



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 08-16-12
Date of Incident: 05-14-14
Date of Oral Report: 05-15-14

FAMILY NOT KNOWN TO:

Schuylkill County CYS

REPORT FINALIZED ON:

09/29/14

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, 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. Schuylkill County has not convened a review team in accordance with Act 33 of 2008 related to this report. The agency unfounded the case in under 30 days and the family was not known to the agency.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	08-16-12
[REDACTED]	Father [REDACTED]	[REDACTED]-85
[REDACTED]	Mother	[REDACTED]-85

Notification of Child (Near) Fatality:

On May 15, 2014, Schuylkill County received a near fatality report regarding [REDACTED]. The child was reportedly admitted to the hospital after ingesting 10 [REDACTED] tablets. The pills were reportedly in the back of a drawer that the child would have had to climb to reach. This was not witnessed and the child was found with pill fragments in his mouth, and he was lethargic. Child was initially taken to Hazleton General Hospital E.R. and later transferred to Lehigh Valley Hospital. The child was [REDACTED] due to lethargy, slow respirations, and low heart rate. This was the mother's [REDACTED]. The mother has a [REDACTED]. The child was certified by Doctor [REDACTED] as being in [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

On May 15, 2014, Northeast Regional Office of Children, Youth and Families (NERO) was notified of the near fatality. The preliminary report was completed on the same day. NERO discussed the preliminary findings with the County after the County interviewed the parents. NERO requested and received a copy of the investigation including the notes from the interviews with the parents. It should be noted that there was no file to review prior to the CPS report because the family had not been known to Schuylkill County Children and Youth (SCCYS) prior to this incident. Because this case was not known to SCCYS and the report was unfounded in less than 30 days, there was no Act 33 meeting held regarding this case.

Children and Youth Involvement prior to Incident:

As mentioned previously, this family had no prior involvement with Schuylkill County Children and Youth.

The mother does have a [REDACTED]. When she gave birth to [REDACTED] in August of 2012, Luzerne County Children and Youth Services (CYS) reportedly came to the hospital due to her being [REDACTED] Luzerne County reportedly did not see a need to open a case at that time.

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

On May 15, 2014, this case was reported to ChildLine as a near fatality due to the child ingesting 10 [REDACTED] tablets. [REDACTED]. The father was the caretaker for the child when he ingested the pills. The father reported he had gone to the bathroom and the child got in to a drawer. The father was unaware that the pills were in the drawer. The pills were reportedly [REDACTED] the mother's. The father immediately noticed that the child may have taken pills and contacted the mother to see what they were. The father reported that the child appeared lethargic. The mother was on her way home from work and advised the father to wait until she arrived and they would take the child to the hospital. The child was taken to Hazleton General Hospital and later transported to Lehigh Valley Hospital.

Schuylkill County CY met the parents at the hospital to interview them regarding the incident. The caseworker received background information as well as a synopsis of what occurred regarding [REDACTED] ingesting the pills that evening. The caseworker was allowed to view the texts back and forth between the mother and the father that evening. The texts corroborated the claims by the parents that this was accidental and they immediately took the child to the hospital for treatment. SCCYS subsequently went to the house and had the father show them where the event occurred and where he was at the time.

On 5-19-14, SCCYS sent a CY-104, referral to law enforcement regarding this case.
On 5-30-14, the case was unfounded.

Current Case Status:

SCCYS did open the family for services as a result of the report of abuse. While the case was unfounded, SCCYS felt the family could benefit from ongoing services. The mother did have a [REDACTED]. Additionally, the father was in a bike accident in the beginning of June and was out of work related to that accident. He was [REDACTED] related to this. SCCYS will monitor the supervision related to the medication in the home. The family was instructed to get a lock box for all medication and to keep it out of the reach of the child. The family has been compliant with this request.

There are no other children in the home and the child appears to be developmentally on target. It is anticipated that this family will remain involved with SCCYS on a short term basis.

There are no pending criminal charges in relation to this case.

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

There was no Act 33 meeting required in regards to this case because the case was unfounded in less than 30 days and the family was not known previously to SCCYS.

Department Review of County Internal Report:

None required.

Department of Public Welfare Findings:

SCCYS completed their investigation within the 30 day time period. They met with all parties and ensured the child's safety in the home. All regulatory paperwork was completed in regards to this case. There were no weaknesses identified at the county level and no areas of noncompliance were noted.

Department of Public Welfare Recommendations:

The NERO has no further recommendations in regards to this review.