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REPORT ON THE NEAR FATALITY OF:



DATE OF BIRTH: 8/31/2005
DATE OF NEAR FATALITY INCIDENT: 5/20/2011
DATE OF ORAL REPORT: 5/21/2011

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

REPORT FINALIZED ON: 08/29/2011

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 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. Northampton County Department of Human Services Children, Youth and Families Division 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	8/31/05
[REDACTED]	Mother	[REDACTED]/70
[REDACTED]	Father	[REDACTED]/79
[REDACTED]	Sibling	[REDACTED]/99
[REDACTED]	Sibling	[REDACTED]/10
[REDACTED]	Mother's paramour	[REDACTED]/84
[REDACTED]	Paternal grandmother/caregiver	[REDACTED]/55

Notification of Child Near Fatality:

On 5/21/2011 Northampton County Department of Human Services, Children, Youth and Families Division received a referral [REDACTED] regarding [REDACTED] (victim child). The allegations stated that [REDACTED] (victim child's mother) took the child to the hospital on 5/20/11 due to a [REDACTED]. The treating physician stated that the victim child's condition is a result of [REDACTED]. The victim child's condition worsened as a result of neglect. The victim child was admitted to the hospital on [REDACTED]

On 5/26/11 [REDACTED], the treating doctor certified the victim child to be [REDACTED] by the parents. If he wouldn't have received treatment it would've been life threatening.

Summary of DPW Child (Near) Fatality Review Activities:

The Child Protective Services (CPS) investigation was conducted by the county agency. The Northeast Regional Office of Children Youth and Families (NERO) investigation consisted of a review of the CPS file, review of case file, interviews with Northampton County Department of Human Services, Children and Youth Division staff and participation in the Act 33 meeting on June 23, 2011.

Summary of Services to Family:

Children and Youth Involvement Prior to Incident:

November 5, 2000 the case was opened due to an Indicated report of abuse by [REDACTED] (mother) paramour. [REDACTED] was also indicated for abuse by omission. [REDACTED] and her children received [REDACTED]. The perpetrator initiated [REDACTED]; however, he failed to complete it and moved to North Carolina.

September 19, 2004 Northampton County Department of Human Services, Children, Youth and Families Division received a report due to domestic violence and [REDACTED]. The report was screened out. No services were provided at that time.

December 9, 2004 Northampton County Department of Human Services, Children, Youth and Families Division received a report that the children [REDACTED] and the mother is behind on her rent.

May 11, 2005 the agency received a referral due to homelessness, [REDACTED]. On May 17, 2005 the family moved to Monroe County. The family was referred to Monroe County Children and Youth Services and the case was closed.

September 25, 2005 Northampton County Department of Human Services, Children, Youth and Families Division received a report that [REDACTED] (father) kicked [REDACTED] bassinet over while child was in it. As a result [REDACTED] had a bruise on his head. [REDACTED] was arrested and charged with one count of simple assault, endangering the welfare of a minor and recklessly endangering another person. The report was substantiated. There is a Founded report of Physical abuse [REDACTED] on [REDACTED] with his father being the perpetrator. The family obtained a [REDACTED] against father. The family received [REDACTED]. The case was closed December 29, 2005.

January 8, 2007 Northampton County Department of Human Services, Children, Youth and Families Division received a report that [REDACTED] was withdrawn and depressed. His sister [REDACTED] and was admitted to the hospital for [REDACTED]. No services were provided at this time. The case was closed January 18, 2007 after the agency investigated the allegations. The family continued to have a [REDACTED] against father.

October 2, 2007 Northampton County Department of Human Services, Children, Youth and Families Division received a report that 2-year-old [REDACTED] was not receiving appropriate medical care. His [REDACTED]. Medical appointments were scheduled for [REDACTED]. The parents were advised to go to custody court. An [REDACTED] referral was made for [REDACTED]. The case was closed November 8, 2007.

February 18, 2008 Northampton County Department of Human Services, Children, Youth and Families Division was court ordered to conduct comparative evaluations of the homes and living circumstances of each parent's home.

April 2008 Northampton County CYF received a referral stating that there was [REDACTED] in the home. The case was open for services and the issues were addressed by the ongoing worker.

May 1, 2008 Northampton County CYF received a report stating that [REDACTED] was not receiving appropriate dental care. Parents are in a custody battle. The issue with [REDACTED] dental care were addressed with both parents participating in the decision making process. Both parents agreed to [REDACTED] on 7/16/08. The case was closed 7/29/08. No other services were provided or offered to the family at that time.

There was no involvement with the family past 7/29/08 until the report of 5/20/2011.

Circumstances of Child Near Fatality and Related Case Activity:

Six-year-old [REDACTED] was hospitalized on 5/20/11 due to having a [REDACTED].

