



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 04/09/2013
Date of Incident: 05/14/2014
Date of Oral Report: 05/14/2014

FAMILY NOT KNOWN TO:

Erie County Office of Children and Youth

REPORT FINALIZED ON:
July 07, 2015

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. 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. Erie 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>
██████████	Victim Child	04/09/2013
██████████	Mother	██████████ 1987
* ██████████	Father	██████████ 1978

*not a resident of the household

Notification of Child (Near) Fatality:

The mother brought the child to St. Vincent Health Center in Erie, Pennsylvania, on May 14, 2014 as the child was in an altered mental state. Blood work was completed and the child's blood alcohol level was .289, which is 4 times the legal limit for an adult. The mother reported that she brought the child to the hospital because when she woke up "she was not acting right." ██████████ stated that the child would not have been able to independently consume the amount of alcohol needed to raise her blood level this high. The child was life flighted to Children's Hospital of Pittsburgh. The ChildLine report was generated prior to the transfer.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the ██████████ family. The regional office also participated in the County Internal Fatality Review Team meeting on June 19, 2014 where copies of the medical reports, court record, documentation, and mother's ██████████ records were obtained. The Erie County Office of Children and Youth caseworker and supervisor were interviewed on June 19, 2014 as well.

Children and Youth Involvement prior to Incident:

There was no previous involvement with the agency prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

On May 14, 2014, the agency received a report regarding an allegation that the child had a blood alcohol level of .289 when she arrived at the emergency room. The agency responded by immediately going to the hospital. When the caseworker arrived, there was an unidentified male (the babysitter) in the child's room who smelled of alcohol. The babysitter reported that he was at the mother's apartment when the baby came home at 10:18pm. He reported that the baby was crying a lot so he went to the store to get milk; returned and fed her a bottle and she went to sleep. The mother reported that she had arrived home around 11:30pm. The babysitter stated that he left the home around 12:45 am. After this reporting from the babysitter, the babysitter left to use the restroom and left the hospital without telling anyone. The police were trying to locate his whereabouts. The mother reported that she had dropped the child off at a friend's home at 1:00pm on May 12, 2014 and the child was with this friend until she was returned to the babysitter's care on May 14, 2014 at 10:18pm. The mother's story was inconsistent regarding whether the babysitter spent the night at her home. The mother stated that she and the child woke up around 9:00am and the babysitter was gone. The mother stated that on that morning of May 14, 2014 the child hit her head off the coffee table and was acting "goofy" because of this. The mother admitted that the babysitter had been drinking alcohol while he was babysitting.

The mother reported that she works from 3-11, and that she would take the 1:30pm bus to her friend's house to drop off her daughter; she would take the 11:00pm bus and arrive home around 11:30pm. The friend would usually then bring the child home to the mother around 1:00am. The mother reported that she was a foster child and does not have family support. The child's father was in Erie County jail at this time.

After the hospital visit, the caseworker and detective assigned met with the mother at her residence. The cupboard was all empty and there was only one can of formula. The mother stated that the child drank from a Sippy cup in the morning, but she washed it before she went to the hospital. The babysitter continued to text the mother the entire visit. The police completed a search of the residence and did not find anything of concern. The child was flown to Children's Hospital of Pittsburgh (CHP) later that evening [REDACTED].

The mother was charged with Endangering the Welfare of Children, Recklessly Endangering Another Person and Furnishing Liquor to a minor, and the charges were held for court. The criminal hearing was scheduled for March 09, 2015.

On May 15, 2014, the CHP [REDACTED] reported that the child was doing okay and that the [REDACTED] and labs came back normal; however the child did have an abrasion on her right eye. It appears as though the child did not experience any physical trauma and that the child was [REDACTED] later that day. The physician stated that the blood tests were initially completed at 2:00pm, and when the child arrived at CHP at 6:00pm, the blood alcohol level was .005. There was no sign of head injury and no fractures and the child weighed about 20 pounds. The physician stated that the alcohol ingestion could not have happened the night before as the ingestion would have occurred within a few hours of when the first blood test was taken. It is the doctor's opinion that the child was given the alcohol between 10:00am and 10:30am, but it could have been as early as 9:00am, but definitely not the night before. The caseworker shared this

information with the police officer. Arrangements were made for the child to be placed in foster care upon discharge. The child was placed into foster care on May 15, 2014.

