pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/21/2015
Date of Incident: 8/5/2016
Date of Report to ChildLine: 8/5/2016
CWIS Referral ID: [redacted]

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

Northampton County Children, Youth and Families Division

REPORT FINALIZED ON:
1/19/17

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

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.

Northampton County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/23/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	11/21/2015
	Mother	[redacted]1992
	Father	[redacted]1991
	Paternal Grandfather	[redacted]1958
[redacted]*	Paternal Grandmother	[redacted]1963

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:

This Child's Near Fatality was first reviewed by Agency administration, on-call and intake staff to review the issues, determine if a safety plan was appropriate and recommend next steps of the investigation.

The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective Services (CPS) investigation. NERO staff participated in the Act 33 Near Fatality meeting on 08/23/2016. Law Enforcement Officer was also present at this meeting and provided information regarding their investigation.

Children and Youth Involvement prior to Incident:

There was no prior agency involvement with this child or family.

The family was residing in [redacted], Florida and did have a prior report in Florida at the time of birth, due to the child's [redacted] testing positive for marijuana. The mother was not positive for any drugs. The case was opened for a few weeks, the family had what was needed for the child, the home was deemed to be appropriate and the case was closed at the intake level.

Circumstances of Child Near Fatality and Related Case Activity:

On 08/05/2016 the victim child was brought by his mother, father, and paternal grandfather into St. Luke's Anderson Campus Emergency Department as it was reported the child fell off of the bed, was inconsolable and went limp. [redacted] The victim child presented with a small bruise on the forehead and back of the head, the child was listless and couldn't pick his head up, he was vomiting after feeding. [redacted] the victim child was certified to be in critical condition as a result of suspected child abuse. The victim child was given a good prognosis to survive. The victim child was transferred to Lehigh Valley Cedar Crest [redacted]

The victim child was admitted [redacted], and remained hospitalized from 08/05/2016 until 08/12/2016. [redacted]

On 08/05/2016, the Northampton County Children, Youth and Families Division (NCCYF) caseworker visited the parents and the maternal grandmother and her paramour at the hospital. The caseworker met individually with the family members. The parents reported they arrived in PA on Tuesday, 08/02/2016 for a family wedding and have been staying at the paternal grandfather's home for the week of the wedding events. The family reports spending time with the victim child the prior evening and he was a very busy eight month old. The child was pulling himself up and taking small steps. The family had a late family gathering at the paternal grandfather's home. The parents and the child went to sleep in the same bedroom; the child was in a pack and play at the foot of the bed.

The father reported the morning of the incident the victim child was sleeping in his pack and play. The father's brother woke the family up at around noon and also woke up the child. The father reported he took the victim child out of the pack and play and put him in bed in between him and the mother. The father reported the victim child played, pulling on the father's ear like he always does. The father's alarm rang at 12:30 and he got out of bed and opened the blinds. The father reports he went into the bathroom. He reported he heard the victim child hit the floor and start wailing. The father immediately came out of the bathroom and tried

to calm the child. The father reported the child's body went limp and his arms were out and stiff. He reported the child was not holding his head up. The father reported the child's breathing was "weird" and he had a whine that was not normal for him. The family was running out of the bedroom with the child as the paternal grandfather was returning to the home, so he immediately drove them to St. Luke's instead of waiting for an ambulance. The father reports they got to the Hospital in 6 minutes. The father reported there was no one else in the home. The mother told him she reached to get a diaper for the child and that's when he got to the edge of the bed and fell. He stated the mother told him she did not see the child fall.

The mother reports the morning of the incident they were all sleeping and the father's brother came into the room and woke them up, including the baby. The mother reported the uncle left the room and the father got the victim child out of the pack and play and put him on the bed. She stated the father then got up and went into the bathroom and shut the door. She reported the bathroom is connected to the bedroom. The mother reported she got up to get a diaper for the victim child and he fell off the bed onto his head. The mother reported she knew it was the child's head that hit because of how loud it was. The mother reported it sounded as if someone was punching the floor. She immediately crawled across the bed to get the child and he was lying on his back and crying. The mother reported she picked the child up and tried to calm him, the child went limp and they took him to the hospital. The mother reported the father immediately came out of the bathroom when he heard it.

