COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: August 17, 2011
Date of Near Fatality Incident: December 4, 2011

FAMILY KNOWN TO:
Luzerne County Children and Youth

Date of Oral Report: 12/05/2011
Date of Report Finalized: 02/01/2013

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 reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.[1]

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 convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	August 17, 2011
[redacted]	Mother/Child of [redacted]	[redacted] 1994
[redacted]	Father	[redacted] 1993
[redacted]	HHM/[redacted] Paternal Great Aunt	[redacted] 1955
[redacted]	Maternal Grandmother of [redacted] Mother of [redacted]	[redacted] 1972
[redacted]	Maternal Uncle of [redacted]	[redacted] 1995
[redacted]	Maternal Uncle of [redacted]	[redacted] 2001
[redacted]	Maternal Uncle of [redacted]	[redacted] 2002
[redacted]	Maternal Aunt of [redacted]	[redacted] 2007
[redacted]	Maternal Great Grandfather of [redacted]	[redacted] 1946
[redacted]	Father of [redacted]	
[redacted]	Father of [redacted]	[redacted] 1965
	Maternal Grandfather of [redacted]/Father of [redacted]	Unknown

Notification of Fatality/Near Fatality

On December 4, 2011, Luzerne County Children and Youth (Agency) received a general protective services referral regarding the victim child. The child had been brought to the Wilkes-Barre General Hospital in cardiac arrest and was revived. The child went into cardiac arrest due to bleeding in the head but it was unknown if the injury was non-accidental, therefore, it was not registered at that time as a child abuse investigation or a near fatality. The child was then life-flighted to Geisinger Danville Hospital. The exam revealed a [redacted]. The parents had no explanation for the child's condition. On December 5, 2011, the agency [redacted] registering the report as a case of suspected child abuse. The child was expected to live; however, he was certified to

[1] 23 Pa, C,S, § 6343(c)1,2.

be in critical condition as a result of suspected abuse on December 7, 2011 by [redacted] at Geisinger Hospital, Danville.

Summary of DPW Child (Near) Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families obtained and reviewed all past and current case records pertaining to this family. The Regional Office also attended and participated in two Act 33 review meetings in regards to this near fatal incident. Information was also obtained, discussed and reviewed with the Luzerne County CPS Supervisor, the Ongoing Casework Supervisor and the County CYS Manager.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

The victim child's maternal grandmother and her children, including the victim child's mother, have had a long history with children and youth agencies in New York and Pennsylvania. She has an ongoing history with Luzerne County Children and Youth dating back to 1991 with issues related to her parenting ability, [redacted]. In June, 1991, she moved from Luzerne County, PA to Rochester, NY with her three oldest children. These three children were removed from her care when she was in New York and placed into the custody of the children's maternal grandfather. Reports indicate that the maternal grandmother had physically abused her oldest son and was unable to care for the other children. In September, 1992, she gave birth to her fourth child while a resident of Luzerne County. The case was reopened through Luzerne County Children and Youth due to her long standing history of [redacted] and lack of parenting ability. The maternal grandmother did participate [redacted] and parenting including admitting herself (with her son) [redacted]; however, she was unsuccessful in these services leading to her fourth child joining his siblings in the care of the maternal grandfather. In August, 1995, [redacted]; therefore, they have not been included in the family constellation section above.

The maternal grandmother subsequently gave birth to five more children. The oldest of which is the mother of the victim child. Luzerne County Children and Youth became re-involved with the family upon receipt of a referral in April, 2010 alleging that the fourth oldest child was truant from school. The agency addressed the allegations by attending a meeting to re-enroll the child in the [redacted]; however, because there were only a few weeks left to the school year, the child was not going to begin school until the next school year. On May 27, 2010, prior to closing the case, the agency received a second referral [redacted] was requesting that children and youth conduct an assessment due to the mother's inability to be located and lack of attendance at [redacted] who was active [redacted] and [redacted]. As a result of the assessment completed by children and youth, the agency [redacted]. The case has remained open since July, 2010.

In August, 2011, the agency received a referral regarding the birth of the victim child because the mother [redacted]. As a result of this assessment, this child's case was opened for services. The parents were referred for the [redacted] parenting program, [redacted] Therefore, at the time of this incident, there were two open cases with Luzerne County Children and Youth regarding this family. One case involved the maternal grandmother and her five children, including the victim child's mother who was seventeen at the time and one case regarding the victim child and his parents who were residing separately with the father's aunt.

