pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/09/2014
Date of Incident: 10/25/16
Date of Report to ChildLine: 10/28/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Luzerne County Children and Youth Services

REPORT FINALIZED ON:
05/12/2017

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.

Luzerne County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/02/2016. However, it should be noted that Luzerne County was not required to convene a review team or prepare a report as the investigation was unfounded prior to 30 days. The county was unaware of this and organized the meeting, but did not provide a report capturing the meeting which was held.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/09/2014
	Biological Mother/ [redacted]	[redacted]1989
[redacted]	Biological Father	[redacted]1980
	Biological Sibling (Twin)	[redacted]2014
	Maternal Cousin/HHM	[redacted]2007
	Maternal Cousin/HHM	[redacted]1977

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the current Child Protective Services (CPS) referral file.

NERO staff participated in Act 33 Near Fatality meeting on 12/02/2016.

Summary of circumstances prior to Incident:

The family did not have history with Luzerne County Children and Youth Services (LCCYS), nor were any other service providers identified as providing services.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/28/2016, the report was made to ChildLine. Referral source was [redacted] made the report to ChildLine due to the concerns of the delay in medical attention for the victim child after the injury was sustained and the inconsistent story that mother provided to the two hospitals. CY47 documented that [redacted] stated the child was in serious condition due to the neglect of medical care. Child Protective Services (CPS) referral identified the biological mother as the alleged perpetrator for causing bodily injury to child through recent act/failure to act. Resulting injury was listed as an [redacted]

On 10/28/2016, the 2-year-old victim child presented with his biological mother to Lehigh Valley Hospital-Hazleton Emergency Department. Lehigh Valley Hospital-Hazleton reported that the mother stated that the victim child had fallen down four steps in the home with an approximate timeline of four days ago. The biological mother reported to Lehigh Valley Hospital-Hazleton that the child began vomiting about 5-6 hours after the fall. The mother also reported the child had diarrhea, but was not concerned as his twin brother did also. Mother assumed both children were ill. The child was transferred to Lehigh Valley Hospital–Allentown due to his injury [redacted]

On 10/28/2016 at Lehigh Valley Hospital-Allentown the victim child [redacted] The mother informed the staff at this hospital a different story about the child's symptoms. [redacted] the mother reported the victim child did fall down about four steps. This occurred as the victim child and his twin brother were playing at the top of the stairs. The mother reported [redacted] that the child was not vomiting after the fall but has had a continuous nose bleed for four days. [redacted] reported she questioned mother as to why had she decided to bring victim child to the hospital on that evening after several days had passed. Mother reported that she became concerned because while the victim child was asleep he continued to have a nose bleed. The mother was present in the home with the victim child and the twin sibling when the incident occurred. The victim child's 9-year-old cousin was also present in the home as he was watching television when the incident occurred.

[redacted]

On 10/28/2016, Luzerne County Children and Youth Services received the report at 11:48 PM. The supervisor on call made the response time of the referral 24 hours. Caseworker responded to the home and to the hospital on October 29, 2016.

[redacted]

[redacted] On 10/30/2016, the victim child [redacted] with his mother. The hospital staff relayed the possible language barrier as an issue regarding mother as her primary language is Spanish and the interpretation of what the mother reported may not have been accurate. This may have contributed to the discrepancy in the report of the victim child's symptoms to different staff. [redacted] reported child was alert, active and acting like a healthy toddler. No additional concerns were reported regarding mother's care of the victim child.

As a result of various interviews the county agency learned that the family had relocated to the [redacted] area approximately one month prior to the incident from [redacted], Pennsylvania [redacted] Mother did not have a pediatrician for the children at the time of the incident. The victim child was [redacted] until August 2016 when the family moved. Victim child was recommended for a follow-up appointment [redacted] There are 2 other children that continue to reside in the home; this includes his twin brother and maternal cousin. Luzerne County Children and Youth Services (LCCYS) did not identify safety threats regarding the children that remain in the home.

