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REPORT ON THE FATALITY OF

Conner Orner

Date of BIRTH: November 13, 2009
Date of FATALITY: June 18, 2010

FAMILY KNOWN TO
Berks County Children and Youth

Date of Report: October 22, 2010

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 on July 3, 2008 and went into effect on December 30, 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.

Circumstances of Fatality/Near Fatality:

The agency was made aware of this incident on June 19, 2010. The victim child, Conner Orner, was brought to the Emergency Room at Reading Hospital on June 12, 2010 due to vomiting blood and bloody stool. He was brought to the hospital by his maternal grandmother who was caring for him. He was later transferred to St. Christopher's Hospital in Philadelphia. The child was being cared for by his maternal grandparents. His mother, [REDACTED], was involved in drug and alcohol use, had an [REDACTED] and lived at home sporadically. The child's father was not involved with him. The hospital admitted Conner on June 12, 2010 and administered a number of medical tests in order to try to determine the cause of his serious condition. He had been at a well baby check the week before this incident and appeared to be well, thriving and attached to his grandmother. [REDACTED]

[REDACTED] The child died on June 18, 2010. [REDACTED]

An autopsy was conducted on the child on June 20, 2010.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1998
Orner, Conner	Victim Child	11/13/2009
[REDACTED]	Brother	[REDACTED] 2008
[REDACTED]	Maternal grandfather	[REDACTED] 1965
[REDACTED]	Maternal grandmother	[REDACTED] 1965

Not living in the home:

[REDACTED]	Father [REDACTED]	[REDACTED] 1989
[REDACTED]	Father [REDACTED]	[REDACTED] 1981

Documents Reviewed and Individuals Interviewed:

The documents reviewed included the Safety Assessment, Safety Plan, Risk Assessment and entire case file for this incident as well as the previous contacts the agency had with this family. Interviews of the caseworker, supervisor and administrator of intake were conducted. The Berks County Death Review was attended by Northeast Regional Staff and the document developed by the team was also reviewed.

Case Chronology:

Conner passed away at 2:50 pm on June 18, 2010. On June 19, 2010 the caseworker spoke with [REDACTED], who stated that the autopsy was not yet completed. [REDACTED]

[REDACTED] condition and there were no signs of abuse. The hospital did a skeletal survey and found nothing. The [REDACTED] recognized the [REDACTED] but no cause was discovered definitively for the condition.

On June 19, 2010, [REDACTED] instructed the caseworker to go to the home of maternal grandparents to give [REDACTED] letters, get pictures of [REDACTED] and develop a safety plan.

On June 19, 2010 the Caseworker arrived at the home of the maternal grandparents. Maternal grandfather was cooperative. He was putting [REDACTED]. Caseworker asked [REDACTED] Caseworker explained the letters to the grandfather. [REDACTED] was very sad and obviously bonded to [REDACTED] who would be willing to come to help supervise the contact between him and his grandson. [REDACTED]

[REDACTED] was also willing to participate in the safety plan. He was cleared and the safety plan was signed. The plan stated that [REDACTED] could not have unsupervised contact with [REDACTED]. However, the maternal grandmother was still in [REDACTED]

[REDACTED] While waiting for [REDACTED] ambulance. [REDACTED] the maternal grandmother reported to him that parts of Conner's intestines were dead. She was "devastated" that anyone would think [REDACTED] They also said [REDACTED] be alone with the children. At this time, [REDACTED]

June 20, 2010, a phone call was received from [REDACTED], investigator at the [REDACTED] Office. She spoke to the caseworker and informed her that the autopsy would be done today. [REDACTED]

The Caseworker reported that maternal grandfather is a [REDACTED] and maternal grandmother [REDACTED]. There was no evidence of drug and alcohol use and

both appeared [REDACTED]. Maternal grandmother was well informed about child development and was comforting to [REDACTED].

On June 20, 2010 the Caseworker [REDACTED] [REDACTED] No trauma was found. There was a yellow substance on the tissues and organs which indicated an infection. [REDACTED] [REDACTED] was knobby and unlike anything [REDACTED]. He planned to have another [REDACTED] look at this area tomorrow. The cause of death was left undetermined pending the toxicology results.

On June 21, 2010 the Caseworker called [REDACTED] to check to see how she was doing. [REDACTED] just devastated and repeated she would never hurt Conner.

On June 21, 2010 [REDACTED] contacted the caseworker. He stated he could not believe that this happened [REDACTED]. Caseworker explained that until the autopsy results are complete, the safety plan would remain in effect. The caseworker also arranged for [REDACTED] to be taken to Children's Health Center for a full exam.

On June 21, 2010 the [REDACTED] called the caseworker with a follow up regarding the hemorrhages. They were determined to be [REDACTED] [REDACTED]

June 22, 2010 [REDACTED] [REDACTED] this was Conner's last well checkup. He was cooing, laughing, eating and appropriate. There were no concerns regarding his temperament or mood. [REDACTED]

[REDACTED] was confirmed for June 22, 2010 at 9:50am at the Children's Health Center.

[REDACTED]

On June 25, 2010, Supervisor [REDACTED] confirmed that the safety plan could be released on the grandparents but the mother will still require supervised contact at all times.

The Caseworker visited the home [REDACTED] [REDACTED] reported it has been difficult. She stated that [REDACTED] [REDACTED] The family is going through a lot.

On July 16, 2010 the caseworker

[REDACTED]

On July 23, 2010,

[REDACTED]

The Caseworker visited the grandparent's home on August 8, 2010 and explained that

[REDACTED]

PREVIOUS INVOLVEMENT

Berks County became aware of

[REDACTED]

The caseworker

[REDACTED]

did not allow the children to have unsupervised contact with [REDACTED]. The children were in the exclusive care of the grandparents and the grandparents were receiving support [REDACTED]

Statutory and Regulatory Compliance by the County Agency:

The agency was in compliance with all regulatory requirements. However, difficult as it was to work with [REDACTED], the agency did not have a great deal of contact with her or the providers that were working with her. Although she was gone for some time, she was also coming in and out of her parent's home sometimes causing a disturbance. The agency should have initiated a meeting with the providers who were working with her to better understand [REDACTED] issues and needs. [REDACTED]

provided a more timely response to help address the custody issues.

Findings and Recommendations:

The agency needed to demonstrate a better effort to engage the mother of the children and become more proactive with getting her [REDACTED] level. [REDACTED]

[REDACTED] The agency did, however, respond in a timely manner and was compliant with completing all required paper work. Assigning the case to the same caseworker for the second allegation was a good decision.