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

At the time of this incident, there was a safety plan in effect due to the parent's use of marijuana. The safety plan required that both mother and father not be left unsupervised with the child. The father's aunt (HHM) and a family friend were identified as the responsible parties for ensuring that the plan was adhered to. The caseworker made both announced and unannounced visits to the family home; however, it would later be learned by the children and youth caseworker that the plan was ineffective in that it was not being adhered to by the parties involved.

It was reported that on the day of the incident, the maternal grandmother had stopped by the house to see the child after church and she and the mother left to go to the store. The father was feeding the child and the child began to vomit. The father put the child on his shoulder and burped the child and the child was not breathing. The mother and maternal grandmother returned home to the father yelling that the child was not breathing. The mother took the child from the father and the child was lifeless. The mother took the child into the streets knocking on doors and screaming for help. A neighbor from one road over heard the yelling, responded and attempted to perform CPR on the child while on the phone with 911. The child was not responding. The police and ambulance arrived and took the child to Wilkes-Barre General Hospital. Neither parent nor the paternal great aunt (household member) had an explanation for the child's injuries.

The child was life-flighted to Geisinger Hospital Danville where he was diagnosed with [redacted] After further examination, the hospital concluded that the number and location of the [redacted] as well as the presence [redacted] is absolutely [redacted] of abusive head trauma.

The child had [redacted] on December 6, 2011 to reduce the pressure caused by [redacted]. The child was on a [redacted] but was able to take breaths on his own. He was displaying basic brain function activities, was responding to pain and was able to cough. He had [redacted] to [redacted]. On December 22, 2012, the child was [redacted] Rehabilitation Center in Scranton, PA. Within a week, the child was transported back to the hospital with an elevated temperature and seizure activity. A determination was made that [redacted] and needed to be removed. The caseworker was unable to contact the mother so a court order had to be obtained to do [redacted]. Ten days later, the child returned to the rehabilitation center.

The father was interviewed by law enforcement on December 9, 2011 and admitted to shaking the baby on one occasion. He was arrested and was incarcerated.

Current/Most Recent Status of Case:

Both cases continue to remain open with the agency; however, mother is now eighteen. The child has remained in the rehabilitation center since being [redacted]. The physicians report that the child is [redacted] and will require 24 hour care and will not have coherent thoughts and will not walk or talk.

The mother has not engaged in [redacted] services which include a [redacted], and parenting education [redacted]

The father has remained incarcerated pending charges of Aggravated Assault, Simple Assault, Endangering the Welfare of Children and Recklessly Endangering Another Person. He has participated in [redacted] while incarcerated and has begun to study for his GED.

The CPS investigation was concluded on January 19, 2012. The case was INDICATED due to the

physical abuse of the child. The father was named as a perpetrator for physically injuring the child and the mother and paternal aunt were named as perpetrators for failing to protect the child by not adhering to the safety plan.

County Strengths and Deficiencies as Identified by the County's Near Fatality Report:

County Strengths: The county near fatality report indicated that all regulatory mandates were met in regards to the CPS report including response times, interviews and paperwork.

County Weaknesses: The county near fatality report indicated deficiencies in the county's GPS intervention prior to this incident. The county near fatality report stated the following: Although a risk assessment was completed, there was no indication that it was reviewed by a supervisor. A safety assessment was also completed; however, this too was unsigned by the supervisor and, therefore, it is unknown if it was an accurate description of safety threats. Although the safety assessment did not reflect a need for a safety plan, a safety plan was developed. On at least one occasion, the plan was violated. The plan was also difficult to monitor as the child resided in the home with his parents.

Another weakness identified by the county near fatality report was the adolescent unit's involvement with the case due to their focus primarily being on the child that was delinquent/dependent and the other children in the home were not seen on a consistent basis. The mother of the victim child was residing outside of the home and, despite being a minor, her circumstances were not assessed.

Although the county near fatality report stated that the safety assessment did not reflect a need for a safety plan and the mother of the victim child was residing outside of the home, these are inaccurate statements that will be addressed in the Department of Public Welfare (DPW) Findings section below.

