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**REPORT ON THE NEAR FATALITY OF:**



**DATE OF BIRTH: October 13, 2010**  
**DATE OF NEAR FATALITY INCIDENT: April 4, 2011**

**FAMILY KNOWN TO:**  
**Luzerne County Children, Youth and Families**

**REPORT FINALIZED ON: December 13, 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 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Luzerne County has not convened a review team in accordance with Act 33 of 2008 related to this report. The review has not been conducted due to the agency's difficulty in securing a chair person to lead the process. A review will be conducted once a chair person is identified.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	10/13/2010
[REDACTED]	Half-Sibling	[REDACTED] 2011
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	Father of [REDACTED]	unknown
[REDACTED]	Father of [REDACTED]	[REDACTED] 1985
[REDACTED]	Mother's paramour	[REDACTED]
[REDACTED]	MGF	[REDACTED] 1964
[REDACTED]	Maternal Step-Grandmother	[REDACTED] 1954
[REDACTED]	Child's Kinship Foster Parent	[REDACTED] 1986

**Notification of Child Near Fatality:**

On April 5, 2011, Luzerne County Children and Youth received a call [REDACTED] concerning the victim child. The information that the agency received reported that the mother stated that the previous day, the child rolled off the changing table when she turned her back. The child was found lying on her back and the presumed injury was to the back and head. The child was taken to, treated and [REDACTED] on April 4, 2011. The mother stated that no studies were done; just an exam and the child was released.

The child was brought to the Wilkes-Barre General Hospital Emergency Room the next day, April 5, 2011, because the child showed a decreased interest in her toys, decreased oral intake and increased irritability. A CT Scan of the head was performed and the child [REDACTED] [REDACTED]. The attending physician certified the child to be in serious condition due to suspected abuse.

### Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Information was also obtained from the CPS Supervisor and the Ongoing Casework Supervisor.

### Summary of Services to Family:

#### Children and Youth Involvement Prior to Incident:

November, 29, 2010 - The agency received a referral from [REDACTED] concerned about mother's [REDACTED] and concerns for the mother's ability to bond with the child as observed by mother not showing warmth to the child, yelling at the child for wiggling during a diaper change and yelling at the child when child did not cooperate when being given [REDACTED]. The agency assigned a response time of 24 hours. The mother and child were first seen on November 30, 2010. A safety assessment was completed on November 30, 2010 and there were no safety threats identified.

December 18, 2010 - The agency received a referral from [REDACTED] stating that mother was incoherent and did not know where her baby was. The [REDACTED] didn't know why the mother was [REDACTED]. She was crying and had been [REDACTED] a few times that week. She gave several answers as to where the baby was including at home in a swing and with neighbors. The [REDACTED] called the State Police-Wyoming. The referral was assigned an immediate response time. The worker and the State Police responded to the home immediately. The neighbors reported that mother had texted them "help-911". They went next door to find the mother on the floor crying but barely breathing. The medics were called. The neighbors reported that, after mother was taken by ambulance, they brought the child to a friend's home who could care for the baby. They then called the child's maternal grandfather to come care for the baby and he was on his way. The caseworker and State Police responded to the friend's home. The police initially [REDACTED] of the child because [REDACTED] had reported that mother was incoherent and could not give permission for the maternal grandfather to care for the baby. The caseworker and maternal grandfather went to the mother's home to gather belongings for the baby. The caseworker went to the maternal grandfather's home to conduct a home evaluation. The child remained in the care of the maternal grandfather and step-grandmother.

At the conclusion of the intake assessment on January 20, 2011, the agency determined that the mother's [REDACTED] appeared under control at the time. The [REDACTED] denied a [REDACTED]. The mother had been [REDACTED] for a while and was consistent with appointments. The mother had some family support in her parents who had helped her care for the child while she was [REDACTED]. They also helped her with transportation until the mother's car was fixed. The mother also had a friend that took the mother and child in for a few days after the mother was released from the hospital to help care for the baby. The child appeared safe and clean on all home visits. The mother appeared to be bonded to the child and was observed tending to the child's needs in

the presence of the caseworker. The mother was also involved with [REDACTED] who reported no concerns with the care of the child. They were concerned with mother's lack of support [REDACTED]. Parenting and other services were offered to the mother by the caseworker but were declined. Mother felt she had all the support she needed and adequate connections to community resources to meet her and the child's needs. The mother was [REDACTED]. The agency made the determination that there was no evidence of Child Abuse or Neglect, the mother was adequately connected to [REDACTED] had some support to help with transportation and caring for the child and there was no further role for CYS at that time. The case was closed at the Intake level on January 20, 2011.