On 10/31/2016, LCCYS spoke to [redacted] the certifying physician on this case. The physician identified there was no medical evidence to support the child's condition worsened due to the delay in medical attention. The victim child did have an underlying medical condition [redacted] Further discussions between LCCYS and the physician revealed that the doctor did not feel that the injury was the result of abuse or neglect. Based on this conversation, LCCYS contacted the Department requesting the report be decertified as a Near Fatality.

LCCYS provided a letter from the physician stating that the child presented in serious / critical condition [redacted] but that the injury was not classified as 'near fatal'. Physician also noted in the letter that she did not feel the injury was the result of child abuse but that the family would benefit from resources and teaching. The Department's review of the information provided at the time of the initial report including the child's condition and the allegations reported determined that the case was appropriately classified as a Near Fatality and that the subsequent information being reported would be information used to reach status determination.

On 11/22/2016, LCCYS Unfounded the CPS referral.

On 12/02/2016, an ACT 33 meeting was convened at the agency.

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

The case was unfounded in less than 30 days and although the county convened a review team meeting, there was no county report; thus, no further information to report.

Department Review of County Internal Report:

N/A

Department of Human Services Findings:

- County Strengths: LCCYS completed a thorough investigation of the report. The agency gathered information from medical professionals. The agency utilized translation services to interview biological mother [redacted] and other household members as the family's primary language is Spanish. The county agency followed up with Lebanon County regarding the family and invited them to participate in the ACT 33 discussion. The agency provided the family with safety gates for the stairway. LCCYS provided [redacted] in the area to the family. The family continued to receive [redacted] services and discussed linkage to community resources during the investigation.

  The Department recommended at the time of the review that the family be connected to additional services since they are new to the area. [redacted] The program is available in every county in PA. This would help with the victim child [redacted] may be able to assist in this connection. It is also recommended that the family be connected with other community resources such [redacted] or a program activity like [redacted]

- County Weaknesses: The family primarily speaks Spanish. The language barrier was discussed in the ACT 33 meeting as contributing to the discrepancy in the stories that [redacted] Mother provided. The agency would better serve the family by providing [redacted] correspondence to the family in Spanish. LCCYS was also not familiar with the Implementation of Child Fatality and Near Fatality Review and Report Protocols as required by ACT33 of 2008 and ACT44 of 2014 Bulletin as they were not aware the ACT 33 meeting was not needed when a case is unfounded in less than 30 days.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. No areas of non-compliance.

Department of Human Services Recommendations:

It is recommended that the hospital obtain an interpreter for families much earlier in the process to complete thorough interviews in order to obtain more accurate information. The phone interpreter was used; however information may have been misinterpreted during the translation process.

This case identifies need to continued education related to Near Fatality definition and applicability and continued review of the decertification process. It is recommended that the Department engage organizations such as American Academy of Pediatrics as well as hospital organizations regarding the Near Fatality classification and decertification process. It is also recommended that this process be reviewed with county agencies that have the direct conversations with the physicians. When a decertification request is submitted, it is recommended that the Department provide timely response to the county as to the decision as this impacts county ability to maintain compliance with Act 33 timeframes.

It is further recommended that the county agency schedules any ACT 33 meetings at the onset of the referral. Although in this case the meeting did not need to be convened, the agency was not aware of this at the time it was scheduled. The meeting was held outside of the 30 day time frame as required.
The Department should ensure that the category of abuse / neglect match the allegations made by the referral source in the initial referral at the time the report is being made. In this case, the RS made the report to ChildLine due to the concern for the delay in medical care and not that the mother caused the injury to the child. This report however was registered as a CPS, with the mother identified [redacted] for causing bodily injury to the child through recent act / failure to act, subcategory was causing, and resulting injury was [redacted] despite a description alleging such.

It is recommended that the agency review their internal policy regarding response times. Certain case circumstances such as this case should warrant an immediate response. It is important that the allegations in the report are considered and that an appropriate timeline should be assessed. It is also necessary when other children are listed on referral in order to properly assess safety.