



## **REPORT ON THE NEAR FATALITY OF:**

██████████

**Date of Birth: 08/24/2016**  
**Date of Incident: 12/19/2016**  
**Date of Report to ChildLine: 12/20/2016**  
**CWIS Referral ID: ██████████**

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

Luzerne County Children and Youth

**REPORT FINALIZED ON:  
06/05/2017**

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.

Luzerne County did not convene a review team. The investigation was unfounded within 30 days; therefore, the county was not required to convene a review team.

**Family Constellation:**

<u>First and Last Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	08/24/2016
[REDACTED]	Biological Mother	[REDACTED] 1983
[REDACTED]	Biological Father	[REDACTED] 1984
[REDACTED]	Full Sibling	[REDACTED] 2014
** [REDACTED]	Maternal Grandmother	[REDACTED] 1951
** [REDACTED]	Maternal Grandfather	unknown
** [REDACTED]	Maternal Aunt	unknown

\*\* 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:**

The Northeast Regional Office of Children, Youth and Families (NERO) was unable to review the file upon conclusion of the investigation due to the record being damaged by fire and water after an incident that occurred at Luzerne County Children and Youth. However, all pertinent information is contained in this report as the family did not have any prior history with the agency. The county agency was not required to convene an Act 33 review team meeting due to the investigation being unfounded within 30 days.

**Children and Youth Involvement prior to Incident:**

The family did not have any prior history with Luzerne County Children and Youth prior to this incident.

### **Circumstances of Child Near Fatality and Related Case Activity:**

On 12/20/2016, Luzerne County Children and Youth received a referral [REDACTED] [REDACTED] alleging abuse of the victim child. The victim child was transferred from a local hospital to a pediatric specialty hospital [REDACTED]. The mother had reported that the victim child was in the care of the maternal grandmother at the time of the incident. According to the mother, the maternal grandmother told the mother that she had fallen asleep holding the victim child and she awoke to hearing the infant crying and on the floor. The distance to the floor was about 17 inches and the victim child allegedly fell onto a carpeted floor per the interview with the mother. The report was filed due to the explanation not being consistent with the injuries presented by the victim child. It was also reported that the grandmother did not call the mother when the injury occurred; she told the mother what had happened hours later when the mother arrived. The county reported that, upon receipt of the referral, safety of the victim child and his full sibling was assessed in the children's home with their mother and father and the children were determined to be safe in the care of their parents.

Also on 12/20/2016, within 2 hours of receipt of the first report, a supplemental report was received by Luzerne County Children and Youth. The referral source stated that the maternal grandmother was watching the victim child and, at approximately 4:30AM on 12/19/16, the child rolled off the couch and onto the floor. The victim child was taken to the local hospital at 5:00PM on 12/19/16. The victim child presented with swelling to the left side of his head but that was the only visible injury [REDACTED]. The referral source reported that it was unknown where the mother and father were but the incident was believed to have happened at the maternal grandmother's house. It was further reported that the victim child was born premature at 27 weeks but otherwise was born healthy. The mother and father brought the child to the local hospital and the victim child was transferred to a pediatric specialty hospital. Upon receipt of this supplemental report, the incident was certified as a Near Fatality.

On 12/21/2016, a second supplemental report was received by Luzerne County Children and Youth [REDACTED] regarding the incident. There were no new details as a result of this referral. At the time of the receipt of this report, the victim child had already [REDACTED] to his parents.

The mother, father, aunt, maternal grandfather and maternal grandmother participated in interviews. The maternal grandmother stated she fed the victim child around 3:00AM and was holding him on the couch when she must have fallen asleep. She awoke to the sound of the victim child crying. She picked him up and saw a bump on his head. For the rest of the day, she kept a cold compress on the bump. According to the maternal grandmother, the victim child did not show signs of a concussion; she checked his eyes, he didn't vomit and he had stopped crying after one minute of picking him up. Although the victim child did [REDACTED] [REDACTED] the incident was determined to be accidental. When the parents became aware of the bump, they took the victim child immediately for medical attention.

The local police department interviewed the maternal grandmother and she passed a voice stress analysis. No criminal charges are being pursued. Luzerne County Children and Youth unfounded the case on 01/06/2017 and the case was closed.

**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;

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Deficiencies in compliance with statutes, regulations and services to children and families;

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

**Department Review of County Internal Report:**

The case was unfounded in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

**Department of Human Services Findings:**

- County Strengths:

There were no strengths identified as a result of this review.

- County Weaknesses:

There were no weaknesses identified as a result of this review.

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

There were no Statutory or Regulatory areas of non-compliance identified as a result of this review.

**Department of Human Services Recommendations:**

There are no recommendations as a result of this review.