pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE NEAR FATALITY OF:

[redacted]

**Date of Birth: 3/25/14**
**Date of Incident: 9/22/15**
**Date of Report to ChildLine: 9/22/15**
**CWIS Referral ID:** [redacted]

**FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

**Northumberland County**

**REPORT FINALIZED ON:**
2/22/16

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.

Northumberland County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/7/15.

## Family Constellation:

| First and Last Name: | Relationship: | Date of Birth: |
|---|---|---|
| [redacted] | Victim Child | 03/25/2014 |
| | Biological Mother | [redacted]1993 |
| | Full Sibling | 2011 |
| | Mother's Paramour | 1993 |
| | Maternal Grandmother | 1973 |
| | Maternal Grandfather | 1965 |
| | Full Sibling | 2015 |
| * | Maternal Great Grandmother | 1952 |
| * | Biological Father | 1992 |
| * | Paternal Grandmother | 1973 |

* 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 Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records, court records, and the Agency casework dictation that outlined contact with the family. Follow up interviews were conducted with the Caseworker, Supervisor, Intake Director, and Administrator on 10/2/15 and 11/23/15. The regional office also participated in the County Internal Near Fatality Review Team meeting on 10/7/15 where details of medical reports, criminal interviews, and case history were presented. A follow-up meeting occurred with the County Internal Near Fatality Review Team on 11/04/15 to discuss additional information that was obtained during the investigation.

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

Northumberland County Children and Youth Services first became aware of the family upon receipt of two referrals on 1/10/15 and 1/22/15 alleging that the mother did not have heat in the home but was using electric heaters. These referrals were screened out due to no abuse or neglect allegations.

Additional referrals were received on 2/27/15, 3/3/15 and 3/31/15 all alleging no heat in the home other than space heaters, no running water and no food. These referrals was assigned and assessed. Upon contact with the mother and minor children, it was found that all basic needs were being met. The home had running water and there was an adequate supply of food for the children. The home was safe with no safety hazards. The home did have an issue with the heating source, however, mother was utilizing electric heaters which appeared safe for the children and the house was warm. The children appeared clean. The natural mother was very difficult to get a hold of and was minimally cooperative. Agency personnel recommended that the mother have the heating system fixed by September following the direction that the code enforcement office had given the mother. The case was closed on 4/28/15 due to no safety threats observed and all basic needs being met.

On 6/11/15, a referral was received alleging that the maternal great grandmother (MGGM) was driving without a license with the minor children in her car and she was pulled over by police. The MGGM was taken into police custody and there was also concern with the children's hygiene. The child returned to the mother's care; however, the family was accepted for services on 6/12/15 due to the lack of appropriate family support and concerns for the suitability of the caregivers of the children. The mother agreed to involvement as she felt she could use additional assistance. She also agreed that the MGGM will neither drive with the children in the car nor would the MGGM babysit the children at her home due to the concerns with the MGGM's home conditions. The Agency maintained monthly visits with the family but the mother became resistant to services and met only minimally with the worker. On 7/16/15, a home visit was conducted and this was the first time Agency personnel met [redacted]. The mother reported he was a friend and was staying with her for a few days. On 8/7/15, a home visit was conducted and the mother's parents and siblings were residing in the home due to their home getting condemned. The mother's younger siblings were placed in foster care [redacted] The mother could not support her own children and also provide support for her minor siblings. The MGPs remained in the home with the mother.

On 9/6/15, a GPS referral was received alleging that the victim child (VC) was being watched by the mother's paramour and fell down the stairs. The referral stated that the mother reported that the child was being admitted to the hospital for possible injuries. On 9/8/15, a referral was received alleging Serious Physical Neglect (lack of supervision) of the victim child. The mother's paramour was the

caretaker at the time. The VC had fallen down the stairs, sustained injuries, and the mother's paramour was the caregiver of the children at the time of the incident. Both referrals were made [redacted] Contact was made with the paramour who stated he was leaving the home and moving "south". Contact was made with the mother and children at a different location. The mother reported that she was going to stay in [redacted] County with the paternal grandmother. A Safety Plan was developed and signed by the mother stating that her paramour would have no unsupervised contact with the minor children. The VC was observed to have significant facial bruising, bruising to his shoulder and spine.

NCCYS learned that the VC was seen at Geisinger Shamokin Community Hospital on 9/3/15 for the injuries sustained in the fall. The VC was taken to the hospital by the paramour who reported to hospital staff that the child fell down an unknown number of steps. The VC had bruising to both eyes and the bridge of his nose. [redacted] No report was made to the Agency. The VC was brought to Geisinger Medical Center ER in Danville on 9/6/15 by the mother and her paramour due to his facial bruising worsening. They documented cuts over his lips and bruising over his face, shoulders, arms, legs and lower back [redacted] and the child [redacted] home with no report being made to the Agency.