County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:

It was recommended that the caseworker and supervisor receive additional training; however, they are no longer employed at the agency. It was further recommended that, in the future, assessments be completed on the entire family and all children's needs continue to be evaluated and assessed and that the adolescent worker complete the assessment and provide services to the family, as the case was already open through shared case management.

Department of Public Welfare Findings:

County Strengths: The county agency has a defined referral process for shared case management cases and has a good working relationship with their Juvenile Probation Department. The agency has been participating in safety support sessions on a monthly basis to increase knowledge and competency in the utilization of the safety assessment and planning process.

County Weaknesses: The assessment by children and youth in this shared case management (SCM) case was clearly focused on the identified child rather than the assessment of the entire family. The family had been open with the agency since July, 2010; however, the focus was on one of the children's involvement with the juvenile probation office rather than the assessment of the entire family; including four other children residing in the home. Although the identified SCM child was seen monthly by either the children and youth caseworker or Juvenile Probation Officer, the other four children were not. They were initially seen in April and May, 2010. One of the four children was seen in November, 2010 and two of the four children were seen in December and January, 2011. Despite the victim child's mother disclosing her pregnancy during the November, 2010 contact, she is not seen again by a children and youth worker until the referral is received in August, 2011 due to the birth of the victim child and mother's [redacted]. Caseworker visitation with the three children remaining in the

home began again in November, 2011; however, one of the children was not seen in March, 2012 and none of the children were seen in June, 2012. The agency reported that the children were not seen in June because they are with their father in New York for the summer.

Although a preliminary safety assessment was completed upon a referral that the victim child's mother [redacted] at the time of the victim child's birth, the safety threat that was identified [redacted] appears to be a risk rather than meeting the criteria to be considered a serious, out of control, imminent threat to the child. The safety plan developed was too difficult to monitor since it involved two persons responsible; one that worked full time and the other that did not reside in the home. A bus pass was provided to the mother and father that would require they take the bus unsupervised with the child. Neither the safety assessment nor plan was signed by the casework supervisor. The risk assessment was also not signed by the supervisor. Because the identified safety threat was unclear, it was also unclear what the plan was keeping the child safe from. Given the information gathered, a safety plan did not appear to be warranted at that time. Although the preliminary safety assessment completed on August 22, 2011 states that the father was seen, the case notes indicate that he was not seen because he was at a job interview. The record reflects that the father was first seen in person during the November 8, 2011 home visit.

The county internal report contained inaccurate information including that the mother resided outside of the home. At the time the case was opened in July, 2010, the mother of the victim child was not pregnant and was residing in the family home. At the time of the August, 2011 referral, she was residing outside of the family home. The internal report also stated that "although the safety assessment did not reflect a need for a safety plan, a safety plan was developed". The safety assessment completed on August 22, 2011 did identify a safety threat; however, the justification/explanation provided did not appear to meet the safety threshold and therefore, at that time, the identification of a safety threat was inaccurate.

It is clear that supervision of this case was lacking. Given the previous children and youth history with the family, this case warranted more intense supervisory oversight and continuous assessment of the safety of all of the children. The need for supervisory oversight has repeatedly been discussed, reiterated and supported by DPW through technical assistance, licensing, NGA/case review meetings and Safety Support Sessions.

Statutory and Regulatory Compliance Issues:

There were several regulatory compliance issues pertaining to this case including the following:

1) The minimum monthly face to face contacts with all of the children in the family did not occur since the opening of the case in July, 2010.
2) Upon receipt of the August 19, 2011 referral regarding the birth of the victim child, a response time was not assigned.
3) The initial safety assessment completed on August 22, 2011, did not provide an appropriate explanation for how [redacted] met the safety threshold. The safety assessment stated that the father of the child was seen on that date; however, the record reflects that he was not present for the home visit. According to the record, he was not seen until November 8, 2011. Neither the safety assessment nor safety plan was signed by the supervisor.
4) The initial risk assessment completed at the conclusion of the assessment in July, 2010 included the four children residing in the home; however, subsequent risk assessment completed in January, 2011 and July, 2011 only included the child receiving SCM services. The other four children were not assessed again until November/December, 2011. Although risk assessments do not have to be completed every six months if the risk remains low, the children in the home were not seen monthly; therefore, a low risk could not be concluded.
5) The risk assessment dated August 22, 2011 was not signed by the supervisor.
6) Ten day supervisory reviews for the August, 2011 GPS referral and the December, 2011 CPS referral were not conducted as required.