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REPORT ON THE NEAR FATALITY OF



BORN: [REDACTED] 2006

DATE OF NEAR FATALITY:
04/11/2011

FAMILY NOT KNOWN TO:
Schuylkill County CYS

REPORT DATED 06/29/2011

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 No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Father	[REDACTED]/82
[REDACTED]	Mother	[REDACTED]/85
[REDACTED]	victim	[REDACTED]/06
[REDACTED]	sibling	[REDACTED]/08

Notification of Near Fatality:

- On 4/13/11 Schuylkill County Children and Youth Services received a [REDACTED] report which was subsequently received by the Northeast Regional Office on the same day. The child reportedly fell from a third story window onto a roof and then fell from a roof into a neighbor's yard. The mother found the child in the yard. The mother said the child fell because the screen in the window was loose (unknown to her at the time). The child was unconscious for a short period when the mother found him. The child was going in and out of consciousness. The child's [REDACTED]. The child was [REDACTED]. The child was expected to survive. The referral source expressed concern about a possible [REDACTED] because it suggested [REDACTED] that resulted in a [REDACTED].
- Preliminary information revealed that the attic area where the children were playing was used as a playroom. Mother was sitting at the bottom of the steps finishing her breakfast when the incident occurred. The window opens out from the top and there was a screen in the window. The mother was unaware at the time that the screen was not in securely.

2. Documents Reviewed and Individuals Interviewed:

The agency was notified [REDACTED] on 4/12/11 of the incident, and the case was [REDACTED] however on 4/13/11, [REDACTED] notified the agency that the case had been [REDACTED]. The [REDACTED] worker spoke with [REDACTED], Lehigh Valley Hospital [REDACTED] who stated [REDACTED]. All medical documents were forwarded to the Northeast Regional Office for review. On 4/14/11, Mother and [REDACTED] sibling were interviewed regarding the incident. [REDACTED] was not interviewed due to his medical condition. The Northeast Regional Office also reviewed the entire file including interviews and contacts, and spoke with the caseworker and supervisor regarding the case.

Case Chronology:

On 4/12/11, a referral regarding [REDACTED] was called in [REDACTED]. The case was opened for service planning at that time. The victim child was in the hospital at the time, and [REDACTED] did not feel there were immediate supervision issues regarding the child at home. [REDACTED] reported that they felt the incident was accidental but referred it to CYS as a precaution. On 4/13/11, the incident occurring on 4/12/11 was registered as a near fatality by ChildLine.

On 4/14/11 the mother and younger sibling were interviewed regarding the incident. By both accounts, the fall appeared accidental in nature and it did not appear that it was due to lack of supervision. The victim child was also seen at the hospital on this date, but not interviewed due to the child being [REDACTED].

On 4/14/11 the mother noted her intention to move back to Baltimore, Maryland where she had family supports. She was residing in Schuylkill County to help care for her mother, but at present, her mother was in a nursing home and no longer needed her assistance.

Schuylkill County CYS spoke with [REDACTED], Mother's sister on 4/14/11 as well as 4/15/11. She advised that the mother and children will be residing with her when they returned to Maryland and she provided her address. Schuylkill County spoke with [REDACTED] of Baltimore County CYS. She reported that the family had no history of involvement with their agency, but she recommended that Schuylkill County call Baltimore City CYS to see if there was any involvement with the family through their agency. The Schuylkill County worker phoned Baltimore City CYS and spoke with a Supervisor [REDACTED] who said he'd have a worker look into this. On 4/21/11, Schuylkill County CYS received a letter from [REDACTED] stating that Baltimore City CYS had no prior involvement with this family.

On 4/15/11 a CY-104 (referral to law enforcement) was sent to the Schuylkill County District Attorney's Office by CYS as per CPSL.

[REDACTED] to his mother's care. [REDACTED] recommendations were to follow up with a [REDACTED] in 2 to 4 weeks. Mother reported that she will make appointments for follow up with John Hopkins Hospital.

On 5/04/11 Schuylkill County phoned the mother who reported that [REDACTED] was doing well and was following up with his medical appointments.

Previous Children and Youth Involvement:

As was noted above, the family had no previous involvement in either Schuylkill County, or Baltimore, Maryland where she resided previously.

