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REPORT ON THE NEAR FATALITY OF



BORN: 05/17/2007
DATE OF NEAR FATALITY: 01/07/2010

FAMILY KNOWN TO: Lehigh County Children and Youth Services

DATED: 07/29/2010

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 31, 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 reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child/household member	05/17/2007
[REDACTED]	Mother/household member	[REDACTED] 1986
[REDACTED]	Father of [REDACTED] /household member	[REDACTED] 1986
[REDACTED]	Sibling /household member	[REDACTED] 2001
[REDACTED]	Sibling /household member	[REDACTED] 2003
[REDACTED]	Sibling /household member	[REDACTED] 2005
[REDACTED]	Sibling /household member	[REDACTED] 2009
[REDACTED]	Sibling /household member	[REDACTED] 2004
[REDACTED]	[REDACTED] Paternal grandmother.	[REDACTED] 1966
[REDACTED]	Niece of [REDACTED]	[REDACTED] 1993
[REDACTED]	Father of [REDACTED]	[REDACTED] 1981
[REDACTED]	Father of [REDACTED]	[REDACTED] 1985
[REDACTED]	Maternal Grandmother	unknown

Notification of Near Fatality:

The [REDACTED] was dated 01/07/2010 and stated that the victim child came to the emergency room because a television had fallen on his head. The caretaker had entered the room and found the television on top of the child. The child was at the hospital with a head injury. According to the ambulance crew, the caretaker could have been the grandmother who was not in the room at the time of the incident. The [REDACTED] was listed as "unknown" on the initial [REDACTED] report. The doctor certified that the child was in critical condition at the time and was unsure if the child would survive.

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families (NERO) Program Representative reviewed the [REDACTED] case file as well as the agency's prior involvement with the family. The program representative met with the caseworker, supervisor, and administration to discuss the case.

Case Chronology:

- 01/07/2010 Near death of the child. [REDACTED] notified.
- 01/07/2010 Law enforcement took photos of [REDACTED]. Lehigh County Children and Youth Services caseworker and Allentown Police Detective began interviews with the family. Preliminary safety assessment was completed by the [REDACTED] caseworker with a determination that the children were safe.
- 01/10/2010 Supplemental report received by Lehigh County Children and Youth regarding allegations of poor home conditions and drug usage.
- 01/11/2010 Home visit to the family residence to address allegations received in supplemental report.
- 01/11/2010 Child [REDACTED].
- 01/13/2010 CY-104 referral form sent to law enforcement by Lehigh County Children and Youth Services.
- 01/13/2010 A second Safety assessment was completed by Lehigh County Children and Youth Services as new information was received and a [REDACTED] caseworker became involved with the family. The children were determined by the [REDACTED] worker to be safe with a comprehensive safety plan. The Safety Plan was formulated and stated that the [REDACTED] would refrain from supervising, babysitting, and/or caring for the minor children with the exception of her 16 year old niece during the [REDACTED] investigation.
- 02/18/2010 [REDACTED] interviewed by County caseworker.
- 03/02/2010 Safety assessment completed at the conclusion of the [REDACTED] and assessment with a determination that the children are safe.
- 03/02/2010 Risk Assessment completed at the conclusion of the [REDACTED] [REDACTED] with an overall severity of High and an overall risk of Moderate.
- 03/02/2010 [REDACTED].

Previous Children and Youth Involvement:

This family has been referred to Lehigh County Children and Youth Services a total of eight times. The previous referrals included concerns such as lack of supervision, poor hygiene, poor home environment and child neglect. The most recent intake referral prior to this incident was from 10/13/2009 to 11/03/2009 regarding housekeeping issues and parenting skills surrounding discipline. The agency found that the home was in acceptable condition and that non-physical methods of discipline were used. The case was closed by the agency. The agency had involvement with the family from 01/08/2009 until 02/18/09 due to allegations of dental neglect. Again, the agency was unable to substantiate the allegations and the agency confirmed with the dentist that the children had dental appointments. The agency had involvement as far back as 2002 when [REDACTED] was a teen mom. The case had been opened from 09/24/2002 and remained open to assist with parenting services until 11/01/2005.

Circumstances of the Child's Near Fatality:

