



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 09/01/2010
Date of Incident: 12/13/2014
Date of Report to: 12/17/2014

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT
OR WITHIN THE PRECEDING 16 MONTHS:**

Lackawanna County Office of Youth and Family Services

REPORT FINALIZED ON:
09/28/2015

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. Section 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, 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.

Act 33 of 2008 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. Lackawanna County has not convened a review team in accordance with Act 33 of 2008 related to this report because the case was unfounded within 30 days.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
██████████	Mother ██████████	██████ 1988
██████████	Grandparent with custody	██████ 1952
██████████	Grandparent with custody	██████ 1967
██████████	Victim Child	09/01/2010

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities: The Northeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the ██████████ family. Follow up interviews were conducted with the Caseworker ██████████, the Supervisor, ██████████ and the Agency Department Manager, ██████████ on December 18, 22, 2015 and several additional dates, in order to get additional information as it became available. Regional Office reviewed the intake as the case was unfounded, closed and referred to ██████████ County in Georgia for a courtesy follow up within 30 days.

Children and Youth Involvement prior to Incident:

Lackawanna County Office of Youth and Family Services did not have any involvement with this family prior to the December incident. The VC ██████████ and ██████████ the next day after being ██████████ to Geisinger

Hospital in Danville. VC had [REDACTED]; Community Medical Center in Scranton was concerned and sent the VC to Geisinger for evaluation and follow up. Geisinger in Danville did not determine that the VC had [REDACTED]. It was determined that the mother had given the child too much Tylenol because both over the counter [REDACTED] had Tylenol in them.

Circumstances of Child Near and Related Case Activity:

The family was traveling from [REDACTED] County, Georgia to visit in Pennsylvania for the holidays. Prior to leaving Georgia, the VC was sick with a cold, from 12/10/2014 to 12/14/2014.

When VC developed a fever, Mother gave her Tylenol in addition to the cold medication. Upon arrival in Pennsylvania, VC became ill and was vomiting. Family then took VC to the local hospital where she was [REDACTED] on 12/15/2014 [REDACTED]

[REDACTED] VC's grandparents have custody of VC through a private arrangement. The family all lives together and have homes in Pennsylvania and Georgia. They were traveling to the Pennsylvania home and the mother was administering the Tylenol Cold and regular Tylenol, in order to relieve her symptoms while traveling such a long distance. The family was cooperative and concerned about VC and acted appropriately by taking her to the hospital [REDACTED]. While at Scranton Community Medical Center, the VC had blood work done that showed [REDACTED]. [REDACTED] CMC decided to send her to Geisinger [REDACTED] in Danville for evaluation. While at Geisinger Danville she was administered tests [REDACTED]. Her levels were elevated due to the medication but [REDACTED] and she [REDACTED] the following day. The family returned to their home in Georgia and a referral was made to [REDACTED] County, Georgia. Follow-up by the county indicated no need for services from that county in Georgia. Case was unfounded.

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

- Strengths in compliance with statutes, regulations and services to children and families;

Agency responded in a timely manner.

Agency collaborated with medical personnel regarding the child's condition.

Agency collaborated with [REDACTED] County Children and Youth Services, located in Georgia.

- Deficiencies in compliance with statutes, regulations and services to children and families;
None
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
No recommendations
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
No recommendations
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
No recommendations

Department Review of County Internal Report:

The County did not conduct an internal review as the case was unfounded within 30 days. There is no indication the time frame for administering the medication occurred only in Pennsylvania. VC was provided the medication while traveling from Georgia to Pennsylvania. The family was not active in Georgia.

Department of Human Services Findings:

- County Strengths:
The County followed all recommendations and followed regulatory and CPSL requirements.
- County Weaknesses:
None
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
None

Department of Human Services Recommendations:

The County responded to the case immediately and made a referral to ██████ County in Georgia where the family resides. The County followed up that referral by calling the ██████ County Children and Youth Services in Georgia to confirm that they did meet the family and determined there was no need for services.