



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

## OFFICE OF CHILDREN, YOUTH AND FAMILIES

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### REPORT ON THE NEAR FATALITY OF



**BORN:** [REDACTED] **2012**  
**DATE OF NEAR FATALITY:** **09/22/2012**

**FAMILY KNOWN TO:**  
Berks County Children and Youth Services

**DATED:**  
February 20, 2013

**Reason for Review**

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-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.<sup>1</sup>

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. Berks County has convened a review team in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1995
[REDACTED]	Father	[REDACTED] 1991
[REDACTED]	Great Maternal Grandmother	[REDACTED] 1958
[REDACTED]	Maternal Great Uncle	[REDACTED] 1986
[REDACTED]	Victim Child	[REDACTED] 2012

**Notification of Near Fatality:**

Berks County Children and Youth received a report on 09/22/2012 that [REDACTED] was at [REDACTED] Medical Center [REDACTED] presenting with bleeding from his mouth and difficulty breathing. It was unclear as to whether the child was sick due to abuse or neglect and he did have a medical history with the hospital. He had been taken to the hospital even prior to the latest incident. The child was first taken to and examined at [REDACTED] [REDACTED] listed as critical. The report stated that the child was alone with his mother at the time the incident occurred.

**Summary of DPW Child Near Fatality Review Activities:**

The Northeast Regional Office reviewed the file, including all contact sheets, safety assessments, risk assessments and medical reports. Interviews were held with the intake supervisor, caseworker and the manager of the intake department. The contacts made by [REDACTED] were reviewed in addition to the county file.

**Summary of Services to the Family:**

**Children and Youth involvement prior to Incident:** The family initially became active with Berks County Children and Youth Services in [REDACTED] of the victim child. The agency received information that there were concerns regarding the parents and their ability to parent [REDACTED] hospital following his birth. [REDACTED] they were confronted by [REDACTED], they did respond positively and stated they

<sup>1</sup> 23 Pa, C,S, § 6343(c)1,2.

understood. During the initial contact with the family, they were cooperative and agreed not to sleep with the infant. The case was opened for intake services and [REDACTED] was offered to the family for assistance with parenting education and to obtain the services in the community which would best meet their needs.

**Circumstances of child's near fatality and related case activity:** On 9/25/2012 Berks County Children and Youth Services was notified that a near fatality child protective services report was made regarding [REDACTED]. The child had been taken to the hospital due to unexplained respiratory issues and later transferred to Hershey Medical Center. On 9/21/2012 the mother had noticed the child was having respiratory issues and took him to the Reading Hospital for examination. The caseworker had been to the home earlier that day for a routine visit at which time the family reported that the child had been fussy and spitting up formula. The caseworker asked the family what they had been doing to help the child and told them not to hesitate to call the physician if his condition did not improve. At the hospital the infant was x-rayed and examined. The hospital did not admit the child but told the mother to return if he did not improve. On 9/22/2012 the mother noticed blood in the infant's mouth, and difficulty breathing. He was taken back to the emergency room. Initial reports indicated that his condition could be caused by infection or a [REDACTED]. There were several other possible diagnoses but the doctor was having difficulty obtaining an accurate history from the parents. It was also stated that it could be due to suffocation. However, x-rays did not show that the child had suffered injury and he had been showing signs of respiratory distress after birth, while still in the hospital, delaying his release. The parents thought it was due to them having a difficult time learning the proper use and placement of the car seat "test", as they referred to the instruction session the hospital conducted. The baby remained at Hershey Medical Center for 11 days and was discharged on 10/03/2012. He did respond well to treatment and showed signs of improvement while hospitalized. The infant was [REDACTED]. Subsequent skeletal survey was negative for fractures. There was no sign of [REDACTED], external bruising, or suffocation. Due to a significant history of respiratory distress and negative results on all the medical test conducted to examine the issue of potential abuse, the case was unfounded for physical abuse. The infant was sent home with his grandmother, who was given safety plan that included her being responsible for monitoring interaction of the parents with the infant, and directly supervising any contact. The safety plan was terminated after 5 weeks due to the cooperation of the parents, no inappropriate parenting being observed and the support offered by the extended family. The case was opened for general protective services due to the need for continued monitoring concerning the child's well being, the mother's young age and maturity level and the need for continued parenting services.

**Current/most recent status of case:** The case is active in the in home services department of Berks County Children and Youth Services. The family continues to be cooperative with services and the extended family continues to be supportive of the parents. The mother reports that she is interested in going back to school to finish her education. The father is employed. Medical care follow-up has been consistent. The young parents continue to live with relatives.

**County strengths and deficiencies as identified by the County's near fatality report:**

**County Strengths:**

- Family sought medical treatment for [REDACTED] on 09/21/2012 and again on 09/22/2012.
- Family is cooperative and receptive to services.
- Family has extended support systems.

- Family has stable housing.
- No history of [REDACTED] for either parent.
- The follow-up [REDACTED] no findings. These are areas of focus that the County's Title 33 Review focused on.

**County Weaknesses:**

- There were multiple reports [REDACTED], perhaps indicating that the parents were having difficulty caring for the victim child and the agency could have intervened more quickly.
- There were inconsistent stories from parents regarding how the child fell ill and the parents not seeming to understand how to care for him.

**County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:**

The county should continue to closely monitor the family and provide [REDACTED] support and access to all pertinent community resources. The review of the case also noted that families who are facing an emergency should always call 911 for emergency assistance as opposed to transporting critically ill family members and children themselves to the hospital.  
[REDACTED]

**Department of Public Welfare Findings:**

**County Strengths:**

Berks County Children and Youth Services completed the investigation in a timely manner and due to [REDACTED]. The agency completed a risk assessment and safety assessment. All documentation necessary for the investigation was completed, including the supervisory 10 day reviews and medical records.  
[REDACTED]

[REDACTED]. The response time for investigation was met and the caseworker had consistent contact. Berks County Children and Youth Services did hold an Act 33 meeting on December 11, 2012. Berks County Children and Youth Services submitted the data collection tool in a timely manner. It was submitted on 9/26/2012.

**County Weaknesses:**

**Statutory and Regulatory Compliance Issues:**

The Act 33 Meeting was held 3 months after the near fatality.

There were no other statutory and regulatory issues which were not in compliance.