



Jacquelyn Maddon
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE NEAR FATALITY
of



BORN: 4/26/10
DATE OF NEAR FATALITY: 8/19/10

FAMILY KNOWN TO:
Northampton County Department of Human Services Children, Youth and
Families Division

REPORT DATED 1/13/11

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. On October 2, 2010, Northampton County convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Child	4/26/10
[REDACTED]	Twin Sibling	[REDACTED]/10
[REDACTED]	Mother	[REDACTED]/90
[REDACTED]	Maternal Grandmother	[REDACTED]/68
[REDACTED]	Maternal Uncle	[REDACTED]/92
[REDACTED]	Father	[REDACTED]/87
[REDACTED]	Father's paramour	[REDACTED]/90
[REDACTED]	Paternal Uncle	[REDACTED]/98
[REDACTED]	Paternal Aunt	[REDACTED]/01

Notification of Near Fatality:

On 8/19/10 [REDACTED] notified Northampton County Department of Human Services Children, Youth , and Families Division of a report that [REDACTED] the child was driven to the [REDACTED] Hospital [REDACTED] by her mother due to falling off of a bed. The reporting source stated that the child does not roll or anything. [REDACTED]. The child was transferred to [REDACTED] via ambulance. The mother accompanied the child in the ambulance. [REDACTED] the child had a serious injury and a serious medical condition, however, the child was expected to live. [REDACTED]

Summary of DPW Child near Fatality Review Activities:

The [REDACTED] investigation was conducted by the county agency.

The NERO investigation consisted of a review of the [REDACTED] file, interviews with Northampton County Department of Human Services, Children and Youth Division staff and participation in a MDT meeting regarding the child on August 24, 2010.

Case Chronology:

On August 19, 2010, the Northampton County Department of Human Services, Children, Youth, and Families Division received a referral [REDACTED] [REDACTED] the child had a life threatening injury. The [REDACTED] investigator from Northampton County Department of Human Services, Children, Youth, and Families Division went to the hospital. The [REDACTED] investigator met with the victim child's parents. The parents agreed that the child's sibling would stay at father's home until further notice. The mother was to remain at the hospital with the child. Father and the child's sibling stayed at the hospital overnight.

[REDACTED] It should be noted the law enforcement referral was completed and forwarded to the Palmer Police Department and the District Attorney Office.

On August 21, 2010, the [REDACTED] investigator conducted all clearances on the adults in the father's household.

On August 21, 2010, the caseworker visited the father's home to assure there were proper provisions for the children and there were no safety issues in order for father to assume primary care of the children.

On August 21, 2010, the child was [REDACTED] the hospital. A safety plan was developed and implemented based on safety threats that were identified on the safety assessment. The purpose of safety plan is to control the level of safety threat or to prevent a safety threat from having impact on the child. The safety plan stated that the mother may not have unsupervised visits with the children and the visits would take place at the father's home. Mother is unable to have supervised contact with the children at this time due to not having protective capacities needed to ensure safety of the children.

[REDACTED]

On August 24, 2010, a Multi-Disciplinary Team meeting was held to review the status of the investigation. It was recommended the investigator needed to visit the home where the incident [REDACTED] occurred in order to obtain measurements regarding the distance the child would have moved, distance of the fall and to conduct interviews with the

mother's brother and his girlfriend. Also, the investigator would arrange a polygraph for the mother at the district attorney's office and continue with services being provided through the [REDACTED] for parenting instruction [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

On September 27, 2010, the [REDACTED] investigator, program director and the regional representative met at the Agency office to discuss and review the current findings status of the investigation. It was learned that the police had not yet conducted an investigation. The investigator reported the parents have been observed to have good interaction with the children when visitation occurs.

On October 14, 2010, the [REDACTED] investigation concluded [REDACTED]. The investigative findings determined the child was left on the bed unsupervised on the 3rd floor for over an hour (prolonged) while [REDACTED], the child's mother, socialized with a friend in the basement of the home. During this time the child rolled off the bed [REDACTED] which was considered life threatening.

