pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/03/2013
Date of Incident: 07/15/2017
Date of Report to ChildLine: 07/16/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Berks County Children and Youth

REPORT FINALIZED ON:
1/2/2018

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Berks County Children and Youth Services/Southeast Regional Office has not convened a review team in accordance with the Child Protective Services Law related to this report. The report was unfounded within 30 days.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Subject Child	09/03/2013
	Maternal Half Sibling	04/12/2006
	Adoptive Sibling	02/11/2005
	Adoptive Sibling	08/17/2011
	Adoptive Sibling	08/03/2014
	Foster Sibling	08/15/2016
	Adoptive Mother	04/28/1986
	Adoptive Father	09/23/1989

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) investigated the near fatality and the Child Protective Services (CPS) investigation as this is a subsidized adoption and foster care home. The Southeast Regional Office reviewed the medical reports of the near fatality. In addition the SERO obtained and reviewed the foster care records provided by foster care agency. Interviews were conducted with county Children and Youth workers that included the adoption worker and the foster care worker, hospital staff that included medical staff and social work staff. SERO interviewed all of the children in the home. The alleged perpetrators that included the adoptive mother and father were interviewed. SERO also collaborated with local law enforcement.

Children and Youth Involvement prior to Incident:

There was no children and youth involvement prior to the incident. The child was adopted by the family during early infancy.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 07/16/2017, the Southeast Regional Office received a CPS report alleging that the subject child was taken to the hospital in response to ingesting [redacted]

medication. The child along with his two-year-old adoptive sibling were transported to the hospital via ambulance. [redacted] The child was certified as a near fatality. The certifying physician stated that the child was expected to survive.

On 07/15/2017, the subject child and his two-year-old adoptive sibling climbed up on a kitchen chair and on top of the stove and got into the cabinet where [redacted] medication was stored. The children were able to open the cabinet and the medication pill box. The subject child ingested the medication. The adoptive sibling did not ingest any of the medication; he was transported to the hospital, medically evaluated [redacted] The incident occurred while adoptive mother was in the bathroom. The adoptive father was outside mowing the lawn and the three older children were outside with him. At the time of the incident the child, the two-year-old adoptive and the one-year-old foster sibling were in the home with the adoptive mother. It was determined that the child had ingested [redacted] medications. The medications that the child ingested were [redacted]

The investigation determined that adoptive mother prepares [redacted] medication for the week every Saturday morning [redacted] The medications are placed in a pill box and are housed in a kitchen cabinet over the stove. She reported that while in the bathroom she did hear the boys moving the kitchen chairs around. However, she was not concerned as they move the chairs around playing with them as if the chairs are cars. She had placed the one-year-old foster sibling in a high chair while she was in the bathroom. When she returned from the bathroom, she found the two boys standing on top of the stove and the child had the pill organizer in his hands. She tried to have the children throw up. The child was not able to throw up but the two-year-old adoptive sibling did throw up. She then noticed that the child was becoming lethargic. She screamed and called for her husband. The husband came into the house and found the child lethargic and called 911. Both the child and the two-year-old adoptive sibling were transported to the hospital.

The adoptive mother denied that she had left the medication out on a table or accessible to the children and she denied reporting that she left the medication out on the table. She informed that after she had given [redacted] medication she returned the medication to the cabinet where the medication is housed in a safety packet/pill organizer. She stated that she closed and latched the cabinet as she always does. [redacted]

On 07/16/2017, the one-year-old foster sibling was medically cleared [redacted] It was determined that he did not ingest any of the medication.

On 07/16/2017, At the request of Berks County, the foster care agency working with the foster sibling removed the child from the home in response to the incident.

On 07/17/2017, the SERO program representative conducted a safety inspection of the home. The program representative informed the adoptive mother that the medication should not be kept in the cabinet over the stove. The adoptive mother stated that she will keep the medication in a locked room and in a locked box within that room.

On 07/18/2017, the program representative returned to the home and completed a safety check. The medication was housed in a locked room adjacent the kitchen. The medication will be housed in the locked room in a locked box [redacted]

On 07/18/2017, Berks County Children and Youth notified the foster care agency that the one-year-old foster sibling could be returned to the home and he was returned to the family.

[redacted]

On 07/19/2017, Berks County Children and Youth completed a general protective services assessment for the child [redacted] and returned to the home. It was determined there were no safety threats and no child abuse or neglect were found.

On 07/19/2017, the child [redacted] and returned to his home.

On 08/09/2017, The SERO determined the investigation unfounded.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:
There was no Act 33

- Strengths in compliance with statutes, regulations and services to children and families;
- Deficiencies in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and There were no recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. There were no recommendations.

Department Review of County Internal Report:

- This was a regional investigation.

Department of Human Services Findings: This was a SERO investigation

- County Strengths:
- County Weaknesses:
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

Department of Human Services Recommendations:

- The Department recommends public service announcements regarding safety storage of medications.

- The Department recommends that proper medicine storage procedures be reviewed with resource families during annual re-evaluation.