Circumstances of the Child's Fatality or Near Fatality:

On 4/13/11 Schuylkill County Children and Youth Services received [REDACTED] report which was subsequently received by the Northeast Regional Office on the same day. The child reportedly fell from a third story window onto a roof and then fell from a roof into a neighbor's yard. The mother found the child in the yard. The mother said the child fell because the screen in the window was loose (unknown to her at the time). The child was unconscious for a short period when the mother found him. The child was going in and out of consciousness. The child's [REDACTED]

[REDACTED]. The child is expected to survive. The referral source expressed concern about [REDACTED] because [REDACTED]

Current / Most Recent Status of Case

- The case was unfounded on 5/03/11. The investigation found that the injury was accidental in nature. The mother was reportedly sitting at the bottom of the steps when the incident occurred.
- The case was not opened for services, nor was it referred after the family moved. The investigation did not reveal any deficits in family functioning and there were no issues to refer when the family moved back to Maryland.
- The children were not removed from their parent during the course of the investigation. Mother was appropriate and cooperative throughout the investigation, and there were no grounds for removal.
- The hospital referred [REDACTED] for follow up care which was reportedly done through John Hopkins Hospital in Maryland. The caseworker made a follow up call to the mother to make sure that [REDACTED] was receiving follow up care.

- The police investigated the incident and found the incident to be accidental in nature. There are no further criminal proceedings involving this case.

Statutory and Regulatory Compliance

- Safety Assessments were conducted with the first face to face contact and then again at the conclusion of the investigation. Both assessments revealed no safety threats to the children.
- The Initial Safety Assessment was done immediately after the first contact with the family. There were no safety threats identified, therefore, no safety plans were completed. Although the last contact with the family is dated 5/03/11 and the case was unfounded on the same day, the Safety Assessment required at the conclusion of an investigation was not completed until 6/10/11, well over 30 days since the last face to face contact.
- The investigation by the county was completed in a timely manner. The county unfounded the case within the 30 day time frame.
- [REDACTED] the victim child, was not interviewed regarding the incident. (*See findings*)
- A risk assessment was completed on 5/28/11 and found the children to be at low risk for abuse.
- The family was not accepted for services; therefore, no family service plan was completed. The investigation did not reveal any concerns for the family functioning. The family did indicate that they'd be moving back to Maryland, and the county did make collateral contacts to the mother's sister to ensure that the family would have a place to stay until they could locate their own housing.
- There was a 3 year old sibling in the home. She was interviewed regarding the incident and was able to provide a statement. There was no indication of a need for [REDACTED] services. [REDACTED] was not done on this child nor was it mandated.
- The hospital made medical referrals for follow up care for [REDACTED]. No CYC referral was made because the family did not appear to have any deficits requiring a referral.
- The CY-104 (referral to law enforcement) was sent to the District Attorney's Office on 4/15/11.

Findings:

It appears that, overall, the county conducted a thorough investigation and worked closely with law enforcement and the hospital during the investigation. The former county in which mom resided was contacted, as were relatives. No Act 33 Fatality Review meeting was conducted because the case was unfounded in less than 30 days and the family was not previously known to the county. One concern that the Northeast Regional Office noted was that the victim child was not interviewed over the course of the investigation. While it is understandable that the victim could not initially be interviewed due to his medical condition, NERO felt that once the child's condition improved, efforts should have been made to interview him. There was no indication that the child was delayed in anyway or unable to be interviewed. In fact, the county did interview the 3 year old sibling. According to the file, the mother was very cooperative with the agency, and although she advised she'd be returning to Baltimore upon the child's discharge, there was no indication that she would not have made the child available for an interview. Another concern was that the safety assessment at the conclusion of the case was not done in a timely manner. The county had full knowledge that the family was not going to reside in the county and they had decided not to refer the case to Baltimore. The agency had no contact with the family after 5/03/11, the same day the case was unfounded. NERO concludes that the Safety Assessment should have been done at this time so that the expectation of seeing the child within 30 days of the assessment would have been met.

Recommendations:

As follow up, NERO would recommend that Schuylkill County obtain necessary releases and ensure that the child has made his follow up appointments, since the case has not been referred to Baltimore for services. In addition, NERO has issued a Licensing Inspection Summary regarding regulation 3490.55, relating to interviewing the victim child in a CPS investigation, as well as a citation of 3130.21(b) and the Safety Assessment and Management Bulletin, regarding the timeliness of the Safety Assessment.