pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/12/2009
Date of Incident: 04/14/2016
Date of Report to ChildLine: 04/14/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Berks County Children and Youth Services

REPORT FINALIZED ON:
12/05/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Berks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on – 05/02/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Biological Mother	[redacted]1970
	Biological Father	1969
	Victim Child	02/12/2009
	Half-sibling	[redacted]1998
	Sibling	2002
* [redacted]	Half-sibling	[redacted]1995
	Sibling	Deceased

* 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 Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. These records were obtained on 04/21/2016, 08/23/2016 and 08/24/2016. SERO conducted interviews of the Berks County Caseworker, Casework Supervisor, and the Intake Services Manager on 08/23/2016 and 08/24/2016. SERO staff did not participate in the Act 33 meeting that occurred on 05/02/2016 in which county child welfare professionals, medical professionals, community advocacy groups and law enforcement were present and provided information regarding the incident as well as historical information.

Children and Youth Involvement prior to Incident:

There are no prior reports of children and youth involvement from Berks County.

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

Berks County Children and Youth Services received a report on 04/14/2016 stating that the victim child was in the emergency room at 5:00 PM on this same day because he had been sick for several days. The parents stated that they had checked on the victim child in the home and found him unresponsive. The family called 911, but did not wait for ambulance to arrive as they drove the victim child to the hospital themselves. The parents drove the victim child to the hospital with the child on Mom's lap facing away from mother. The child presented gray/blue in color, not breathing and eyes dilated. The hospital [redacted] was successful in resuscitating the victim child. The victim child's blood glucose level [redacted] Normal range for a non-diabetic is 70-99 mg/dl before meals and under 140 mg/dl after meals. The victim child's temperature was also 102.4 at the time of arrival. The reporting source stated that the low blood glucose level meant that the child hadn't eaten in several days. [redacted] The reporting source stated that the victim child had to be in poor condition for a significant amount of time. It was unclear if the victim child was going to survive. The reporting source stated that no bruises or marks were seen on the victim child. The reporting source stated that if the victim child would have been brought into the hospital sooner he would not have been in this serious condition.

Upon initial contact with the family the parents informed caseworkers that they moved to Berks County from [redacted], New York in 2011. Mother informed the caseworker that they had a child who passed away in 2011 when he was 4 years old due to an unknown virus. Mother stated that the victim child has been sick frequently this year and has missed 11 days of school due to primary care physician and emergency room visits. Mother also reported that the victim child was sent home from school on 04/13/2016 as he was feeling ill. She gave him Tylenol that evening. Victim child refused to eat solid foods and vomited throughout that night. Victim child was reportedly given apple juice and water throughout the night. Victim child did not go to school on the day of the incident and woke up with a fever. Mother continued to give him Tylenol but said it was not working. Victim child was reportedly given juice or water every 20 minutes but would vomit shortly after each drink. At approximately 4:00 PM victim child's sibling checked on him and discovered he was not breathing. The parents called 911 but decided to take the victim child to the emergency room themselves.

Victim child was last seen at [redacted] in February of 2016. [redacted] the victim child's initial presentation was due to [redacted] which can cause patients to deteriorate very quickly in the setting of another illness [redacted] This doctor confirmed [redacted] that the Children's Hospital of

Philadelphia did not have any concerns or reason to suspect that the child's initial presentation was caused by another individual or was the result of neglect or abuse. Subsequent follow up with the victim child confirmed that he has been [redacted]

The victim child [redacted] the Children's Hospital of Philadelphia on 04/29/2016 with a referral to [redacted] and the victim child's primary care physician for follow up. On 05/17/2016 Berks County Children and Youth received another report on this family regarding physical discipline. The report alleged that the father used a belt to discipline the victim child's 14 year old female sibling. The father initially denied the allegations and downplayed the severity of the report. The victim child in that report had bruising from the father beating her with a belt. The father justified his actions saying that the Bible says he can use physical punishment. This case was opened for services with a referral to [redacted] to assist the family with accessing community resources and [redacted] for the child and father. [redacted]

This near fatality case was unfounded on 06/06/2016. Berks County Detectives have also closed this case and will not be recommending any charges related to this case.

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;

- Family cooperated with investigation and plan of care
- Family has a support system
- Family has stable housing, children are enrolled in school
- Safety of the other children in the home was assessed
- Abuse or neglect was not identified as a cause of this child's hospitalization
- Communication between medical providers and CYS was effective.

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

- None identified in the way the case was handled
- Previous death of a sibling under similar circumstances

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

- None

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

- None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

- None

Department Review of County Internal Report:

SERO reviewed the County Internal Report on 08/23/2016. The information from the case was presented thoroughly. The recommendations in the report do not incorporate strengths or deficiencies in regards to compliance of regulations. The report also does not address recommendations for changes at state and local levels to reduce likelihood of future child fatalities or near fatalities, monitoring or inspection of county agencies, or collaboration of community agencies and service providers. SERO will address this report and suggest changes to incorporate these items into their final reports for the future.

Department of Human Services Findings:

- County Strengths:

The county had no regulatory non-compliance in this investigation
The county opened this case to continue monitoring this child's progress

- County Weaknesses:

Medical records from New York were not obtained to confirm the account of the first child's death.
Children and Youth Services records were not obtained from New York

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

There are no regulatory areas of non-compliance by Berks County.

Department of Human Services Recommendations:

SERO recommends that the Berks County Child Fatality/Near Fatality Review Report be amended to incorporate information regarding compliance or noncompliance of regulation, recommendations at state and local levels to reduce the likelihood of future child fatalities and near fatalities, monitoring or inspection of county agencies, or collaboration of community agencies and service providers.