On 9/10/15, a home visit was conducted and the mother's paramour was still residing in the home. The mother reported that she was following the Safety Plan. The paramour was formally interviewed regarding the allegation. He reported that he and the children were upstairs, he went down to the kitchen to make lunch while the children continued playing and the next thing he knew was VC fell down the stairs. The mother was also interviewed and reported that her paramour was upstairs with the children and he was giving older sister a bath and VC must have pushed on the baby gate at the top of the stairs and fell.

On 9/14/15, a referral was received alleging that mother's paramour was babysitting minor children while the mother worked and that the children are afraid of him. Agency personnel assessed the situation and the mother and paramour denied the allegations. Agency personnel also spoke with the MGGM, and she confirmed that she is always at the home when the mother is working. She reported that she may be outside reading and that [redacted] would be alone in the house with the children. Agency personnel was very adamant with the family what no unsupervised contact meant and reminded them that the paramour cannot even be alone in a room with the children. On this day, Agency personnel observed bruising on [redacted] (on forehead, bump on right side of head, yellowish bruises on her chest, scrape on chin and bruise to right upper arm). The mother was questioned and reported that [redacted] was wearing her footie pajamas and slipped on the floor.

There were no services provided to the mother and her paramour in Northumberland County as children.

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

The Agency received a report [redacted] on 9/22/15 from alleging a near fatality of victim child (VC). The VC was brought into the hospital via ambulance [redacted] due to the critical nature of the injuries. The VC had multiple [redacted] and bruises across the forehead, left ear and bilateral buttocks. [redacted] The mother, mother's paramour, MGM, and MGF were all in the home with the victim child prior to the incident. [redacted]

While in the hospital, it was reported that the MGPs did allow the paramour to be alone in his room with the children while the mother was at work, despite the agreement to adhere to a plan of supervision. [redacted] The paternal grandmother (PGM) was identified and approved as kinship caregiver of the older sibling and assume care of the VC [redacted] The PGM Assumed care of the sister the same day. The PGM resides in Bradford County but was agreeable to travel to all needed appointments in Northumberland County to assure a continuum of care. The father also lived in Bradford County but was not able to assume care of his children.

On 9/22/15, the mother's paramour was interviewed by [redacted] Police and confessed to causing the injuries to the VC. He reported drinking excessive amounts of alcohol and being angry at the VC's biological father. He was immediately detained and incarcerated. The paramour is charged with three counts of Aggravated Assault, Endangering the Welfare of Children, and Recklessly Endangering another person. The charges are pending criminal proceedings. The mother was interviewed on 9/22/15 in conjunction with the police and she denied any knowledge of the paramour ever harming the children. She did leave the paramour alone in the room with the children where she left for work but the MGGM and MGPs were also in the home to supervise him. The mother was scheduled to work from 8:00 a.m. on 9/21/15 to 7:00 p.m. on 9/22/15. At approximately 1:00 a.m. on 9/22/15, the mother was receiving phone call from her paramour who was in a "facebook fight" with the VC's natural father. The mother spoke to the father and told the paramour to stop bothering the VC's father. The mother reported that she received a call from the paramour after 5:00 a.m. stating the VC was sick and she needed to come home immediately. The mother called the MGM about the phone call and, at that time, the VC was brought downstairs by the AP. The mother told the MGM to have the child taken to the ER.

On 9/22/15, the VC's oldest sister was seen at the Children's Advocacy Center for a medical examination and a forensic interview. The sister had bruising [redacted] She also had

abrasions on her chin and elbow and a healing abrasion on her upper lip. [redacted] and she had multiple insect bites all over her body in various stages of healing. The child reported physical discipline at the hands of the paramour. The injuries were registered as a report. The mother denied knowing how minor child received the injuries; however, stated that minor child had slipped and fallen in her footie pajama's. The MGGM stated to the case worker that the older sister had told her that the paramour was hitting her but she didn't believe the child because she laughed after telling her.

On 9/23/15, a report of serious physical neglect of the victim child was registered as the caretakers waited 2 hours before calling for EMS help for him when he was found unresponsive in the home. During the time the family waited, the MGM was on the phone with the mother. It was stated that, at one point, the mother told her to wait until she got home. It was also reported that when MGPs were told to get the VC to a hospital, they stated they did not have the gas to do that. The MGGM was called and when she got there, she stated that no one seemed inclined to call for the EMS so she did it herself. The MGGM told the caseworker that the reason maternal grandparents didn't do anything is because, if mother took paramour's side, they would have no place to live.

The mother gave birth to the VC's younger sister on 10/2/15. [redacted] the infant's biological father is unknown. The newborn sister was placed in a county approved foster home. The permanency goal for all three children is return home with a concurrent goal of adoption. Both the mother and father have bi-weekly supervised visits. The siblings also have visits on a bi-weekly basis.

