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## REPORT ON THE FATALITY OF

**Jose Alvarado III**

**BORN: 06/15/2001**

**DATE OF FATALITY: 01/08/2010**

**FAMILY NOT KNOWN TO:**  
Lehigh County Children and Youth Services

**Report Dated June 23, 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 31, 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>
Jose Alvarado III	Victim Child	06/15/2001
[REDACTED]	Mother [REDACTED]	[REDACTED] 1984
[REDACTED]	Father [REDACTED]	[REDACTED] 1984
[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Father of [REDACTED]	[REDACTED] 1978
[REDACTED]	Maternal Grandmother	[REDACTED] 1963

**Notification of Fatality:**

Lehigh County [REDACTED] caseworker called ChildLine to obtain a [REDACTED] once their agency received information regarding the death of the victim child from [REDACTED]. The incident occurred on January 8, 2010 and the report was made that same day. According to the [REDACTED], the child shot himself in the neck and is deceased. The child was reported to have the father's gun. The report initially stated that there were two guns in the home that were kept out all the time and that the two siblings witnessed the incident, while the parents were sleeping. The Northeast Regional Office of Children, Youth and Families received the notification on January 8, 2010.

**Documents Reviewed and Individuals Interviewed:**

The Northeast Regional Office of Children, Youth and Families reviewed the Lehigh County [REDACTED] case record. The Northeast Regional Office Program Representative met with the Lehigh County [REDACTED] manager, supervisor, and caseworker to obtain information regarding the investigation of the child's death.

**Case Chronology:**

01/08/2010 Death of Child

01/08/2010 CY 104 referral sent to law enforcement by Lehigh County Children and Youth Services

01/08/2010 Caseworker had direct contact with family and siblings. Interviews conducted by caseworker and law enforcement with the family.

01/08/2010 Preliminary Safety Assessment completed by Lehigh County Children and Youth Services. Children were deemed safe with a comprehensive plan. Maternal grandmother was to be the sole caretaker of the children and the children were to reside with her. Maternal grandmother would supervise contact between the children and their mother and father [REDACTED]. Safety plan was signed by the mother and the maternal grandmother.

02/04/2010 Risk Assessment completed by Lehigh County Children and Youth Services with a severity of high and a risk assigned of low.

02/04/2010 Safety Assessment completed at the conclusion of the [REDACTED] investigation. The children were deemed safe and the safety plan was lifted. However, the family continued to remain with the maternal grandmother due to their grief and not wanting to reside in the household where the incident occurred.

02/08/2010 [REDACTED] completed by Lehigh County Children and Youth Services with an [REDACTED].

02/27/2010 Medical records received by Lehigh County Children and Youth Services from Lehigh Valley Hospital.

03/10/ 2010 Father arrested and charged with involuntary manslaughter regarding the death of his son.

**Previous Children and Youth Involvement:**

The family did not have any prior agency involvement. [REDACTED] was reported to be involved with [REDACTED]. The mother reported that she was also involved in [REDACTED] prior to the death of her son and will continue to [REDACTED].

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

On January 8, 2010, Allentown Police Department responded to the family's residence due to Jose III (06/15/2001) accidentally shooting himself. He died shortly after the incident from the gunshot wound. On the day of the incident, the family got up to get the children ready for school. It was snowing so the mother and father told the children to go back to bed as they were not going to school that day. The mother went to sleep in her room with the youngest child and the father went downstairs to the couch to go back to sleep. The two other children (Jose and [REDACTED]) went into their room. Approximately twenty minutes later, the mother and father said that they heard a loud noise. The father went upstairs and found Jose in the bathroom. The child had the gun and shot himself. The parents reported that there is one gun in the house and it is

