



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: May 27, 2012
DATE of NEAR-FATALITY : August 24, 2012

FAMILY KNOWN TO: Lehigh County Children and Youth Services

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 child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

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. *Northampton County Department of Human Services, Children, Youth, and Families Division* has 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]	Victim Child	5/27/12
[REDACTED]	Mother	[REDACTED]/80
[REDACTED]	Father	[REDACTED]/84
[REDACTED]	Household Member/Caregiver	[REDACTED]1958
[REDACTED]	Household Member/Caregiver	[REDACTED]/57

Notification of Fatality/Near Fatality

On August 25, 2012 Northampton County Children, Youth, & Families received a call from [REDACTED] concerning the victim child. The victim child (VC) was lying on his mother's lap. When the mother went to stand up her knee gave out. The VC fell on the floor and hit his head on the linoleum floor. The VC cried immediately but slept after the incident. The VC's parents drove the VC to the St. Luke's Hospital Emergency room. Upon examining the VC it was determined that the VC has [REDACTED]. The VC's injuries do not match the mother's explanation; therefore a report of suspected child abuse was called into [REDACTED]. The child was also certified to be in serious and critical condition.

The VC was transported to Lehigh Valley Hospital Cedar Crest Campus for further assessment. A CAT scan was completed at Lehigh Valley Hospital Cedar Crest Campus. The CAT scan determined that the VC had [REDACTED]. The VC has [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

The Child Protective Services (CPS) investigation was conducted by the county agency. The NERO investigation consisted of a review of the CPS file and interviews with Northampton County Department of Human Services, Children and Youth Division staff.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

The family was not known to Northampton County Department of Human Services, Children, Youth, and Families Division (NCDHS-CYFD), however, were active with Lehigh County Children & Youth Services (LCCYS) at the time of the incident. LCCYS was involved with the family since 5/27/12 because the victim child [REDACTED]. Home visits were conducted, urine screens were collected, the child appeared to be appropriately cared for, and a review of medical records for the child illustrated no risks or health concerns. LCCYS was in the process of closing the case when the child was examined at the hospital [REDACTED].

NCDHS-CYFD has continued services for the family that have been offered by LCCYS, in place for the family such as parenting education, random urine screens, home visits. In addition to those services NCDHS-CYFD has also offered [REDACTED] evaluations and [REDACTED] evaluations for the parents. The VC remains [REDACTED] until further assessment.

Circumstances of child's near fatality and related case activity:

On August 25, 2012 NCDHS-CYFD received a report [REDACTED] regarding the victim child. The report stated that the victim child (VC) was lying on his mother's lap. When the mother went to stand up her knee gave out. The VC fell on the floor and hit his head on the linoleum floor. The VC cried immediately but slept after the incident. The VC's parents drove the VC to the St. Luke's Hospital Emergency room. Upon examining the VC it was determined that the VC has [REDACTED]. The VC's injuries do not match the mother's explanation; therefore a report of suspected child abuse was called into [REDACTED]. The child was also certified to be in serious and critical condition.

The VC was transported to Lehigh Valley Hospital Cedar Crest Campus for further assessment. A CAT scan was completed at Lehigh Valley Hospital Cedar Crest Campus. The CAT scan determined that the VC had [REDACTED]. The VC has [REDACTED].

On August 25, 2012 a NCDHS-CYFD CPS investigator went to the Lehigh Valley Hospital Cedar Crest Campus [REDACTED] to conduct a 24 hour safety assessment of the VC. Based on the safety assessment it was determined that a safety plan was needed. The safety plan stated that the VC's parents could not have unsupervised contact with him until further assessment.

On August 25, 2012 a NCDHS-CYFD CPS investigator called the VC's parents and notified them of the CPS report that was received. The NCDHS-CYFD CPS investigator also informed the parents of the safety plan that was developed due to the safety threats that are present and the parents diminished protective capacities.

On August 25, 2012 a NCDHS-CYFD CPS investigator received a call from [REDACTED] the Lehigh Valley Hospital Cedar Crest Campus. [REDACTED] reported that a CAT scan was

performed on the VC. The CAT scan revealed that the VC had [REDACTED]

On August 25, 2012, a NCDHS-CYFD CPS investigator sent a referral to law enforcement.

On August 27, 2012 a NCDHS-CYFD CPS investigator conducted a home assessment and interview with the VC's father. The father reported that on the date of the incident the Alleged Perpetrator (AP/VC's mother), father, [REDACTED] (HHM/Caregiver) and [REDACTED] (HHM/Caregiver) were in the family's home in the kitchen. He reports that AP was holding the VC on her lap while sitting down. AP stood up, her knee buckled and she dropped VC on the floor. AP fell on the ground. The father picked the VC up off of the floor. AP called the ambulance. Father gave the VC to [REDACTED] held the VC with a rag. Father reports that the VC looked like he wanted to sleep, but [REDACTED] attempted to keep him awake. When the ambulance arrived AP and the VC got into the ambulance and father followed behind the ambulance to the hospital.