The [REDACTED] reported that on the day of the incident she was staying at her son's house as she had been visiting the family. She reported that her son had asked her to baby-sit three of his children as the other children were in school. She stated that she had agreed to babysit the children. She said that the children's room is located next to the room where she was staying. She said that she sat on the stairs in the children's room which leads to the third floor for approximately fifteen minutes watching all three children. She said that the victim child and his sister were sitting on the edge of the bed watching TV in their room. She said that she took the baby back into her room and sat on the bed while the two other children continued to watch TV in their room. She said that the door remained open between the two rooms. She said that she sat on the side of the bed and the baby was at the end of the bed playing. Her TV was on. She said that five to seven minutes had passed before she heard the children's TV fall to the floor. She believed that it was no more than ten minutes had passed that the children were in their room by themselves. When she heard the crash of the TV, the alleged victim's sister was standing in the doorway crying and making a motion to get her to come into the room. She immediately went into their room and observed the TV and the fish tank stand on the ground, reporting that the TV was on top of the alleged victim. (The TV was on the fish tank stand). She called to her niece's boyfriend who was in the house with her niece and had him lift the TV off the child and put the TV and the stand back into place. The alleged victim had his eyes closed and was reported to be limp. He was not responsive when the TV was lifted off of him. There was not a phone or cell phone in the residence so her niece's boyfriend left to call 911. The ambulance responded and she went with the child to the hospital. She reported that she had given them her other last name because she was scared that she had truancy related warrants for her niece as she was the guardian for her niece. They were visiting the alleged victim's family. She believes that the child may have been trying to climb on the front of the TV stand and it tipped over. The child was taken to Lehigh Valley Hospital where he was [REDACTED]. The child did not have an [REDACTED]. No [REDACTED] intervention was warranted at the time. The child was [REDACTED] on 01/11/2010. The recommendations for follow-up were to see his [REDACTED] and to follow-up with a [REDACTED]. The child has been referred for an [REDACTED] assessment and is reported to be doing well. All parties involved had been interviewed by Lehigh County Children and Youth Services and law enforcement investigated the incident also. The agency reported that the TV was an older model 20 inch TV that was on a wooden aquarium stand. The agency had also received a supplemental report alleging that the children are not being taken care of in regard to lack of food and dirty clothing in addition to drug involvement in and out of the home. Lehigh County Children and Youth Services did send the mother and father to [REDACTED] for a [REDACTED]. Both parents [REDACTED] and the mother's [REDACTED].

Current / Most Recent Status of Case:

The case was [REDACTED] Unit on 03/02/2010. The agency could not [REDACTED]

[REDACTED] Unit to determine if the family was in need of in home services or any community services. The victim child was referred for [REDACTED] in addition to medical follow up. The case was closed as the agency felt that the family had a significant amount of support from extended family members and was not in need of agency services. The agency reported that the family was cooperative with Lehigh County Children and Youth Services. Law enforcement completed their investigation and did not press any charges.

Statutory and Regulatory Compliance:

Lehigh County Children and Youth Services assigned a [REDACTED] Caseworker to investigate the [REDACTED] report of the near death of the child and also assigned a [REDACTED] Caseworker to assess the family's need for further agency services. As a result of both units assessing the family simultaneously, both workers completed preliminary safety assessments. The [REDACTED] Caseworker completed a preliminary safety assessment on 01/08/2010 with a determination that the children were safe. The [REDACTED] Caseworker completed a safety assessment on 01/13/2010 with a determination that the children were safe with a comprehensive safety plan. The safety assessment completed on 01/13/2010 was mislabeled as a "preliminary assessment." It is believed that this assessment was completed based on the supplemental report with new information that came to the agency's attention. The safety plan was that the [REDACTED] would not be a caretaker for the children and would have contact with the children supervised by the parents. A final safety assessment was completed by the [REDACTED] Caseworker on 03/02/2010, at the conclusion of the investigation. This safety assessment determined that the children were safe and was correctly labeled "conclusion of investigation/assessment."

Findings:

Lehigh County Children and Youth Services also investigated the supplemental report that came into the agency in addition to the [REDACTED] Report. However, the mother and father were sent for a [REDACTED] to determine if the drug and alcohol allegations received by the agency were able to be substantiated. The mother's [REDACTED]. There is no documentation in the record to show that the agency sent her for another [REDACTED] as the agency record refers to her [REDACTED]. The father's [REDACTED]. The [REDACTED] had also reported that she has a history of marijuana use, stating that her last use was over a month ago from the time of her interview. It is mentioned in the case record that she was [REDACTED] but there isn't documentation to support this or a copy of the [REDACTED]. She reports that she has custody of her sixteen year old niece from Lancaster County Children and Youth Services. Lehigh County Children and Youth Services conducted a chronic case review of this family's referrals on February 5, 2009.

Lehigh County conducts a review of all the referrals received and determines if the case can be closed or if the family is in need of agency services. This is done when there are several referrals received on the same family.

Recommendations:

NERO has informed Lehigh County Children and Youth Services that when a safety plan is formulated it needs to be signed by all parties involved. In this case, only the paternal grandmother signed the safety plan as she was not to be a caretaker for the children during the investigation. The children's parents did not sign the safety plan. The county agency has agreed to follow this recommendation and has been doing so in recent record reviews.

The agency closed the case with an overall risk rating of moderate. The rationale supporting the rating indicated that the overall risk could have been rated as low. If the agency assessed that the case should remain at a moderate level of risk, then consideration should have been made for the case to be opened for ongoing or supportive services.

The internal review conducted by the agency on 01/12/2010 was not detailed and was not a critical analysis of the agency's previous involvement in this case. NERO has discussed with Lehigh County Children and Youth Services administration that their internal review process needs to be more detailed and reflect strengths and challenges in the agency's handling of the case along with recommendations for improvement, either case specific or systemic. The agency uses a team approach before deciding to close a case, which does provide constructive input to the caseworker and supervisor. It is recommended that the team take a closer look at all required documentation prior to authorizing the case closure and also make sure that all allegations are resolved as well. It appears in this case that there were unresolved issues remaining such as the [REDACTED].