pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/30/2014
Date of Incident: 12/05/2016
Date of Report to ChildLine: 12/05/2016
CWIS Referral ID: [redacted]

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

Monroe County Children and Youth Services

REPORT FINALIZED ON
05/15/2017

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.

Monroe County has not convened a review team in accordance with the Child Protective Services Law related to this report as the report was determined to be unfounded on 12/30/2016 - 25 days from the date of the original report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/30/2014
	Twin Sibling	[redacted]2014
	Mother	[redacted]1981
	Father	[redacted]1964

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth, and Families (NERO) obtained and reviewed all case records pertaining to the family of the victim child. The county did not convene a review team as the report was determined to be unfounded within 25 days of the original report.

Summary of circumstances prior to Incident:

Monroe County Children and Youth Services (MCCYS) had no involvement with the family prior to this referral incident. The family reported no prior involvement with [redacted] services and no criminal history. The family has resided in Pennsylvania since 2010. They are from Morocco and lived in [redacted], New Jersey prior to moving to Pennsylvania.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/05/2016, MCCYS received two near fatality reports regarding the victim child and his twin sibling. The report stated that the parents of the child were either cooking or heating on a charcoal fire in the home. The fire wasn't vented and carbon monoxide built up. The children were taken to the Pocono Medical Center Emergency Department for smoke inhalation and then transferred to Lehigh Valley Hospital. It was reported that the children were in serious/critical condition and

expected to survive. The children were in [redacted] Lehigh Valley Hospital at the time of the report while the parents were in the [redacted] It was reported that the family [redacted] that day but that the victim child [redacted] The report was registered for physical abuse with both parents named as alleged perpetrators.

Upon arrival at the Emergency Department, the mother's carbon monoxide (CO) level was 22. The twin sibling's level was 14 and the victim child's level was 6.5. The victim child was [redacted] at Pocono Medical Center and transferred to Lehigh Valley Hospital. The child remained hospitalized at Lehigh Valley Hospital overnight [redacted] A child protection team consult was completed while the victim child was hospitalized at Lehigh Valley Hospital. The assessment was child neglect. [redacted] it is difficult to determine if the parents understood the potential consequences of bringing a charcoal grill into the home. The team reportedly discussed with the parents the importance of not bringing a grill into the home due to the risks of carbon monoxide poisoning. The team also recommended a home evaluation, parenting classes, and follow up with MCCYS.

Interviews were also conducted with the parents by MCCYS and law enforcement. The interviews revealed that the mother had been cooking on a charcoal grill outside and it was very cold outside so the father moved the charcoal grill into the home. Both parents reported that this was the first time the grill had ever been used inside the home. The parents reported that within 10 minutes, the mother was feeling ill and the children were not acting like themselves, they were just lying around. The father reported that he got everyone out of the house and drove them to the Pocono Medical Center Emergency Department. The father reported having to pull over on the way to the hospital as the mother vomited. The father reported that he arrived home from work around 7:30pm – 7:45pm and was at the hospital by 8:30pm. [redacted] there would be no way to determine how long it would take for the victim child to have carbon monoxide poisoning as many different factors, such as the amount of carbon monoxide produced, the size of the space, and the draft, would have to be considered.

During the investigation, MCCYS completed multiple home visits and interviews which revealed no ongoing protective services issues. No safety threats were identified and the risk assessment identified the overall risk as low. The investigation determined that the incident was accidental and there was no evidence that the parents acted knowingly, intentionally, or recklessly. MCCYS [redacted] as well as provided education regarding appropriate use of the heat sources within the home. The case was closed with MCCYS upon completion of the investigation.

MCCYS submitted their status determination for the investigation as unfounded. The unfounded status was submitted on 12/30/2016.

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

*The county did not convene a review team as the report was determined to be unfounded within 25 days of the original near fatality report. Therefore, the county did not identify any strengths, deficiencies, or recommendations for change.

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

*See note above.

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

*See note above.

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

*See note above.

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

*See note above.

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

*See note above.

Department Review of County Internal Report:

The county did not convene a review team as the report was determined to be unfounded within 25 days of the original near fatality report. Therefore, the county did not submit an internal report.

Department of Human Services Findings:

County Strengths:

MCCYS began their investigation immediately upon receipt of the initial report and were at the hospital within 3 hours of receiving the initial report.

MCCYS immediately initiated a multi-disciplinary investigative team by contacting law enforcement within 2 hours of receiving the initial report.

MCCYS completed the investigation within 25 days. The investigation was thorough and met all regulatory requirements, including securing medical records, interviews with all persons known to have information, and consult with two physicians.

The county provided [redacted] and educated them on the use of their heat sources, including recommending that the family have their chimney cleaned and inspected.

County Weaknesses:

No county weaknesses have been identified.

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

There were no areas of non-compliance by MCCYS.

Department of Human Services Recommendations:

No recommendations are being made at this time as this incident appears to have been accidental. There were no protective services, [redacted] developmental, medical, or education issues active or known within this family. The family is not involved with any community service providers.