



Jacquelyn Maddon
4376 Regional Director
963-3453

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-
Fax (570)

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE NEAR FATALITY OF



BORN: [REDACTED] 2010

DATE OF NEAR FATALITY: 05/26/2011

FAMILY WAS NOT KNOWN TO LEHIGH COUNTY CHILDREN AND YOUTH SERVICES

DATE 07/05/2011

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 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] 1983
[REDACTED]	father	[REDACTED] 1983
[REDACTED]	brother	[REDACTED] 2008
[REDACTED]	victim child	[REDACTED] 2010
[REDACTED]	maternal grandfather	[REDACTED] 1951
[REDACTED]	maternal grandmother	[REDACTED] 1963

Notification of the Near Fatality:

On 05/27/2011, [REDACTED], PA, made a referral to Child Line regarding [REDACTED]. The Victim Child's (VC) maternal grandparents brought the VC to the [REDACTED]. The [REDACTED] transferred the VC to [REDACTED]. Upon transfer, the VC was admitted to [REDACTED]. The child was [REDACTED]. The child had [REDACTED]. As a result, the Lehigh County Children and Youth Services (LCCYS) was assigned an investigation for lack of supervision resulting in a physical condition.

2. Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the Child Protective Services case file and communicated with the supervisor to obtain documentation pertaining to the case.

Case Chronology:

05/26/2011 the maternal grandparents (MGP) were babysitting the VC and his older brother at their home. While at the maternal grandparents, the VC drank charcoal lighter fluid from a cup that the maternal grandfather (MGF) had sitting out. MGF had screws soaking in the cup of charcoal lighter fluid. According to MGP's there was only enough fluid in the cup to cover the screws. The VC had been sitting on the lap of the maternal grandmother (MGM). The MGF placed the cup on the ground behind a tree. The VC got off the MGM's lap and ran over to the tree. The MGM reports that she ran after the VC but did not get to him in time to prevent him from ingesting some of the lighter fluid in the cup. The VC was lethargic and vomiting. The MGPs took the VC to [REDACTED]. The VC was then transported to [REDACTED].

05/27/2011 [REDACTED] contacted Childline to report a lack of supervision resulting in a physical condition. As a result, LCCYS was given the Childline number for investigation. Case registered as a near fatality with the MGPs listed as alleged perpetrators. A LCCYS caseworker (CW) traveled to [REDACTED] and met the VC's family and reporting source. The CW reported the family was cooperative and emotionally distraught as a result of the incident. [REDACTED]

[REDACTED] The CW also completed the CY-104 referral to law enforcement on this date. The CW saw the VC and his sibling. A safety assessment (preliminary) was completed. Both children were determined to be safe.

05/29/2011 VC discharged from the hospital.

06/13/2011 The CW conducted a home visit. The VC and his sibling were seen. The family cooperated with the investigation and demonstrated cognitive and physical abilities to care for the children. A safety assessment (conclusion of investigation) was completed, Both children were determined to be safe.

06/22/2011 A case conference was held at the child advocacy center and the CY-48 was completed for the lack of supervision resulting in a physical condition allegation. The report was assigned an unfounded status.

Previous CY involvement:

The family was not known to the LCCYS.

Circumstances of Child's Near Fatality:

On 05/26/2011 the maternal grandparents were babysitting the VC and his older brother at their home. While at the maternal grandparents (MGP) home, VC drank charcoal lighter fluid from a cup that the maternal grandfather (MGF) had sitting out. MGF had screws soaking in the cup of charcoal lighter fluid. According to MGP's there was only enough fluid in the cup to cover the screws. The VC had been sitting on the lap of the maternal grandmother (MGM). The MGF placed the cup on the ground behind a tree. The VC got off the MGM's lap and ran over to the tree. The MGM reports that she ran after the VC but did not get to him in time to prevent him from ingesting some of the lighter fluid in the cup. The VC began to vomit. The MGPs took the VC to [REDACTED]. The VC was then transported to [REDACTED]. The VC was admitted to the [REDACTED] and [REDACTED]. The doctor reported that VC was in critical condition due to being in [REDACTED] and having to be [REDACTED]. There does not appear to be any permanent damage to the VC.

Current / most recent status of case:

- The case was unfounded.
- LCCYS determined ongoing/community services were not needed.

Services to children and families:

The family was not in need of ongoing/community services

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

A child fatality team meeting was not held because the case was unfounded within 30 days. However, a case conference was held and the case was reviewed by members of the multidisciplinary team. As a result of the review, there were no recommendations for change.

Statutory and Regulatory Compliance issues:

As a result of the DPW review of the circumstances surrounding the VCs near fatality incident including the CPS case file, it was determined that the LCCYS conducted safety assessments and risk assessments accurately, the investigation was conducted in a timely manner, law enforcement was notified through the submission of a CY104. At the time of the near fatality the family was not receiving any services from LCCYS.

Findings:

The family/children were not known to the agency. The agency's investigation was completed in a timely and efficient manner.

Recommendations:

None