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**OFFICE OF CHILDREN, YOUTH AND FAMILIES  
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**REPORT ON THE NEAR FATALITY OF**



**BORN: June 23, 2008**  
**DATE OF NEAR FATALITY: June 4, 2010**

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

**DATED: October 20, 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 by Governor Rendell 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 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.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	06/23/2008
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father of [REDACTED]	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Maternal grandmother	[REDACTED]
[REDACTED]	Maternal aunt	[REDACTED]
[REDACTED]	Father of [REDACTED] (non household member)	[REDACTED]
[REDACTED]	Father of [REDACTED] (no contact with family)	[REDACTED]

**Notification of Near Fatality:**

The report was received and [REDACTED] by [REDACTED] on June 4, 2010. The report stated that the child had been in a severely altered mental state. [REDACTED]

[REDACTED] The child was reported to be completely healthy and not on any prescribed drugs prior to this incident. The child was [REDACTED] certified to be in critical condition. The child was expected to survive [REDACTED]. There was reported to be a number of prescription medications in the home. The maternal grandmother was reported [REDACTED]

[REDACTED] The case was [REDACTED]. The incident was reported to have occurred 1 to 3 days prior to the report. The [REDACTED] was listed as unknown as it was not determined as to how the child got the medication or to whom the medication belonged.

**Documents Reviewed and Individuals Interviewed:**

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the [REDACTED] case file and met with the caseworker, supervisor, and Program manager to discuss the case. The Program Representative also attended the agency internal review. The [REDACTED] case file was also reviewed.

### Case Chronology:

06/04/2010 Near death of child.

06/04/2010 CY 104 (referral to law enforcement) was completed and sent to the District Attorney's office.

06/04/2010 Maternal grandmother and mother interviewed by law enforcement. All medications in the home obtained by law enforcement and reviewed by medical personnel.

06/05/2010 Preliminary safety assessment completed by on call caseworker as case came in over the weekend. Children deemed safe with a comprehensive safety plan. The safety plan stated that the maternal grandmother would not allow anyone to have unsupervised contact with the children and that the maternal grandmother would supervise contact between the mother and the child at the hospital.

06/07/2010 The mother, maternal grandmother, and the father of the child all [REDACTED].

06/07/2010 Child discharged with above safety plan in place by the agency.

06/10/2010 Safety assessment completed by the [REDACTED] Caseworker based on new circumstances as the medication belonged to the maternal grandmother and she was the initial supervisor of contact between the mother and her children.

06/10/2010 Revised safety plan formulated stating that the maternal aunt was to supervise contact between the children and their mother and the maternal grandmother. Children resided with the maternal aunt at this time.

06/11/2010 Medical records were requested by the [REDACTED] caseworker.

06/15/2010 Medical records received by Lehigh County Children and Youth Services

06/17/2010 Mother and maternal grandmother administered and passed polygraph.

06/21/2010 Safety plan was lifted by Lehigh County Children and Youth [REDACTED] [REDACTED] caseworker and the mother was advised that she no longer needed to have supervised contact with her children.

07/01/2010 Safety assessment completed at the conclusion of the [REDACTED] [REDACTED]. Children were deemed safe.

07/10/2010 Risk assessment completed at the conclusion of the [REDACTED] [REDACTED] with an overall severity of low and an overall risk rating of moderate. The case remained active as it was already assigned to a [REDACTED] [REDACTED] caseworker.

07/27/2010 [REDACTED]

### Previous Children and Youth Involvement:

Lehigh County Children and Youth Services received a [REDACTED] report on May 10, 2010. [REDACTED] referral [REDACTED] looking for [REDACTED] [REDACTED] because she was going to be evicted in several days. The family had lived in the same apartment for a few years but they had got behind on their rent. The case was accepted for services by the agency due to housing issues and the county's need to provide supportive services. The county completed a family service plan to address

the housing issues and to link the family to community resources. The caseworker conducted safety assessments at the required intervals and the children were deemed to be safe. There had also been a previous report received by Lehigh County Children and Youth Services regarding housing issues in May of 2009. The agency followed up on this referral and found that the family was residing in a house that was smaller than their actual needs but the family could not afford anything larger and more adequate at the time. The family did have beds for all the children. The agency provided the family with an [REDACTED] so that they could get on a list for more suitable housing. The caseworker did send a letter of recommendation to the Lehigh County [REDACTED] so that the family would be considered for [REDACTED]. The agency then closed the case [REDACTED].

