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REPORT ON THE NEAR FATALITY OF

[REDACTED]

DATE OF BIRTH: [REDACTED], 2010
DATE OF NEAR FATALITY: December 25, 2011

FAMILY WAS NOT KNOWN TO:
Lehigh County Children and Youth Services

REPORT FINALIZED: September 24, 2012

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, 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; Department of Public Welfare 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. Lehigh County was not required to have a review because the report was unfounded and a status determination was made within 30 days of the oral report to childline.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED] 2010
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father	[REDACTED]
[REDACTED]	Maternal Grandmother	[REDACTED]
[REDACTED]	Maternal Uncle	[REDACTED]

Notification of Near Fatality:

On December 25, 2011 [REDACTED] received a referral from [REDACTED] at [REDACTED] [REDACTED] Allentown, Pennsylvania, regarding the near fatality of the 13-month-old Victim Child (VC). The VC was brought to the [REDACTED]. The VC came into the [REDACTED] in [REDACTED]. The VC's [REDACTED] and he required [REDACTED]. The VC was listed in [REDACTED] but expected to survive. It was believed that the VC had [REDACTED] some of the [REDACTED]. The [REDACTED] takes [REDACTED] a day. The Mother, maternal grandmother and maternal uncle were all at home when this occurred. [REDACTED] keeps her [REDACTED] in a lock box in mother and father's bedroom. At this time it was not clear how child got [REDACTED] but the mother had stated that she found several of the [REDACTED] wrapped in a piece of aluminum foil on her parents' bedroom floor and some of the [REDACTED] appeared to be partially chewed. [REDACTED] was listed as [REDACTED] on this report. The report was numbered for lack of supervision. The Northeast Regional Office of Children, Youth and Families received the report of the near fatality. [REDACTED] from the [REDACTED] Police Department responded to the initial call along with [REDACTED].

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office of Children and Youth Human Service Program Representative met with the Child Protective Services supervisor, caseworker, and manager to discuss this case. The Program Representative had obtained and reviewed the entire file regarding this family.

Children and Youth Involvement Prior to Incident:

The family had no prior children and youth involvement.

Circumstances of Child Fatality and Related Case Activity:

On December 25, 2011 at approximately 12:10PM the mother was holding VC and noticed he was not moving at all. The family called 911 and Emergency Medical Services were called to the family home [REDACTED] Police Department was also called to assist. At the scene the VC was connected to [REDACTED] and was given [REDACTED]. While in transit to [REDACTED] the VC was given a [REDACTED] and the VC had an immediate reaction which led the [REDACTED] to believe the VC was exposed to some type of [REDACTED]. The VC arrived at the hospital and went into [REDACTED] and was placed on a [REDACTED]. Police requested a full [REDACTED] was assigned the case. [REDACTED]. The [REDACTED] was listed as the [REDACTED] due to lack of supervision.

During the course of the police investigation it was discovered that the [REDACTED] who also resides in the home takes [REDACTED]. She works at a local [REDACTED] and during the winter she wears layers of clothing to keep warm. She wraps her daily [REDACTED] in aluminum foil and carries them in her pocket. Her [REDACTED] are stored in a lock box in her bedroom but each morning she takes her daily [REDACTED] out of the lock box. Some of her [REDACTED] was found on the parents' bedroom floor and it had been partially eaten. The foil was also found, it was determined that he [REDACTED] fell out of her pocket when she was taking her work clothes off and she did not realize this. The VC found the aluminum foil packet on the floor and had ingested some of the [REDACTED]. The VC's full [REDACTED]. The VC [REDACTED], it was never determined exactly how much [REDACTED] the VC ingested. The VC was released from [REDACTED] Hospital on December 26, 2012. [REDACTED] Police and Lehigh County Children and Youth both felt this was an accident. No charges were filed and Lehigh County Children and Youth unfounded the case and closed the family on January 19, 2012. The home and all family members were appropriate and there were no safety issues or concerns.

Current / Most Recent Status of Case:

The case was unfounded on January 19, 2012 by the Lehigh County Children and Youth Child Protective Services Unit. The incident was believed to be accidental and it was determined the [REDACTED] who was listed as the [REDACTED] was not neglectful in her supervision of the child. The child was released from the [REDACTED] Hospital the next day and did not suffer any long term affects due 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.