On August 27, 2012 a NCDHS-CYFD CPS investigator met with the AP and informed her of the allegations. The NCDHS-CYFD CPS investigator also asked the AP about her lack of visitation with the VC while in the hospital. The AP stated that she has been working and unable to visit with the VC.

[REDACTED]

[REDACTED]

[REDACTED]

On August 29, 2012 a NCDHS-CYFD [REDACTED] interviewed the AP. AP reported that on the day of the incident the VC was sitting on her lap. AP reported that she was sitting in the kitchen on a folding chair next to the refrigerator. [REDACTED] entered the kitchen and sat next to her, and then [REDACTED] came in the kitchen. She reported that the father eventually came in the kitchen. The AP was holding the VC. The VC was awake. AP reported that she went to get up to give the VC back to [REDACTED] When the AP got up

she stated that she got completely up, went to take a step, and fell back down. The AP stated that she fell onto her knees. The Father picked up the VC. The VC was crying. The AP reported that [REDACTED] was running to pick the VC up and she almost fell, but she caught herself. The AP reports that she was still on the ground. The AP reports that [REDACTED] took the baby from his father and placed a cold compress on the VC's head. The AP reported that the father attempted to help her up, but she needed to wait until her pain subsided. The AP reported that she finally got up. The AP reported that [REDACTED] was still holding VC. The VC was attempting to fall asleep, but his leg started trembling. The AP reports that she stepped outside and called the ambulance. The AP reported that she went back into the house to wait for the ambulance to arrive. The AP reported that the VC was trying to fall asleep, but [REDACTED] kept talking to him and tickling his feet to keep him awake. The AP also reported that [REDACTED] kept changing the VC's compress. The AP reported that when the ambulance arrived she rode in the ambulance with the VC. The AP reported that once they arrived at the hospital she registered the VC and accompanied VC [REDACTED] AP joined the father.

On August 28, 2012 a NCDHS-CYFD CPS investigator spoke with the father. The father discussed [REDACTED]. He also reported that they have been in a relationship for almost 2 years. He reported that the AP has two older children that live with their biological father. He reported that he does not know their whereabouts and they do not have access to or contact with them. The Father reported that the parents were looking for daycare when [REDACTED] volunteered to babysit the VC. The Father also reported that the family moved into their own apartment on August 8, 2012. Prior to that they were living with relatives. The Father reported that on 8/23/12 he worked from 7am-7pm and the AP worked from 9am-9pm. He reported that he gave the VC a bath at 9:30pm. The AP fed the VC. The Father reported that he got up at 4am to feed the VC. He reports that on 8/24/12 he worked from 6:30 am-3:30pm. He reported that when he got up for work that the AP got a bottle to feed the VC. [REDACTED] watched the VC at her sister's home. The Father picked the VC up at 4pm. The Father and VC went back to their apartment. [REDACTED] also went to the family's apartment. The Father showered and then fed VC around 5pm. The VC slept for about an hour. The AP came home around 8:30pm. The VC was awake and lying on the bed. The AP and [REDACTED] went to pick up racks from storage to help organize the apartment that the family recently moved in. [REDACTED] assisted the AP. [REDACTED] cared for the VC at this time, while the father did other things.

On August 28, 2012 a NCDHS-CYFD CPS investigator interviewed [REDACTED]

[REDACTED] stated that the AP usually drops the VC off and the father picks him up. [REDACTED] reported that on the date of the incident the AP dropped the VC off at around 11:30 am and the VC's father picked him up around 3:00 pm. During this time [REDACTED] cared for VC at her sister's home. The father picked up VC and [REDACTED] and they went to the family's apartment. [REDACTED] reported that when they arrived at the family's home, the father took the VC upstairs. The father and the VC came back downstairs because he said it was too hot and VC was fussy. [REDACTED] reported that when the father and the VC came downstairs, the VC was whining. [REDACTED] reported that she took the VC. [REDACTED] reported that she and VC were lying in the bed. [REDACTED] reported that the AP arrived home approximately 30-60 minutes later. [REDACTED] reported that the AP asked her why the VC was with her and not with the father. [REDACTED] reported

that the AP picked the VC up and went into the kitchen. [REDACTED] reported that the AP was sitting on a chair in the kitchen. [REDACTED] reported that the AP was holding the VC across her body. [REDACTED] reported that the AP went to get up AP's legs gave way and the AP fell to the ground. [REDACTED] reported that the AP went one way and the VC went another way. [REDACTED] reported that the VC was laying on his back, but he hit his head on the floor and rolled. [REDACTED] reported that she and father attempted to pick VC up, however, she tripped on an electrical cord and [REDACTED] caught her. [REDACTED] reported that father picked up VC from the floor. [REDACTED] reported that father went to leave the room and she told father to give VC to her. [REDACTED] reported that she placed a cold rag on the VC's head. [REDACTED] reported that VC was crying on and off. [REDACTED] reported that the VC was trying to dose off. [REDACTED] reported that the AP called the ambulance. [REDACTED] reported that she held the VC until the ambulance arrived. [REDACTED] reported that the AP remained on the floor. [REDACTED] reported that everyone was in shock [REDACTED] reported that the father told her that the AP has had knee problems for awhile.