On 11/06/15, the Agency made a determination on the report received 9/8/15 that resulted in bodily injury of the VC. The mother's paramour was indicated as perpetrator by commission.

On 11/19/15, the Agency made a determination on the report received 9/22/15 that resulted in bodily injury and registered as a near fatality of the victim child. The mother's paramour was indicated as perpetrator by commission and the mother, maternal grandmother, and maternal grandfather were indicated as perpetrators by omission.

On 11/19/15, the Agency made a determination on the report received 9/22/15 that resulted in bodily injury of the VC's older sister. The mother's paramour was indicated as perpetrator by commission. The mother, maternal grandmother, maternal grandfather, and maternal great grandmother were indicated as perpetrator by omission.

On 11/19/15, the Agency made a determination on the report received 9/23/15 that resulted in the serious physical neglect of the victim child through the failure to provide medical care or treatment. The mother, her paramour, maternal grandmother, and maternal grandfather were indicated as perpetrator by commission.

[redacted] The VC [redacted] to the PGM's kinship home on 10/23/15 [redacted] The VC continues [redacted] The eldest sister is participating [redacted] Services for the mother include [redacted] The father was also referred [redacted] but had not initiated enrollment. He is enrolled in GED classes.

**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 interactions between CYS and medical personnel at the Children's Advocacy Center, specifically with Dr. [redacted] and Dr. [redacted], were noted as positive. The agency has been able to consult with both doctors throughout the review of the case.
  - There was also a positive working relationship between CYS and [redacted] Police Department during the investigation. Everyone was kept well informed of all information between the police department, DA's office and CYS throughout the investigation.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None identified.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - It was recommended for CYS to develop a policy involving coordination and consultation between workers when there are two CYS workers assigned to a family. In Northumberland County, when a family is accepted for services, the family is assigned an In-Home worker but when a CPS report comes into the agency a CPS worker is also assigned. The In-Home workers do not investigate CPS reports.
  - The County CYS should consult with the CAC if there is questionable bruising/concerns, even if medical records/notes indicate otherwise. In this case, the child was seen in two separate Geisinger Medical Center Emergency Rooms for an alleged fall down the stairs resulting in the child having significant injuries. Both ERs [redacted] with no referrals made to CYS.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  - None identified.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - The agency should contact Geisinger Medical Center's legal department regarding concerns that were identified during review of the case. [redacted] It should also be noted that Dr. [redacted] indicated that he planned to consult [redacted] regarding the handling of the ER visits.
  - Local EMTs should receive training about child abuse, what to look for and how to keep the potential crime scene preserved.

**Department Review of County Internal Report:**

The County Internal Near Fatality Review Team held an Act 33 meeting on 10/17/15 where medical information and case history were presented. A follow up meeting occurred on 11/4/2015. The County report was received on 12/23/15. On 12/31/15, CROCYF notified NCCYS Administrator via letter that the report on the VC was reviewed and the regional office accepted the recommendations of the Act 33 review team.

**Department of Human Services Findings:**

- County Strengths:
  - The County worked cooperatively with law enforcement and medical providers.
  - The county solicited medical consultation from members of the Act 33 review team to ensure a comprehensive evaluation from a child trauma specialist after concerns were raised about the other medical examination conducted by emergency room staff.
  - The county convened a follow up meeting with the Act 33 team to discuss additional information obtained during the investigation to support the effectiveness of the review.

- County Weaknesses:
  - The ongoing casework staff noted bruising on the VC's sister at the 9/16/15 home visit that was not noted at the visit on 9/10/15. It was discussed with the supervisor but the child was not interviewed away from the mother about the bruises. Two additional CPS caseworkers were involved due to additional reports and the ongoing CW consulted them. It was discussed that no one saw the bruises at the prior visit but no additional action was taken other than asking the mother how they occurred.

- On 8/15/15, the Agency placed the four minor children of the MGM and MGP due to concerns about their ability to provide adequate care of the children. The MGPs were then allowed to act as supervision over the mother's paramour as part of a safety plan.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - Per weakness identified above, the caseworker did not assure safety at every contact. The child was seen with bruising but was not interviewed about how her injuries occurred. A licensing inspection summary will be issued citing the areas of regulatory non-compliance. The Department will follow up with the county to assure compliance with their plan of correction.

**Department of Human Services Recommendations:**

DHS offered the following practice recommendations as a result of the findings in this review:

- The Agency should hold team reviews when multiple caseworkers from different units are working cooperatively with a family. Caseworkers and their respective supervisors should jointly discuss all case activity on a scheduled basis to address how their individual roles affect the comprehensive picture of the family.
- The Agency should evaluate the Safety Planning process and the individuals the Agency is approving as able to provide supervision of an alleged perpetrator. It should be discussed as to when individuals with recent or active placements of their own should be considered as supervising caretakers.
- The Administrative review process for how case supervision is documented should be reviewed to assure timelines are met.