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REPORT ON THE NEAR DEATH OF



BORN: 1-14-08
DATE OF NEAR FATALITY: 4-11-09

FAMILY WAS NOT KNOWN TO:
PIKE COUNTY CHILDREN AND YOUTH

REPORT DATE: 01/14/10
REPORT FINALIZED: 02/04/10

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 by Governor Rendell 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 review 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]	Mother	[REDACTED] 1968
[REDACTED]	Father/Step-father	[REDACTED] 1962
[REDACTED]	Half-sibling	[REDACTED] 1994
[REDACTED]	Half-sibling	[REDACTED] 2003
[REDACTED]	Half-sibling	[REDACTED] 2005
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Victim	1/14/2008

Notification of Near Fatality:

On 4/04/09, Mother reported child was looking out the a first floor window, the screen pushed out and the child fell out the window. The child was taken to Bon Secours Hospital. A CAT scan was done with normal results. The child was released to his parents. This was not originally called in to CYS. On 4/11/09, child was running in the house. Mother heard a thud. Mother found child lying on the floor. Child was lethargic and mother took him to Newton Memorial Hospital. Child was transferred to Morristown Memorial Hospital. Child was found to have a [REDACTED] and a [REDACTED]. [REDACTED]. Child was admitted to the hospital at this time.

2. Documents Reviewed and Individuals Interviewed:

Pike County interviewed several doctors regarding this case (see chronology). The mother, father, grandmother, and children were also interviewed. NERO reviewed the CPS file including medical records, Safety Assessment, and Risk Assessment.

Case Chronology:

4/11/09-referral received by county.

4/11/09-CY-104 sent to law enforcement.

4/11/09-County worker interviewed mother at the hospital. County worker also spoke on the phone with [REDACTED] at Morristown Memorial, a family friend, the maternal grandmother, and Trooper [REDACTED] (PSP). Victim Child seen and photos taken. A

safety assessment was done on the victim child at this time. The child was deemed to be safe without a plan.

4/12/09-County worker called Morristown [REDACTED] for an update on the child.

4/12/09-County went to the home to assess Safety of the other children by using the safety assessment tool and not in need of safety plan. The older girls were seen privately at school.

4/13/09- County worker called Morristown Hospital and spoke with [REDACTED], Dr. [REDACTED]. At this point Dr. could not conclusively say how injury occurred.

4/13/09- County worker called Dr. [REDACTED] for an opinion regarding this type of injury. Dr. [REDACTED] stated generally that the 2nd fall could have exacerbated the first injury.

4/13/09- County worker spoke with Dr. [REDACTED], Morristown Memorial Hospital, on the phone. He stated that the first injury could have caused a small injury that could be missed in the CT scan, and the 2nd injury could have exaggerated the first injury and caused the bleed. Dr. does not believe this injury is consistent with child abuse.

4/13/09- Child discharged from the hospital to his parents. The county learned on 4/15/09 that the victim child was discharged from the hospital and released to his parents. The county made a home visit on 4/16/09 and assessed the children to be safe without a plan. The mother had family supports. The grandmother and father were also in the home to assist with supervision. The county did not feel the need to take custody of the child upon discharge from the hospital.

4/15/09- PC to mother. Told mother she will be doing a visit in 2 weeks and likely close the case. Subsequently, the Northeast Regional Office reviewed the file and felt that based on supervision issues and the age of the children, the mother could benefit from services. It was decided that the case would be opened.

4/23/09- PC the [REDACTED] to check on medical on all kids. No issues.

4/24/09 and 4/27/09- County worker called the school to check on the 2 older girls. Some minor issues in school (tardiness, homework not turned in, child coming to school tired).

5/08/09-County worker visited the home to discuss school issues.

5/08/09-case transferred for ongoing services.

5/08/09-[REDACTED]

Previous CY involvement:

This family was not known to Pike County prior to the report on 4/11/09.

Circumstances of Child's Near Fatality:

Child leaned against the screen and fell out the window on 4/04/09. Child was taken to the hospital by mother. This was not called in to CYS. On 4/11/09, the child again fell and was lethargic. Mother took child to a different hospital for this injury. [REDACTED]

[REDACTED], the 4 year old child admitted to leaning against the victim child (at the window) the day the victim child fell out of the window. He also advised that he pushed the victim child off the chair (on 4/11/09), resulting in the second injury. Safety assessments were completed on the children. Safety assessments determined that a safety plan was not necessary. Caseworker did discuss better supervision with parents.

Current / most recent status of case:

- [REDACTED]
- Case was accepted for investigation and opened into ongoing protective services [REDACTED]
- Child was discharged from the hospital to his parents care on 4/13/09.
- As part of the service plan, the family was involved with the Nurturing Parenting Program, The Center for Developmental Disabilities, and Early Intervention. The Agency continued to monitor safety during intervention through visitation with the family.
- There were no criminal charges filed regarding this case.

Services to children and families:

Services to the family included parenting, early intervention, and involvement with The Center for Developmental Disabilities for [REDACTED].

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

There were no recommendations for change at the local level. This family was not known to the agency prior to the report on 4/11/09.

NERO Findings and Recommendations:

NERO reviewed this file at the time of the incident. NERO recommended the responses to evaluate safety of the children at home should be done immediately. NERO did not feel that safety was adequately addressed in this case. The county did not feel that supervision was an issue and did not address with the family a need for closer supervision of the younger children. NERO pointed out supervision concerns and recommended ongoing services for this family.

Statutory and Regulatory Compliance issues:

- Safety Assessments were completed within regulatory requirements.
 - The investigation was completed within 30 days.
 - All pertinent parties were interviewed.
 - RA's were completed accurately.
 - The family was accepted for services and an FSP was developed for the family within the regulatory time frame.
 - All children in the home were evaluated and provided with services as mentioned above.
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