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## REPORT ON THE NEAR FATALITY OF



**Date of Birth:** [REDACTED] **2008**  
**Date of Near Fatality:** **April 19, 2011**

**The family was known to**  
**Lehigh County Children & Youth Services**

**Date of Report:** **October 6, 2011**

This report is confidential under the provisions of the  
Child Protective Services Law and cannot be released  
(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 No. 1147, now known as Act 33, was signed by [REDACTED] on July 3, 2008 and went into effect 180 days from that date, December 31, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

### Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED] 2008
[REDACTED]	Mother	[REDACTED] 1978
[REDACTED]	Sibling	[REDACTED] 1999
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Father	[REDACTED] 1982
[REDACTED]	Maternal Grandmother/AP	[REDACTED] 1958
[REDACTED]	Maternal Aunt	[REDACTED] 1977

### Notification of Near Fatality

On April 19, 2011 [REDACTED] received a referral from a [REDACTED], Allentown, Pa., regarding the near fatality of the victim child. The [REDACTED] brought the child to the [REDACTED] as she thought that the child may have [REDACTED]. The initial levels of [REDACTED] were reported to have been critically high according to the [REDACTED]. The [REDACTED] noted that the child would [REDACTED]. This was based on testing done by the hospital. The child was reported to have been [REDACTED] and his [REDACTED] could be damaged. The child was being certified as being in [REDACTED]. He was being transferred to [REDACTED]. The case was registered for physical abuse resulting in a physical condition and processed as a near fatality. The Northeast Regional Office of Children, Youth and Families received the report of the near fatality and the Lehigh County Children and Youth Services after-hours on-call caseworker received the numbered report and began the investigation.

### Documents Reviewed and Individuals Interviewed

The Northeast Regional Office (NERO) Human Service Program Representative met with the Child Protective Services Supervisor, caseworker and manager to discuss this case. The Program Representative was involved with [REDACTED] as the child had been in [REDACTED]. The Program Representative reviewed the case file in the past and reviewed the current Child Protective Services case record.

## Case Chronology

*April 19, 2011* - Near fatality of the child. The case was called into ChildLine by a [REDACTED]. He was brought into the emergency room by the [REDACTED] who thought that he may have [REDACTED]. The child was certified by the [REDACTED] to be in [REDACTED] as his [REDACTED] were [REDACTED]. It was believed that his [REDACTED] as the [REDACTED] body weight kilogram and the child's levels were at [REDACTED] body weight kilogram. The case was registered by ChildLine for physical abuse. The [REDACTED] was named as the [REDACTED].

*April 20, 2011* - Unannounced visit to the family residence by the former ongoing caseworker whom the case was reassigned to. The victim child was seen at the hospital by the Child Protective Services Caseworker. The safety assessment tool was completed with a determination that the child's three siblings were safe. The victim child was determined to be safe with a comprehensive plan. The safety plan was completed at that time by the caseworker and signed by all responsible parties. The plan stipulated that all [REDACTED] must be locked up and not accessible to the child. He was to be supervised at all times and the maternal aunt would be staying with the family to assist with the supervision of the child.

## Previous Children and Youth Involvement

The family was active with Lehigh County Children and Youth Services from May 5, 2010 until December 29, 2010. The family was a [REDACTED] due to housing issues. The mother wanted the agency to assist her in finding appropriate housing as she was being evicted in several days. The family lived in the same apartment for years and had got behind on the rent. The case was accepted for services by the agency due to the housing issue and the county's need to provide supportive services to the family. During that time, the mother and maternal grandmother brought the victim child to the emergency room on June 4, 2010 as he appeared to be in a [REDACTED]. He was reported to have been healthy and not on any prescribed drugs. The child was admitted to the [REDACTED]. A urine screen was completed and the results were [REDACTED]. The child was certified by the [REDACTED] to be in [REDACTED] and was in a [REDACTED] and in a [REDACTED]. The case was registered by ChildLine for lack of supervision resulting in a physical condition. The alleged perpetrator was listed as [REDACTED] as it was not determined as to how the child got the [REDACTED] or who it belonged to. The child was expected to survive and did. It was determined that the child had taken a [REDACTED] which was the [REDACTED]. This [REDACTED] contains a [REDACTED]. The case was unfounded at that time by the Lehigh County Child Protective Services Caseworker. The child's condition was determined to have occurred accidentally. Law enforcement concluded their investigation without any criminal charges due to the accidental nature of the incident. The case remained open with the general protective services unit to monitor supervision

and to link the family to [REDACTED] as the child was reported by the family to have [REDACTED]. However, a formal diagnosis of that condition was never established. The agency also worked with the family to assure that a lock box was used to store all [REDACTED] and [REDACTED]. The case was closed on December 29, 2010 with no safety concerns.

### **Circumstances of the Child's Near Fatality**

The [REDACTED] who resided with the family took the child to the emergency room. She thought that he had [REDACTED] as he got his hands on a screw cap bottle of [REDACTED]. The child was in the care of the [REDACTED] at the time. The doctor noted that due to [REDACTED], the child would have had to [REDACTED] at least [REDACTED]. The child was [REDACTED] and the doctor was concerned that the child's [REDACTED]. The doctor [REDACTED] Hospital reported that the [REDACTED] body weight kilogram. The child was at [REDACTED] weight kilogram. The child was transferred from [REDACTED] Hospital to [REDACTED] Hospital.

### **Current / Most Recent Status of Case**

The case was unfounded on May 16, 2011 by the Lehigh County Children and Youth Child Protective Services Unit. The incident was believed to be accidental and the lack of supervision was not prolonged or repeated. The child was seen medically at an early stage so that the effects of the [REDACTED] were able to be reversed with no damage to the [REDACTED].

### **Statutory and Regulatory Compliance**

- Safety was accessed for all the children in the home.
- The investigation was conducted in a timely manner.
- All parties were interviewed and received rights letters.

### **Findings**

NERO concurs with the findings of Lehigh County Children and Youth Services.

### **Recommendations**

No recommendations for change were identified.