



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 5/28/14
Date of Incident: 8-26-14
Date of Oral Report: 8/26/14

FAMILY KNOWN TO:

Schuylkill County Children and Youth

REPORT FINALIZED ON:

January 12, 2015

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.

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, DHS 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. Schuylkill County 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>
██████████	Child Victim (CV)	██████/14
██████████	Mother	██████/96
██████████	Maternal Grandmother to CV	██████/69
██████████	Maternal Grandmother Paramour	██████/69
██████████	Alleged Father of CV	██████/87

Notification of Child Near Fatality:

On 8/26/14 at 4:15 am Schuylkill County Children and Youth (CYS) was contacted with a report of suspected child abuse on child victim who was hospitalized due to ██████████. Child's mother reported she was feeding child when child turned blue. Child's mother contacted EMS who stimulated and intubated child. Child was flown to Lehigh Valley Medical Center and a near fatality report was reported ██████████.

The case was assigned to Child Protective Service (CPS) Caseworker, ██████████, at 8:30 AM on 8/26/14 who contacted ██████████ Police for assistance. ██████████ reported ██████████. Police were currently at mother's home ██████████.

Summary of DHS Child (Near) Fatality Review Activities:

The NERO (Northeast Regional Office) obtained a copy of the case file regarding the family. The existing file as well as the new information gathered regarding the current CPS was reviewed. The NERO also participated in the Near Fatality Review Meeting held on September 18, 2014. The parenting provider was present at the meeting so NERO was able to interview them regarding their involvement with the family. Medical reports were also reviewed at this time.

Children and Youth Involvement prior to Incident:

On 6/5/14 Schuylkill County Children and Youth received a [REDACTED] regarding child victim being born premature 5/28/14 and being transferred [REDACTED]. During hospitalization, child's mother needed constant reminders on basic care for child including feeding, changing clothes and diapers and bathing. Hospital staff expressed concern with mother's [REDACTED] and ability to follow through with role modeled tasks. By the end of the child's stay at the hospital, staff felt more positive regarding mother's interactions with and ability to care for child. Child [REDACTED] the hospital [REDACTED] 14 with a recommendation for [REDACTED] checks with pediatrician, a referral for [REDACTED], a referral for [REDACTED] and a referral for [REDACTED].

Child was seen at pediatrician 6/20/14, 6/27/14, 7/3/14 and 7/29/14 for weight checks. When agency staff spoke with child's pediatrician on [REDACTED] 14 he reported concerns with mother's [REDACTED], as she is diagnosed with [REDACTED], but felt child's growth was progressing well since discharge from hospital.

[REDACTED]

Circumstances of Child Near Fatality and Related Case Activity:

On 8/26/14 [REDACTED] responded to the hospital to interview hospital staff and child's mother. At that time, mother admitted that she threw the child against the wall due to the child not eating well.

On 8/26/14 [REDACTED] and child's mother was transported from hospital back to [REDACTED] Police station for further interview. Child's mother was subsequently taken to child's home for videotaped reenactment of incident. Child's mother

was incarcerated on [REDACTED]/14 for [REDACTED]
[REDACTED]

On [REDACTED]/14 a [REDACTED] regarding child. [REDACTED] was present for hearing. Child remained in [REDACTED] was present for [REDACTED]

On 8/29/14 the agency was contacted stating the child was [REDACTED]
[REDACTED]

On 9/8/14 mother presented with counsel for her preliminary hearing and waived all charges for court.

On [REDACTED]
[REDACTED]

On 8/29/14 maternal grandmother and paramour who live in home with child and mother were interviewed by CPS investigator, [REDACTED]. Both denied hearing anything out of the ordinary on morning of said incident. On 9/24/14 grandmother's paramour passed a polygraph in reference to child's [REDACTED] and concerns regarding said morning of incident. On 9/26/14 child's maternal grandmother passed polygraph.

On 10/01/14 the CY48 was completed and submitted to ChildLine with the case status of Indicated for Physical Abuse against child's mother. The child's mother was interviewed by police and CYS and admitted to throwing child against the wall on 8/26/14.

Current Case Status:

Mother remains incarcerated since 8/26/14 for aggravated assault, simple assault and endangering welfare of children.

The child remains in [REDACTED]
[REDACTED]

The county is doing [REDACTED]. The current goal is return home at this time with a concurrent goal of adoption. The county did not initially pursue aggravated circumstances because there was a question as to whether the mother [REDACTED]. At this time, the mother [REDACTED] and the agency

intends to go forward with an aggravated circumstances hearing. The mother has not been receiving services through Children and Youth due to her incarceration. She does not want visitation with the child.

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

- **Strengths:** The strengths identified at the Near Fatality Review meeting included the fact that the mother sought help at the emergency room for issues of the child having difficulty eating and sleeping.
- **Deficiencies:** While the mother seeking help at the ER was identified as a strength, the fact that the ER never reported concerns to CYC was seen as a deficiency. Additionally, the mother did not report these concerns to [REDACTED] agency she was working with which suggests a lack of trust/communication. Another deficiency identified was that the mother was not referred to a [REDACTED] program (i.e. [REDACTED] [REDACTED] usually make this referral. The District Attorney was invited to the Near Fatality Review but did not attend. This has been an ongoing concern in the county.
- **Recommendations for Change at the Local Level:** A recommendation was made for a discussion to occur with ER staff regarding the need for a social work referral or a referral to CYC regarding neglect/GPS issues. Recommendations were made to reach out to the prenatal community to be part of the Act 33 Review Team and for invitations to be mailed to all service providers involved with the family over time for future Review Team meetings. Changes to protocol were also made internally for weekly telephone contact between case managers and contract service providers. A long discussion was held regarding communication between the agency's contracted providers and caseworkers at Schuylkill County Children and Youth. Suggestions were made for immediate telephone calls, team meetings, or co-occurring home visits when families are reluctant to services or concerns are noted with high risk infants.
- **Recommendations for Change at the State Level:** There were no recommendations made regarding change at the state level.

Department Review of County Internal Report:

Schuylkill County's Near Fatality Team submitted their Near Fatality Report on December 12, 2014. This report was reviewed by the NERO. The NERO concurs with the contents of the county report. On December 17, 2014, a letter was sent to the County Director acknowledging receipt of the report as well as concurrence with its content.