On August 28, 2012 a NCDHS-CYFD CPS investigator interviewed [REDACTED]

[REDACTED] reported that he believes that the AP and the father are good parents. [REDACTED] reported that on the date of the incident that he, [REDACTED] AP and the father were hanging out in the kitchen. The VC was in the bedroom awake and whining. [REDACTED] reported that he went to pick up the VC and took him to the kitchen. [REDACTED] reported that he had put 2 folding chairs up. The Father, AP, [REDACTED] were in the kitchen. The AP and [REDACTED] were sitting in the chairs, the father was by the kitchen door, [REDACTED] was by the sink leaning. [REDACTED] reported that he had his head down because her back was hurting. [REDACTED] reported that he saw the AP get up and then fall down. [REDACTED] reported that the AP was holding the VC in a cradle position; VC's body was across her chest. [REDACTED] reported that the VC fell onto the floor. [REDACTED] reported that he heard VC hit the floor. [REDACTED] and the father went towards the VC. [REDACTED] reported that the VC was face down on the floor. [REDACTED] reported that VC was crying and the father picked him up. [REDACTED] reported that [REDACTED] took the VC from the father and checked him out. [REDACTED] reported that [REDACTED] noticed a knot on the right side of the VC's head and she put a cold compress on it. [REDACTED] reported that the AP was still on the floor. [REDACTED] reported that the VC was taken to the hospital via ambulance.

On August 29, 2012 a NCDHS-CYFD CPS investigator received a phone call from [REDACTED], the VC's paternal aunt; [REDACTED] presented herself as a resource for VC. [REDACTED] stated that she heard that the VC was [REDACTED] because the AP and the father had a fight and the AP threw the VC. [REDACTED] stated that father called the police and the AP was arrested. She also stated that the VC is scheduled to be discharged from the hospital this week.

The investigation concluded that the allegations of physical abuse could be substantiated in accordance with the CPSL. The investigation concluded that the VC's injuries are non accidental. The VC's parents were both Indicated for physical abuse on 10/23/12. . The medical personnel stated that the VC's injuries are not consistent with the explanation provided by the perpetrators. Collateral contacts provided information that discredits what the perpetrators reported. Both parents were the sole caretakers at the time of the VC's injuries.

There are no criminal charges pending.

The case has been opened for ongoing services. The VC remains [REDACTED].

Current/most recent status of case: The case remains active for ongoing with NCDHS-CYFD. The VC is [REDACTED]. The VC was evaluated and qualified for [REDACTED] services. The VC is receiving [REDACTED] services while [REDACTED]. The parents are visiting with the VC regularly. The parents are actively participating in services.

County strengths and deficiencies as identified by the County's (near) fatality report:

County Strengths: NCDHS-CYFD assessed the safety and risk of the child as required.

County Weaknesses: There are no areas of concern at this time.

County recommendations for changes at the local (County or State) levels as identified in County's near fatality report: The Act 33 team recommended that NCDHS-CYFD request and review all medical records and not rely on verbal information. The Act 33 team also recommended that NCDHS-CYFD clarify the type of service request for providers.

Department Review of County Internal Report:

NERO received a county report in concurrence with ACT 33. NERO is in agreement with the county's findings.

Department of Public Welfare Findings:

County Strengths: The agency assessed the safety and risk of the VC as required. The VC was deemed to be unsafe in the care of his parents, therefore the VC was placed in out-of-home care until his parents can assume the role as primary caregivers. The agency was also able to connect the parents to appropriate resources to assist with the timely reunification with the victim child.

County Weaknesses:

- The agency did not communicate effectively with other human services agencies.
- The agency had minimal contact with collaterals during the investigation, which prevented the agency from obtaining valuable information about the family.

Statutory and Regulatory Compliance Issues: The agency was in full compliance with statutory and regulatory laws.

Department of Public Welfare Recommendations:

- NCDHS-CYFD should collaborate with neighboring county children & youth agencies in order to obtain accurate and thorough information about families who come in contact with the agency.
- Northampton County Children, Youth, and Families should improve their communication with other social service agencies and the public in order to obtain accurate and detailed information pertaining to the case. Northampton County Children, Youth, and Families should be specific when requesting services from the provider agencies in order to obtain the most appropriate services for families.