registered to the mother and that she has a permit to carry the 9 MM Taurus. The mother stated that she keeps the gun at the top of the walk in closet. She said that she only takes the gun out of the closet when the children's father is not in the home (as he does not reside in the household) as she is home alone with the children. She stated that she has two clips for the gun and that she puts the gun under her mattress when she sleeps and has the clip with her but not in the gun. The mother reported that she got the gun as their house was broken into in the past and she got scared. The father stated that the night before the incident, he took the gun out of the closet and put the gun in his backpack that he uses for school (as he is attending community college) and for the gym. He said that he put the clip in the gun and had the backpack between the dresser and the bed. He stated that the mother was not aware of what he did with the gun. The father said that when he went downstairs he saw that the gun and the backpack were still next to the bed. The mother reported that Jose got in trouble the night before the incident and she took his play station and hid it in another backpack that was in the bedroom. She said that the bag was similar to the bag that the father put the gun in. She said that the child would put his playstation in a book bag to transport the game system to friends and family member's homes. All the book bags were reported to be black in color. The mother said that when she told the children to go back to bed, she had fallen back to sleep and did not hear when Jose came into the room. The mother and the father did not witness the incident but believe that the child took the bag thinking that it was his play station game system and when he saw the gun he played with it. The child's death was ruled accidental and was a self inflicted gunshot wound. There was conflicting information as to if Jose's brother witnessed the incident. Law enforcement and Lehigh County Children and Youth Services felt that from their interviews that the child had not witnessed the incident as he appeared to be asleep when law enforcement arrived on the scene. A safety plan had been developed during the course of the investigation. The maternal grandmother, [REDACTED] was to be the sole caretaker of both children and was to supervise contact between [REDACTED].

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

The case was [REDACTED] by Lehigh County Children and Youth Services as they felt that the incident that occurred was an accident. The agency deliberated over the determination and all parties involved met with the agency director and the management team. The [REDACTED] was completed on February 8, 2010. Law enforcement was investigating the incident and did not give the impression that they would be pressing charges. Upon law enforcement meeting with the District Attorney regarding the case, an arrest was made on March 10, 2010. [REDACTED] was arrested and charged with involuntary manslaughter regarding the death of his son. The agency assessed the family and the need for in home services. However, the family members became involved in [REDACTED] and felt that their needs were being met with this service. They stated that they would not have a gun in their household. The family continues to reside with the maternal grandmother as they felt that they were too grief stricken to return to the site of the incident. The maternal grandmother is a support for the family. The children were deemed safe by the agency and the case was closed.

## **Statutory and Regulatory Compliance**

Safety Assessments were conducted by Lehigh County Children and Youth Services at the appropriate intervals. A safety plan had been put into place where the maternal grandmother was to be the sole caretaker of the children and the children were to reside with her. The maternal grandmother was to supervise contact between the children and their mother, [REDACTED], and with [REDACTED], the father of [REDACTED]. The CY 104 was sent to law enforcement.

## **Findings:**

Lehigh County Children and Youth Services [REDACTED] the [REDACTED] [REDACTED]. All interviews were conducted with all parties involved. Law enforcement chose to arrest the father for involuntary manslaughter charges after the county had [REDACTED] the case. However, the county felt comfortable with their [REDACTED] [REDACTED]. The county did not conduct an internal review as they had no prior involvement with the family and the case was [REDACTED] at the thirty day mark.

## **Recommendations:**

The Northeast Regional Office of Children, Youth and Families has recommended that if new information regarding the case becomes available to the agency, then, the agency should call ChildLine for a [REDACTED]. This recommendation is made as there had been some conflicting information received surrounding the backpacks that were in the bedroom. There was information that law enforcement had initially believed that the gun was in the same backpack as the play station game and then this was not believed to be the case. It is also recommended that the agency continue to review their safety plans as all parties involved in the plan need to sign the plan. The mother and the maternal grandmother signed the plan. Also, the plan needs to clearly define how the plan will be monitored and who will be responsible for monitoring the plan. In this case, the mother and the maternal grandmother are the responsible parties but it was not clear as to how the information would be conveyed to the agency if the plan was not being followed.