was [redacted] but denies any knowledge of the child taking the medication. The medication was double locked according to the safety plan due to child's previous suicide attempt. The [redacted] stated the child took the methadone in the middle of the night while she was sleeping and was deceased when she awoke the next morning. The [redacted] investigation was deemed to be [redacted] and the [redacted] was submitted on 5/13/09. In November 2009 mother was arrested and on 12/23/09 mother plead guilty and was charged in her son's overdose which resulted in his death. On 7/28/10 a hearing was held and mother pled guilty to involuntary manslaughter for failure to act when child took the overdose. Mother was sentenced to two years of probation. Mother was aware that child had taken [redacted] methadone pills, but failed to seek medical attention. As a result child died five hours later. On 7/28/10 [redacted] issued a [redacted] based on current information. On 9/13/10 case was [redacted] Based on the mother's guilty plea, the case was subsequently given a [redacted] status.

Services to children and families:

Prior to the child's death he was seen by a [redacted] once a week due to [redacted] over the loss of his father and previous suicide attempt. After Kevin's death, mother was admitted to a [redacted] hospital, she has since been discharged. [redacted] still resides with family members in [redacted] County and was encouraged to participate in [redacted]. Mother has participated in [redacted] since child's death.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

No recommendations for change were identified.

NERO Findings and Recommendations:

An internal review was held on 6/19/09. NERO concurs with the findings of [redacted] County CYS. On 7/28/10 the child's mother pled guilty to involuntary manslaughter for failure to act when child took the overdose. A new [redacted] number was given and [redacted] County [redacted] the case on 9/13/10.

Statutory and Regulatory Compliance issues:

The following strengths were noted in the county's handling of the case:

*The older sibling was removed and placed with relatives.
*The investigation was conducted in a timely manner.
*All parties were interviewed and received rights letters.
*Risk Assessment was completed in a timely fashion.

No regulatory violations were noted in this case.