Previous Children and Youth Involvement:

Northampton County Department of Human Services CYF Division received truancy referrals on mother as a child. The family was not opened for services.

Circumstances of the Child's Near Fatality and Related Activity:

On 8/19/10 a report was made [REDACTED] that stated that the victim child [REDACTED] rolled off the bed and hit the floor. The injury was deemed life threatening [REDACTED]

[REDACTED] The child was initially seen at [REDACTED] Hospital around 11:30 am and was then transported to [REDACTED] Hospital [REDACTED] for further assessment and treatment.

On 8/19/10, the [REDACTED] investigator from Northampton County Department of Human Services, Children, Youth and Families Division went to the hospital. While at the hospital she met the victim child's family. [REDACTED] investigator interviewed [REDACTED]. He

██████████ he was not with his daughters when the child was injured. ██████████ he lives with paternal grandmother and his two younger siblings. ██████████ paternal grandmother told him what had happened around 1:30pm today. ██████████ the mother ██████████ left the girls on the bed with pillows surrounding them and went to make a bottle. ██████████ she found the child and the pillow on the floor. ██████████ she heard the child crying and that is why she ran upstairs to see what was wrong. ██████████ the mother and children were staying at the maternal uncle's paramour's home. ██████████ she had brought the child to the hospital immediately because she was crying. ██████████ he does not believe the mother would intentionally hurt their daughters and believes this is some type of accident. ██████████ his daughters can be cranky and often cry a lot. ██████████ usually only one child is crying at a time, and then the other child starts once the sibling stops. ██████████ he has never seen any bruises or even diaper rash that would make him think that the mother is not properly caring for his children.

On 8/19/10, the ██████████ investigator interviewed ██████████ mother does not lie and would tell the truth about something that happened to her daughters. ██████████ she is also around the twins whenever they are with their father. ██████████ she has never seen any bruises or anything that would make her suspicious that the girls are not being properly cared for. ██████████ she has witnessed the sibling flipping from her belly to her back but not the child. ██████████ she would not be surprised if the child was able to do it as well. ██████████ it would make sense that the baby "scooted" off the bed because she has seen both girls move all over the crib.

On 8/19/10 the ██████████ investigator interviewed the ██████████ on Wednesday night she spent the night at the maternal uncle's girlfriend's house. ██████████ her daughters also spent the night with her. ██████████ provided the investigator with information on the maternal uncle's girlfriend and the homeowner. ██████████ she is unsure of the homeowner's last name. ██████████ Wednesday night she slept in the homeowner's room because she is away on a business trip. ██████████ the twins slept in their playpen, and the mother slept in the bed. ██████████ both girls got up between 7:00am-7:45am. ██████████ she fed both girls and then changed their diapers. ██████████ she is unsure if she fed the child or her sibling first, but assumed it would have been whoever was crying at the time. ██████████ after feeding the girls all three of them laid on the bed and the mother started watching the TV show Charmed. ██████████ she had the sibling on the left side of her body, and the child was lying in the middle of her chest. ██████████ the sibling started crying so she started feeding her again. ██████████ she had everything she needed for the girls. ██████████ she had bottles with her and didn't need to go anywhere to get the sibling's bottle. ██████████ the sibling fell back asleep after eating. ██████████ the child started fussing at that time. ██████████ she did not have any water left and needed to go the kitchen to get water for the baby. ██████████ she placed the child and her sibling in the middle of the bed with pillows on either side of them. ██████████ when she left the bedroom, the child's sibling was lying on her back, and the victim child was on her belly because that is how each child normally sleeps.

[REDACTED] she then went down into the kitchen to get the water for the bottle. [REDACTED] she thought she heard something but wasn't sure. After getting the bottles, [REDACTED] she went back upstairs and found the child and the pillow on the ground. [REDACTED] the child was not crying very hard but took the child to the ER just in case. [REDACTED] she believes that the child had rolled off the bed. [REDACTED] when the child is lying on her belly, she uses her toes to dig into the bed and pushes her butt into the air. [REDACTED] she believes this is what the child did and ended up rolling over off the bed. [REDACTED] she was the only one with the girls all morning. [REDACTED] denied hearing anyone else walking around upstairs.