### **Circumstances of the Child's Near Fatality:**

The mother and the maternal grandmother brought the child to the emergency room of the hospital on June 4, 2010. They reported to the hospital that since that morning, the child appeared to be in a severely altered state. He was reported to have been healthy and not on any prescribed drugs. The child was admitted to the [REDACTED] unit. A [REDACTED] was completed and the [REDACTED]. The child was certified by the physician to be in critical condition [REDACTED]. The child was expected to survive. Medical personnel reported that [REDACTED].

[REDACTED]. The maternal grandmother and mother were interviewed by law enforcement. All medications that were in the household were obtained by law enforcement and reviewed by medical personnel. The mother and the grandmother had been the child's caretakers for the past 24 hours. The child had been ill with upper respiratory symptoms and had a fever so the mother reported that she had administered ibuprofen to the child. Shortly thereafter, the child was brought to the emergency room. The grandmother [REDACTED]. She had also reported that she had found a bottle of Adderall behind the television in her room. The grandmother was residing in a local hotel where the family had stayed with her. The mother and the children had been staying previously with the maternal aunt of the children but due to a conflict, they moved in with the grandmother at the hotel where she resided. The family provided a history that the child likes to place objects in his mouth and has ingested such items as coins and cat food in the past. Blood testing that was conducted revealed that the child was positive only for barbiturates. The child was [REDACTED].

### **Current / Most Recent Status of Case:**

The case remains open in a [REDACTED] unit as the case had been active prior to the near death of the child. The agency was providing supportive

services to assist the family with housing issues. [REDACTED]

[REDACTED] The child's condition was determined to have occurred accidentally. Law enforcement also concluded their investigation without any criminal charges as it was also believed that the incident was accidental in nature.

### **Statutory and Regulatory Compliance:**

Safety assessments were completed at the appropriate intervals. The CY 104(referral form for law enforcement) was completed by the agency. The agency and law enforcement worked collaboratively on this case. As the case had already been active with a [REDACTED] caseworker, the [REDACTED] caseworker and the ongoing caseworker worked together regarding the completion of the risk assessment.

### **Findings:**

The family is still active in the [REDACTED] unit. The child is reported to be doing well and has been [REDACTED] for an [REDACTED]. His brother is already involved with this service [REDACTED]. His sister is developmentally on target. The family is currently residing with the victim child's sister's father as he has obtained stable housing that is able to accommodate the entire family including the maternal grandmother. The family had obtained a lock box to store all their medications as soon as the incident had occurred and has been following through with this process. Although it is still unknown how the child ingested the medication, it was determined that no one intentionally gave the child the medication nor did anyone possess the knowledge on how he obtained the medication. The child has made a full recovery from the incident and has displayed no residual problems.

### **NERO Recommendations:**

A recommendation made to Lehigh County Children and Youth Services by the Northeast Regional Office Program Representative occurred during the initial stages of the case when the initial safety plan was formulated. The maternal grandmother was to supervise the contact between the mother and the children, however, it was discovered that the medication that the child had ingested belonged to the maternal grandmother. Thus, the agency changed the safety plan to have the maternal aunt supervise contact between the maternal grandmother, the mother, and the children until the completion of the investigation.

### **County Strengths and Deficiencies as identified by the County's Internal Review:**

At the internal review conference of July 21, 2010, the issue of medication and storage was discussed. The assigned worker stated that she did not see any medications

readily accessible during home visits. Team members recommended that storage of any medications should be reviewed with families and documentation should be noted in the case record. Some of the private providers that were in attendance at the meeting discussed that they utilize an extensive home safety list that is completed at an initial home visit with a family. The local health department representative offered that they are available to complete home safety assessments of city residences that review many safety factors with families including storage of medications.

The agency also reviewed the initial safety plan that was formulated placing the grandmother in the role of supervisor of the mother's contact with the children. The grandmother had been a caretaker of the child during the hours preceding the child's hospitalization. The on call worker made the safety plan based on the police detective's opinion that the grandmother would be an appropriate caretaker. While that may have been the detective's impression, the criminal and [REDACTED] still had the grandmother [REDACTED]. Thus, the agency needs to take that into consideration that when using household members as a supervisor of contact with the children, the need to make sure that the household member is not directly involved in the incident.