The child [redacted] hospital on 08/12/2016. A safety plan was put into place and the victim child was staying with his paternal grandmother [redacted] When the police and the caseworker first questioned the family about the referral, and the extent of the injuries, it was learned there was a prior incident, when the child was four months old, he fell off of a bed and cried a little. No medical attention was sought at that time as the baby did not cry long and was functioning normally. When confronted about the injuries the child sustained during this incident the mother became defensive but denied any type of abuse. The father became tearful and stated "I think there is someone I need to talk to about this".

Prior to this incident the child was seen on 08/01/2016 for vaccinations, and was 20 pounds, 29 inches with no concerns by the primary care doctor in Florida. The parents, while in Florida, were residing with the maternal grandmother, aunts and uncles. Both parents were working in Florida and father was working to complete his bachelors program through a Disney work/study program. There is no history of [redacted], Drug/Alcohol or Domestic Violence with the parents. While the child was still in the hospital the parents flew back to Florida, packed up their belongings, and drove back to Pennsylvania. They moved into the paternal grandfather's home until they could find employment and their own residence.

NCCYF initiated services through [redacted] service to both help follow the child medically as well as to provide parenting skills to both young parents. [redacted]

[redacted] The family has been complaint with all services. The paternal family continues to provide support. The mother was encouraged [redacted] Mother was also encouraged to engage [redacted]

The case was reviewed with law enforcement, reviewed at a internal agency staffing, a Near Fatality Review Team meeting on 08/23/2016, and review by the Child Advocacy Center of Lehigh County. The meetings included a review of agency files, a review of medical files and a discussion related to the incident including medical overview and reports from law enforcement related to the status of the case.

The investigation outcome was submitted on 09/29/2016. The investigation yielded an "Indicated" status with a unknown perpetrator. [redacted]

Mother continues to deny any wrongdoing. Medical professionals differed on opinions as to whether the fall from the bed could be consistent with the injuries sustained. The mother and father submitted to Polygraph Examination on 09/02/2016 and both were found to be Non Deceptive.

The Law Enforcement investigation is pending.

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

- Strengths in compliance with statutes, regulations and services to children and families; NCCYF personnel and law enforcement have worked conjointly throughout the investigation. County utilized relative resources for the child.

- Deficiencies in compliance with statutes, regulations and services to children and families; None

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; No recommendations were made

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. The Act 33 report identifies the following. Public Service to continue to stress safe haven for unwanted new borns. Education to be provided surrounding shaken baby, furniture falling on kids and safe sleep. The team also recommended community education in regards to parents feeling comfortable to seek out help with parenting issues. The team would like to have information regarding supportive services such as the "Front Porch Project" available in all community organizations. The team recommended researching how to fund these projects through community organizations not associated with Children and Youth as parents will often work more collaboratively with agencies other than Children and Youth.

Department Review of County Internal Report:

The NERO received the Northampton County Child Near Fatality Team Report on 11/21/2016. The report content and findings are representative of what was discussed during the meeting on 08/23/2016. NERO notified the NCCYF director on 12/09/2016 of receipt and acceptance of the county report.

The NERO requested clarification of one issue which the county replied to by email on 12/09/2016. This issue included:

- The report indicated there was no criminal however a DA certification was received. The agency did clarify this issue. Law Enforcement had reported there would be no charges however had not yet cleared it with the District Attorney therefore the DA certification was requested.

Department of Human Services Findings:

- County Strengths:

DHS/OCYF/NERO has determined that Northampton County Children, Youth and Families Division commenced the CPS investigation of the victim child's case in a timely manner. The county has followed all established protocols for referral to law enforcement agencies and collaboration established by statute and DHS regulations. Record review by DHS/OCYF/NERO has validated that there has been extensive collaboration and information sharing on the part of medical personnel, law enforcement and county child welfare personnel regarding this case.

- County Weaknesses: none identified

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

- The notification letters provided to the alleged perpetrators did not provide the perpetrators with the specific type of abuse. The county will receive a citation.

Department of Human Services Recommendations:

The county should continue to complete timely CPS investigations and work collaboratively with law enforcement.

The Department concurs with the recommendations made by the Act 33 team and would recommend the following be included in relevant future reports:

- Community education to address safe haven for unwanted babies, shaken baby, furniture falling on children and safe sleep.
- Providing information to community organizations as to supportive programs such as the "Front Porch Project".
- Education for parents to help them to feel comfortable asking for help with parenting issues.
- Research as to how these projects could be funded through community agencies as opposed to Children and Youth agencies.