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REPORT ON THE NEAR FATALITY OF

██████████

Born: ██████/08

DATE OF NEAR FATALITY: 5/6/11

FAMILY NOT KNOWN TO: Berks County CYS

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 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 review and provide a written report on any child fatality or near fatality where child abuse is suspected.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED]/84
[REDACTED]	Father	[REDACTED]/83
[REDACTED]	Victim Child	[REDACTED]/08
[REDACTED]	Sibling	[REDACTED]/09
[REDACTED]	Sibling	[REDACTED]/11

Notification of Near Fatality

The family lives in a rural area of Berks County and on 5/6/11 the Victim Child(VC) was outside playing. The VC's Mother was in the kitchen nursing a one month old sibling of the VC. The VC's mother could see the VC from the kitchen. The VC entered a shed which is very close (40-50 feet) to the house. The VC was in the shed for about 5 minutes and came out. The VC then came into the house, within an hour the VC's father came home from work and the family sat down for dinner and the VC began [REDACTED]. The VC's parents called 911 and an ambulance arrived within 10 minutes. The VC was taken to the [REDACTED]. The VC did not die but it was determined the child had [REDACTED]. Child abuse was not suspected but there was a concern for lack of supervision. The initial report listed [REDACTED]. [REDACTED] it was later discovered that the father was working when the incident occurred.

Documents Reviewed and Individuals Interviewed:

Northeast Regional Office reviewed the Berks or any other County Children and Youth Agency (BCCYS) file containing the investigation and Safety Plan. All parties involved and all family members were interviewed by BCCYS. Interviews were documented in the file and reviewed by NERO. NERO interviewed the Caseworker and Supervisor of the case.

Circumstances of Child's Near Fatality:

The VC had [REDACTED].

Previous CY involvement:

This family has never been involved with Berks or any other County Children and Youth Agency.

Case Chronology:

On 5/7/11 at 12:24 AM BCCYS on call worker responded to a call she had received. The report was [REDACTED] by [REDACTED] due to a concern for a lack of supervision. The on call worker, [REDACTED] called the [REDACTED]. The mother, father, victim child and one month old sibling were at the hospital at the time of the report. The Caseworker spoke to the father and informed him of the report and allegations. He stated they (VC's sister ([REDACTED], mother and father) would be staying at the hospital the rest of the night. The VC's other sibling ([REDACTED]) was at home with the [REDACTED]. The room the family was in was next to the [REDACTED] and had a window in it. The [REDACTED] on duty, [REDACTED] stated she would keep an eye on the family.

On 5/7/11 at 8:37 AM Caseworker [REDACTED] went to the [REDACTED] to meet with the mother and victim child. [REDACTED] went to the family home. The Caseworker had interviewed [REDACTED] who stated the child is doing very well and will [REDACTED]. It was reported that both parents were very appropriate and there were no concerns.

At the family home [REDACTED]. This family is [REDACTED]. At this time it was discovered that the father was working when the incident occurred. Father has his own business, [REDACTED]. Both parents gave the same account of what had occurred. Father had arrived home at 7:00 PM on 5/6/11 and they sat down for dinner and VC began to [REDACTED], the VC also had a [REDACTED]. The family called 911 and an ambulance arrived within about 10 minutes and transported VC to the hospital. It was also discovered that on 4/12/11 a friend had given father a box of items. The family did not know that there was pesticide in the bottom of the box. They put the box in the shed. It was later determined by [REDACTED] that the pesticide ([REDACTED]) which the VC [REDACTED] is no longer used in the United States.

On 5/9/11 Caseworker, [REDACTED] went to the family home. The child had been [REDACTED] on 5/7/11 and was doing very well. The family had been very cooperative with the agency and there were no concerns. During both home visits the Caseworkers had seen the three children and walked through the family home.

The Caseworker discussed this case with her Supervisor and it was decided the case would be unfounded as this was an accidental isolated incident. There were no concerns regarding this family and the family would not be opened for services.

Current/most recent status of case:

It was determined that the VC had entered a shed on 5/6/11 at about 6:00 PM and was in the shed about 5 minutes; she had touched a box the pesticide was in and apparently put her fingers in her mouth transferring the chemical into her body. The chemical was [REDACTED] when she vomited. The VC was out of her mother's sight for about 5 minutes when she was in the shed. The day the VC came home from the hospital (5/7/11) the pesticide was gone from the shed and both doors to the shed were pad locked. The VC has not suffered any long term ill effects from this incident.

The [REDACTED] was notified and it was determined they would not be pursuing any criminal charges.

BCCYS will not be providing any ongoing services to this family.

Services to children and families:

This family is a [REDACTED] and they receive a lot of support from [REDACTED]. They have never been involved with any outside services.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

No recommendations for change were identified.

NERO Findings and Recommendations:

NERO concurs with the findings of BCCYS.

Statutory and Regulatory Compliance issues:

- *Safety was appropriately accessed for the younger siblings.
- *The investigation was conducted in a timely manner.
- *All parties were interviewed and received rights letters.

