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**OFFICE OF CHILDREN, YOUTH AND FAMILIES  
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**REPORT ON THE NEAR FATALITY OF**



**BORN: 01/18/2007**

**DATE OF NEAR FATALITY: 12/15/2010**

**FAMILY WAS NOT KNOWN TO TIOGA COUNTY DEPARTMENT OF HUMAN SERVICES**

**DATE 03/31/2011**

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 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 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

**1. Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	uncle/guardian	[REDACTED]
[REDACTED]	aunt/guardian	[REDACTED]
[REDACTED]	cousin	[REDACTED]
[REDACTED]	cousin	[REDACTED]
[REDACTED]	½ sister	[REDACTED]
[REDACTED]	great aunt	[REDACTED]
[REDACTED]	great aunt's paramour	[REDACTED]

**Notification of the Near Fatality:**

On December 14, 2010, a worker at [REDACTED] in Wellsboro, PA, made a referral to [REDACTED] regarding [REDACTED]. The VC's aunt/uncle (guardians) brought the VC to [REDACTED] Emergency Room (ER) at approximately 7:00 P.M. on 12/14/2010. [REDACTED] As a result, the Tioga County Department of Human Services (TCDHS) was assigned an investigation for medical neglect.

**2. Documents Reviewed and Individuals Interviewed:**

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the Child Protective Services case file and spoke with the caseworker, supervisor, and agency director to discuss the case. The Program Representative participated in the agency internal review via telephone.

**Case Chronology:**

**12/14/2010** [REDACTED] contacted [REDACTED] to report [REDACTED]. The address that the hospital had on record for the VC was incorrect. As a result, Lycoming County Children and Youth Services (LCCYS) was given the initial [REDACTED]. The ER also notified [REDACTED] on 12/15 of the Near Fatality certification. LCCYS contacted the guardians on 12/14 via their cell phone as they were driving to Geisinger Hospital. LCCYS was provided the correct address for the VC. LCCYS did not call [REDACTED] until 12/15/2010 to report the correction.

**12/15/2010** A caseworker from TCDHS traveled to Geisinger to see the child and interview the VC's aunt. Another TCDHS caseworker visited the home where the VC's uncle/aunt/great aunt/great aunt's paramour/1/2 sister and two cousins resided. He interviewed the household members regarding the alleged fall on the 12/13.

**12/16/2010** TCDHS caseworker visited the ER to verify information. At that point the agency received conflicting information regarding the timeline of events which was provided by the VC's aunt and uncle. The caseworker contacted [REDACTED] office (VC's primary care physician) to discuss the timeline. The agency received a faxed report regarding the initial call from the aunt/uncle made to the doctor's office. The information was written in three different handwritings and timeframes were unknown, however the report also had some conflicting information which differed from what the family was providing the agency.

**12/17/2010** The TCDHS caseworker contacted Geisinger hospital, hospital staff began to question whether or not the alleged fall on 12/13 could have been the cause of the VC's injury. TCDHS completed a CY-104 referral to law enforcement. TCDHS proceeded to complete a safety assessment and developed an out of home safety plan for the other children who were in the [REDACTED] home [REDACTED]

**12/20/2010** [REDACTED] were completed by [REDACTED]. There were no indications [REDACTED]. [REDACTED] physician from Geisinger Hospital, contacted the TCDHS caseworker and informed him the VC's injury was not caused by the scenario that was provided by the VC's caregivers. The doctor reported [REDACTED]. The doctor had scheduled additional tests to rule out genetic issues, blood issues,

and to conduct a [REDACTED] to check for any previous breaks. As a result of these discussions TCDHS contacted [REDACTED]. As a result, TCDHS was assigned an [REDACTED]

12/22/2010 A TCDHS caseworker visited Geisinger Hospital where he attempted to talk with the VC, but he found that the VC was not able to communicate in a manner that would afford an interview. The TCDHS caseworker observed the interactions with the guardians and found them to be very appropriate. He met and talked with nurses and staff at the hospital.

