pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: [redacted]
Date of Incident: 12/6/13
Date of Oral Report: 12/6/13

FAMILY WAS KNOWN TO:

Lehigh County Children and Youth

REPORT FINALIZED ON: 5/20/14

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 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. As part of Act 33 of 2008, DPW 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 has not convened a review team because on 1/3/14 they filed the Unfounded CY48 with ChildLine; therefore a review team was not required in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]/88
	Sibling	[redacted]/03
	Sibling	[redacted]/07
	Child	4/01/09
	Maternal Grandmother	[redacted]/69
	Mother's paramour	[redacted]/78

Notification of Child Near Fatality:

On December 6, 2013 Lehigh County Children and Youth Services (LCCYS) received a referral regarding [redacted], who was 4 ½ years old at the time. According to the referral, on December 6, 2013 the natural mother, [redacted] called 911 and an emergency medical team went to the home. When they arrived the child was minimally responsive. Child would only wake to painful stimuli. The emergency medical team gave child [redacted] in route to [redacted]. [redacted] is given to reverse the effects of an [redacted]. Child was given [redacted] because the emergency medical team determined child's clinical state was consistent for possible [redacted] ingestion. Child was responding to the [redacted] Child was admitted to the [redacted]. Child was listed in serious condition but expected to survive.

Summary of DPW Child Near Fatality Review Activities:

The Northeast Region Office of Children (NERO), Youth and Families obtained and reviewed all of the current and past case record pertaining to the [redacted] family. All

medical information from [redacted] was obtained and reviewed.

Children and Youth Involvement prior to Incident:
The family had been referred to Lehigh County Children and Youth three times prior to this incident. The first referral was 11/21/06; the case was then closed on 12/13/06. The second referral was 9/16/11; the case was closed on 10/4/11 and the third referral was 8/7/12; the case was closed on 9/4/12. The issues that were addressed during the past referrals are as follows; [redacted], housing issues, parent skill and inappropriate child discipline and inappropriate boundaries. All of these referrals were closed after the intake assessment. No other services were provided to the family. There are three additional involvements involving [redacted] however she was a child during those periods of Lehigh County Children and Youth involvement.

Circumstances of Child Near Fatality and Related Case Activity:

[redacted] reported that on 12/5/13 the child came to her room and stated she did not feel well. The child vomited and passed out. [redacted] took child to the bathroom to get cleaned up and child vomited and passed out again. Child then went back to bed. On 12/6/13 child was not able to be aroused and [redacted] called 911 and an emergency medical team arrived at the home. Child was minimally responsive and would only awake to painful stimuli. According to the emergency medical team the family is well known. They had multiple contacts at the home due to [redacted] by [redacted]. The emergency medical team gave the child [redacted] to reverse the effects of [redacted] and child's condition improved. The emergency medical team determined child's state was consistent with having an [redacted]. Child had multiple doses of [redacted]. Child's preliminary [redacted] Child was admitted to the [redacted] at Lehigh Valley Cedar Crest hospital. Child was listed in serious condition but expected to survive. Mother and grandmother deny there were any narcotics in the house and claim to not know how the child ingested the drugs. The child had [redacted] because there was a small bruise and scratch on the right side of her forehead. [redacted] The other two children, grandmother and mother had [redacted] completed and all were [redacted]. Mother's paramour agreed to a [redacted] but never submitted a urine sample.

All family members were interviewed. The child stated she had woken during the night and had gone into her grandmother's room and taken the pills from grandmother's bag, she indicated she thought they were candy. All of the other household members were sleeping at this time. No one knew child had taken the pills until she became sick. All of grandmother's medications are prescription medications [redacted] It was determined the child took grandmother's [redacted]

Current Case Status:

On 1/3/14 the case was determined to be unfounded. The agency provided General Protective Services until 3/24/14 at which time the case was closed. The family cooperated with random [redacted] No other services were provided to the family. Grandmother now had medications in a lock box in her closet.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

*Strengths:

CPS responded to the report immediately and appropriately.
All parties involved were interviewed.
Child's medical records were obtained and reviewed.
No regulatory deficiencies were identified.

*Deficiencies:

No deficiencies were noted

*Recommendations for Change at the Local Level:

No recommendations identified.

*Recommendation for Change at the State Level:

No recommendations identified.

Department Review of County Internal Report:

An internal review by the county was not required in this case because the determination was unfounded and the CY 48 was submitted to ChildLine within 30 days. Report was received on 12/6/13 and CY 48 completed and submitted on 1/3/14.

Department of Public Welfare Findings:

*County Strengths:

Lehigh County Children and Youth responded immediately to the CPS referral, and conducted a thorough investigation.
Lehigh County Children and Youth obtained medical records of all 3 children in the home.
The agency was responsive to NERO's requests for Child Death Data Collection tool and contents of the file.

*County Weaknesses:

No deficiencies were noted.

*Statutory and Regulatory Areas of Non-Compliance:

There were no areas of non-compliance.

Department of Public Welfare Recommendations:

The NERO concurs with LCCYS, in that the outcome of the investigation is unfounded.