January 24, 2011 - The agency received a referral from [REDACTED] concerned that the child fell from the changing table and was in the [REDACTED]. There were conflicting stories as to who was with the child at the time of the incident. The child was bleeding from the mouth upon arrival at the hospital and was in the process of getting a CAT scan. There were unknown injuries at the time of the referral. The concern was that the child may have been left unattended on a changing table resulting in her falling off the table. There was no indication that the injury was caused intentionally to the child; however, the hospital was concerned that mother was stating that she [REDACTED]. A 24 hour response time was assigned. The caseworker met with the mother and child at the hospital the same day. The child did not receive any serious injuries as a result of the incident. Despite the [REDACTED], the mother insisted that she has [REDACTED] that help care for the child. The child was discharged to the mother because the caseworker was unable to establish that the child was not safe with her; however, the case was opened for ongoing services and the mother agreed to cooperate with a [REDACTED]. The [REDACTED] and [REDACTED] continued to provide services to the mother. The case was opened on January 25, 2011. The caseworker made an announced home visit on January 25, 2011 as a follow-up to the child's trip to the ER. The caseworker's next announced home visit occurred on February 3, 2011. The caseworker discussed the Family Service Plan with the mother during this home visit. Home visits also occurred on February 17, 2011 (Announced), February 24, 2011 (Unannounced), February 25, 2011 (Transportation Provided by CW), March 2, 2011 (Transportation Provided by CW), March 7, 2011 (Transportation Provided by CW), March 11, 2011 (Attempted-Unannounced), March 18, 2011 (Unannounced), March 31, 2011 (Attempted-Unannounced), and April 1, 2011 (Announced). The near fatality report was received on April 4, 2011.

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

The case was registered as a Near Fatality on April 5, 2011 after the child was seen twice in two different emergency rooms on April 4, 2011 and April 5, 2011. She received [REDACTED] after falling from the changing table. The concern was due to the lack of supervision of the child. The child was life-flighted to Geisinger in Danville. The caseworker met the mother and child at the hospital on April 6, 2011. The mother stated that the child was on the changing table and when she turned to get the child's pajamas, the child fell off of the table and hit her head and back. The mother called the ambulance and they were transported to the Geisinger Wyoming Valley Hospital. The child was [REDACTED]. The mother stated that the child was up all night crying, which is not normal for her, she was very irritable and wouldn't eat. The mother called the ambulance again and requested that the child be transported to the Wilkes-Barre

General Hospital. The child was [REDACTED] and was life flighted to Geisinger-Danville Medical Center. The child had [REDACTED]. Her full skeletal [REDACTED]. The caseworker discussed placement options with the mother who named her friend as a potential caretaker. The worker went to the friend's home and conducted a home assessment. The child was [REDACTED] and was [REDACTED] with the mother's identified friend. The child was seen [REDACTED] and had [REDACTED] with her mother twice per week from April through June, 2011 when the visits changed to supervised at the agency office because of the multiple texts that the mother was sending to the kinship caretaker who became uncomfortable supervising the visits in her home. Visitation occurred twice per week at the agency office from July, 2011 through the writing of this report, November, 2011. The mother's current paramour and father of her unborn child started visiting with the child on a regular basis in May, 2011. A 3 month [REDACTED] occurred on September 14, 2011. [REDACTED] and that the mother continue in [REDACTED] parenting services. Mother gave birth to her new son on [REDACTED]. He was [REDACTED] with his sister upon [REDACTED].

[REDACTED] The mother and her paramour have continued to receive parenting [REDACTED]

The mother was indicated for physically neglecting her daughter after the second incident of the child falling from the changing table resulted in significant head injuries. Mother was INDICATED on May 3, 2011 for the Physical Neglect of her daughter.

#### **Current Case Status:**

The mother and her paramour have both participated in [REDACTED] with both children twice per week. They are also both participating in parenting services [REDACTED]. The children have remained [REDACTED] together. The criminal investigation was closed with no charges being filed. [REDACTED]

#### **County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

Act 33 of 2008 requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Luzerne County has not convened a review team in accordance with Act 33 of 2008 related to this report. The county agency has been unable to find a chair person willing to accept the responsibility of chairing the Act 33 committee. They are continuing to seek a chair person and will conduct an Act 33 review team meeting regarding this near fatality when a chair person is found.

#### **Department Review of County Internal Report:**

N/A; The county has not completed an internal report regarding this case.

### **Department of Public Welfare Findings:**

- County Strengths: Safety Assessments were conducted as required according to the Safety Assessment Bulletin and the mother and child were seen frequently by the caseworker. Frequent visitation has been offered to the mother and her paramour. The child was able to be placed in a formal kinship home and currently resides there with her newborn brother.
- County Weaknesses: The agency has been without a chair person to lead the Act 33 Review Committee for several months and has reportedly had no success in finding a willing chair person to date.
- Statutory and Regulatory Areas of Non-Compliance:  
The agency is not in compliance with Act 33 and will be cited for their lack of compliance in reviewing fatality/near fatality cases as required.

### **Department of Public Welfare Recommendations:**

The agency is encouraged to immediately seek a chair person to lead the Act 33 review committee and to begin to review child fatality/near fatality cases as required by law.