12/23/2010 The TCDHS caseworker spoke with [REDACTED] again and he reported that the injury must have happened after lunch on 12/14 and it is [REDACTED].

12/23/2010 [REDACTED]

[REDACTED] notified the agency that they wanted to modify the out of home safety plan as a [REDACTED]

01/03/2011 72 [REDACTED]

01/04/2011 72 [REDACTED]

01/04/2011 State Police and TCDHS caseworker met to discuss case. [REDACTED] have obtained an attorney and are refusing to take a [REDACTED].

01/06/2011 [REDACTED]

1/11/2011 Internal team meeting was held. The meeting lasted for several hours, a variety of departments participated (TCDHS, police, district attorney's office, etc.)

01/18/2011 [REDACTED]

2/17/2011 [REDACTED]

2/18/2011 [REDACTED]  
3/10/2011 [REDACTED]

3/10-to present The [REDACTED] have continued to visit with the VC, attend medical appointments, etc. Ongoing concerns (parent child interaction, parenting, etc.) are being addressed by TCDHS.

\*It should be noted that throughout the case timeline, numerous discussions occurred between TCDHS and New York Children and Family Services. These discussions were the result of past involvement between the VC/VC's 1/2 sibling's mother and the New York agency. [REDACTED] Their mother currently resides in New York State and had [REDACTED]. Therefore discussions were held to obtain additional family information, [REDACTED].

**Previous CY involvement:**

The family was not known to the TCDHS.

**Circumstances of Child's Near Fatality:**

The aunt reported that the Victim Child (VC) fell on 12/13/2010. The morning of 12/14/2010, the VC woke up and vomited and lost consciousness. The aunt called the Soldiers and Sailors Hospital on 12/14/2010 at 7:00 a.m. The hospital instructed the aunt to bring the child to the hospital. However, the aunt reports she was instructed to contact the VC's primary care physician. The aunt contacted the VC's primary care physician office. The aunt provided additional information to the primary care physician. As a result the doctor's office instructed the aunt to take the VC to the hospital. The aunt called the hospital again later in the afternoon. It is not known what was discussed. The victim child was brought to the hospital at approximately 7:00 p.m. By 7:30 p.m. the victim child was [REDACTED]. VC transferred to Geisinger Hospital in Danville Pa. Due to weather concerns they were not able to get [REDACTED] out of Wellsboro so the VC left by ambulance. The ambulance transported the VC to Blossburg, Pa. where he was picked up by another ambulance and taken to Montoursville airport and [REDACTED] to Geisinger Hospital.

**Current / most recent status of case:**

- Both cases [REDACTED].
- Family resources are currently being assessed and a Family Services Plan is being developed.
- The VC [REDACTED]
- [REDACTED] have secured their own housing.
- [REDACTED]

[REDACTED] As a result of discussions with New York Children and Family Services, the VC's mother, etc. other relatives are [REDACTED]. Likewise, it has been determined that NY [REDACTED].

**Services to children and families:**

The family [REDACTED]. The agency has met with the family, however the agency and family could not agree on several services. Services which were agreed upon have begun to be implemented. These services include [REDACTED].

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

There were no recommendations for change at the county level.

**Statutory and Regulatory Compliance issues:**

As a result of the DPW review of the circumstances surrounding the [REDACTED], it was determined that the TCDHS conducted safety assessments and risk assessments accurately, the investigation was conducted in a timely manner, law enforcement was notified through the submission of a CY104. At the time of the near fatality the family was not receiving any services from TCDHS [REDACTED].

**Findings:**

The family/children were not known to the agency. The [REDACTED] was comprehensive. It should be noted the agency conducted a thorough internal review and produced a well written summary of the meeting and meticulous timeline.

**Recommendations:**

LCCYS (the agency which received the initial notification) should have immediately contacted [REDACTED] to report the correct address. The agency should closely monitor the ongoing cases, assess safety, and immediately notify the court if other safety issues arise.