[REDACTED], DDS (treating emergency room doctor) was concerned about the extensive decay and overall neglect of [REDACTED] teeth. [REDACTED] all had access to care through insurance, however, have not followed through with medical recommendations. The victim child has not had [REDACTED] in 23 months. [REDACTED] will need [REDACTED].

[REDACTED], DDS reported that it is hard to determine how quickly things progressed, but without a dental exam at least twice a year, the victim child's [REDACTED] were never addressed. His [REDACTED] was so severe that it required [REDACTED]. If the victim child was not taken to the hospital emergency room for treatment, the [REDACTED] could have [REDACTED].

[REDACTED] dental issues impact his eating and affect the eruption of his permanent teeth. He needs to see a dentist every 3-6 months to monitor for the start of pathology.

This case was assigned an Indicated Status on 7/19/11 based on medical evidence and the CPS investigation. The case remains open for services. The family is receiving parenting education through [REDACTED].

Current Case Status:

- The case was opened for services to monitor the family's compliance with [REDACTED] medical care.
- The agency is monitoring [REDACTED] medical and dental needs and appointments, parenting education, dental education, and nutrition is being provided by [REDACTED].
- [REDACTED] lives with his mother, [REDACTED], Sunday through Wednesday one week and then the next week he lives with his mother Sunday through Thursday. [REDACTED] lives with his father, [REDACTED], Wednesday through Sunday one week and Thursday through Sunday the next week. At this time there does not appear to be any

issues with [REDACTED] siblings and they remain in the care of [REDACTED] on a full time basis. The agency will continue to monitor their dental, nutritional and educational needs as well.

- The criminal investigation is pending.

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

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 convened a review team on June 23, 2011 in accordance with Act 33 of 2008 related to this report.

Strengths: As a result of the OCYF review of the circumstances surrounding the child's near fatality incident including the CPS 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 victim child to stay with paternal grandmother until mother could be assessed. Once the agency completed a safety assessment and clearances, the agency determined that [REDACTED] would not be in any immediate danger while in his mother's care. The victim child was able to resume contact with his mother. The child was determined to be safe each time he was assessed. The agency made an announced and an unannounced home visits to assess the safety of the child during the investigation. The family was accepted for services.

- Deficiencies: The allegations were reported and investigated in 2008. The agency should have contacted the child's dental/medical providers prior to case closure to determine a course of action that should be taken in case the family did not follow through with [REDACTED] medical care.
- Recommendations for Change at the Local Level: Northampton County Children, Youth, and Families should establish a working relationship with local medical providers in order to encourage the accurate reporting of suspected child abuse/and or neglect
- Recommendations for Change at the State Level: OCYF should offer ongoing training on mandating reporting as well as any new laws, regulations and bulletins to public and private social service agencies. This will help keep everyone informed of the requirements and their responsibilities.

Department Review of County Internal Report:

Northampton County Children, Youth and Families internal report met the requirements of Act 33 of 2008. The Department agrees with the findings. Further information is addressed in subsequent sections.

Department of Public Welfare Findings:

- **County Strengths:** The agency assessed the safety and risk of the children as required. The victim child and his siblings were deemed to be safe with their caretakers.
- **County Weaknesses:** The agency did not use the safety assessment to accurately assess all three perpetrators; therefore a safety plan was created that did not meet the SOOVI threshold. The agency needs additional training with the In-Home Safety Assessment Tool.
- **Statutory and Regulatory Areas of Non-Compliance:**
As a result of the DPW review of the circumstances surrounding the child's near fatality incident including the CPS 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 as required. An initial safety plan was implemented which required the child to have supervised contact with his father and no contact with his mother until further assessment. The victim child remained in the care of his paternal grandmother until the agency deemed it appropriate for the child to have unsupervised contact with his father and contact with his mother. The child and his siblings were determined to be safe each time they were assessed. The agency made an announced and an unannounced home visits to assess the safety of the child during the investigation. The family was accepted for services.

Department of Public Welfare Recommendations:

This recommendation is a result of the family's initial contact with Northampton County Department of Human Services Children, Youth and Families Division. When a family is involved with other social services agencies Northampton County Department of Human Services Children and Youth Division, should contact them prior to closing the case to make sure that there are no other issues or concerns that need to be addressed with the family. Northampton County Department of Human Services Children, Youth, and Families Division should have informed the child's medical providers, more specifically the child's dentist, of mandated reporting responsibilities in the event that issues or concerns arise they will be obliged to report concerns.

The agency closed the case without informing the child's medical providers that they should contact the agency if the family fails to follow through with child's medical treatment. Adult Probation assumed that Children & Youth would continue to monitor the father's compliance with [REDACTED] throughout the course of his probation.