[REDACTED] to the mother's apartment and found a water bottle with vodka in it; it was also reported that the mother was smoking marijuana around 11:30am on May 14, 2014 when the child had hit her head and ingested alcohol.

On May 16, 2014, the caseworker received a call from [REDACTED] that had been working with the child since February 2013. It was reported that there were never concerns regarding the mother's parenting; and that the mother was going to [REDACTED]

On May 20, 2014, the mother admitted to the caseworker that she had been using cocaine and [REDACTED], but claimed to have been clean for five years. She admitted to smoking marijuana in her home on May 14, 2014, when she was the primary caregiver for the child.

On May 22, 2014, the caseworker visited the foster home. The child had been seen at the pediatrician and no concerns were noted. The mother and maternal grandmother attended the doctor's appointment, so the foster mother and mother developed a relationship.

On May 22, 2014, the caseworker visited the father in county prison and he reported that the mother told him that she gave the child a sippy cup that had vodka in it, but denied knowing there was vodka in the cup. The caseworker gathered relative information per Fostering Connections. The father stated that his next hearing was May 29, 2014, and he thinks he will be released and plans to get custody of his child. The caseworker provided the father with [REDACTED]

The case was transferred to an on-going caseworker on May 23, 2014. [REDACTED] There was a referral for [REDACTED] The child attended half day daycare five days a week and appears to have no negative side effects from the alcohol exposure.

The CY 48 was indicated on May 27, 2014 against the mother and the babysitter based on the medical evidence, CPS investigation and Perpetrator admission.

Current Case Status:

The mother has been visiting the child regularly; twice per week in her home. She successfully completed [REDACTED] parenting classes in November 2014. [REDACTED]

Since discharge from jail, the father has been using drugs and not cooperating with the agency. He has been incarcerated again since his discharge in May 2014.

Currently, the goal is reunification with adoption as the concurrent goal. The mother has made progress and the agency is looking to begin unsupervised contact and potentially overnight contact, but is waiting for the criminal charges to get resolved. On March 09, 2015, the mother pled guilty to the charges of Endangering the Welfare of Children, Recklessly Endangering another Person and Furnishing Liquor to a Minor. She was placed on two years of probation.

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

Strengths:

- The intake worker is to be commended for the hours spent and for an excellent job establishing a rapport with the mother to get the truth regarding the incident.
- [REDACTED] is being set up for the child.
- There was excellent communication and collaboration between the agency and the police department.
- The home visits conducted by the agency documented observations and everyday interactions in the environment of the mother's home.

Deficiencies:

- It cannot be determined if the child will have any long-term effects from the amount of alcohol she consumed.
- The mother was reared in foster care and has little to no family contact or involvement.
- There is a concern as to why the mother returned to drug use after a reported long period of sobriety. No warning signs were noted from professionals working with her.
- The mother's mental health status is an area of concern. She is in need of parenting training and/or skills and she needs to demonstrate that she is able to apply the parenting skills that she has been taught by having the providers keeping a watchful eye on her.
- The providers must be aware of concerns/issues to be looking for; and to look at the whole picture of what is occurring, as opposed to focusing on completing paperwork.
- Systems/Agencies are not always designed to go into the home; therefore, they cannot get a true picture of the home situation.

Recommendations for Change at the Local Level:

It is recommended that Erie County Office of Children and Youth continue to make efforts to collaborate and have regular communication with law enforcement and other community agencies involved with families served; and that this information be documented. The agency would also like to improve their communication with CHP in regards to discharge time and information so that there is enough time to coordinate efforts to pick up the child when discharged.

Recommendations for Change at the State Level:

There were no recommendations made.

Department Review of County Internal Report:

The Erie County report was finalized on July 14, 2014 at which time a copy was provided to the region. The Department is in agreement with the county findings and recommendations made.

Department of Human Services Findings:

County Strengths:

The agency did an excellent job of engaging both parents to obtain extended family information related to Fostering Connections requirements. They followed through with sending the required notifications, and submitted an ICPC for a potential out-of-state placement relative placement.

County Weaknesses:

None identified.

Statutory and Regulatory Areas of Non-Compliance:

There are no areas of statutory or regulatory non-compliance.

Department of Human Services Recommendations:

The Department recommends that the county continue its current practice regarding the internal reviews for Act 33 cases. The agency has identified a team of professionals that are committed to this process to ensure the agency continues to strive towards achievement of best practices consistently throughout the agency.