The child and her sibling were seen by their pediatrician on a regular basis. The pediatrician didn't report any problems or concerns regarding the girls. The children are up-to-date on their shots.

The mother completed a polygraph exam. Deception was noted on a question that asked if mother caused the child's injury.

Current / Most Recent Status of Case:

The family has been accepted for ongoing services. Mother continues to reside with maternal uncle. Mother continues to have visits with her children that are supervised by Northampton County Children, Youth and Families. The supervised visits occur at Northampton County CYF. Mother is cooperating with services from CYF. Mother is participating in parenting education through [REDACTED]. Mother is receiving non offending parenting education through [REDACTED].

The child and her sibling remain in father's care. Mother has supervised contact with the children. There are no issues or concerns with the safety and well being of the children. The children are up-to-date on their immunizations. [REDACTED]

[REDACTED] Both children will remain in the care of [REDACTED]

The Agency received medical records that showed the children were up-to-date their immunizations and routine medical visits. [REDACTED] had no concerns documented.

[REDACTED] participated in a polygraph examination through the district attorney's office. The polygraph showed deception. [REDACTED] wrote a letter indicating she wanted to do everything she could to [REDACTED] of her daughters. She wrote a desire to address personal issues [REDACTED]

██████████. At this time, ██████████ indicated the children's father was less than ideal and requested her mother be considered a resource for the children.

The Palmerton Police Department has not filed charges thus far, despite the caseworker updating the police department on the status of her investigation. The caseworker is following up with the Northampton County District Attorney's office.

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

- Strengths: ██████████ was employed and caring for her twin children with the assistance of friends and relatives. ██████████ has appropriate interaction with her children. ██████████ was able to obtain routine medical care for her children. ██████████ was receptive to services from Northampton County Children, Youth and families.
- Deficiencies: ██████████ is a young, single parent. ██████████ requires assistance with parenting skills and instruction in order to address areas of concern, ie. unsafe sleeping arrangements.
- Recommendations for Change at the Local Level: Northampton County Children Youth and Families has had difficulty receiving cooperation from the local law enforcement agencies regarding child abuse investigations. The Northampton County Children, Youth, and Families advisory board will meet with local law enforcement to establish a working relationship in order to investigate allegations of suspected child abuse.
- Recommendations for change at the State Level: Parents should be educated on safe sleep initiatives prior to leaving the hospital after delivering child/children.

Department Review of County Internal Report:

Northampton County Children, Youth and Families internal report met the requirements of Act 33 of 2008.

Statutory and Regulatory Compliance:

As a result of the DPW review of the circumstances surrounding the child's near fatality incident including the ██████████ case file and corresponding family file, it was determined that the Northampton County Department of Human Services Children and Youth Division conducted safety assessments and risk assessments accurately. An initial safety plan was implemented which required the child and her sibling to have supervised contact with their mother until further assessment as the child was hospitalized. While the child was hospitalized, her sibling stayed at father's home. Upon the child's release from the hospital, the child joined her sibling at her father's home. The child and her sibling were determined to be safe each time they were assessed in their father's home. The agency made an announced and an unannounced home visits to assess the safety of the children during the investigation. The ██████████ investigation was completed within 30 days. The family was accepted for services. The children were able to remain in the care of their father.

5-01-11

Department of Public Welfare Findings:

- **County Strengths:** The agency assessed the safety and risk of the children as required. The children were deemed to be safe in the care of their father.
- **County Weaknesses:** There are no areas of concern at this time.
- **Statutory and Regulatory Areas of non compliance:** The agency was in full compliance with statutory and regulatory laws.

Department of Public welfare Recommendations:

The Department does not have any recommendations at this time.