



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF**



**BORN: 11/18/04**

**Date of near fatality incident: 1/02/10**

**The family was known to Northumberland County Children and Youth Services.**

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 fatalities that were suspected to have occurred due to 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	11/18/04
[REDACTED]	Mother	[REDACTED]/86
[REDACTED]	Victim Child's half-brother	[REDACTED]/07
[REDACTED]	Father (non household member)	[REDACTED]/82
[REDACTED]	Mother's Paramour	[REDACTED]/87

**Notification of Near Fatality:**

On the morning of January 2, 2010 mother tried to wake up the victim child around 8:00 am. The victim child was lying in bed limp, unresponsive to the mother's attempts to arouse him. The victim child was still breathing. The mother called the victim child's primary care physician (PCP), [REDACTED] at the [REDACTED] around 9:00 am. The mother was told to place a cool damp washcloth on the child's face to attempt to arouse him from his deep sleep. When this along with other actions such as light pinching, clapping, and calling for the victim child to wake did not work, the mother transported the child to the clinic at approximately 10:10 am for an evaluation. The victim child's vitals were good but he was unresponsive. [REDACTED]

[REDACTED] He was certified by medical staff to be in serious critical condition due to his alcohol consumption. [REDACTED]

[REDACTED] The county agency was actively involved with the family at the time of this referral with the county agency having legal custody of the victim child and his sibling, but physical custody being with the mother. [REDACTED]

**Documents Reviewed and Individuals Interviewed:**

The Central Region Office of Children, Youth and Families (CROCYF) reviewed the Northumberland County Children and Youth Services case file on this family, including the child's medical records from Geisinger Medical Center's Children's Hospital and Geisinger Medical Center's [REDACTED] Northumberland County Children and Youth Services were also interviewed regarding this case. The CROCYF attended the County Children and Youth Agency's internal review hearing on February 4, 2010 and March 8, 2010, and received the county agency's formal child near fatality report completed on April 16, 2010. The county agency held an emergency Multi-Disciplinary Team meeting on January 19, 2010 which was attended by CROCYF.

**Case Chronology:****Previous CY involvement:**

The family was known to the agency. On May 14, 2006, Northumberland County Children and Youth Services received a [REDACTED] Report alleging [REDACTED] of an 18 month old child (the victim child referenced in this report). The child was seen at Shamokin Hospital Emergency Room. The victim child had bruising and severe swelling to the left side of his face, left eye, bruising to the back of his left ear, an abrasion on the top of his head and older bruising on his back. [REDACTED]

[REDACTED] Neither the victim child's mother nor her paramour, both of whom were the caretakers of the victim child, were able to provide an explanation for the head injuries. A report was made to law enforcement on May 14, 2006 and the county completed and forwarded the CY104 on May 15, 2006. The county agency caseworker and the police met with the mother, victim child, and mother's paramour at the hospital on the same date as the referral. The mother was interviewed again on May 17, 2006 and the paramour was interview again on June 7, 2006 regarding the allegations.

On May 18, 2006, the victim child was [REDACTED]. Since the mother and her paramour were unable to provide explanation as to how the victim child's injuries occurred it was determined that a return home to mother's care could not happen since the victim child's safety could not be assured. A voluntary entrustment agreement was signed by the mother, placing the victim child in the custody of the county agency. The child was placed in an approved kinship care placement setting on May 17, 2006. On May 22, 2006, the victim child was moved to an agency approved foster home placement, as the kinship parent indicated the victim child was a very active child and she just could not care for him on a day to day basis.

[REDACTED]

Both individuals were in a caretaker role of the victim child. No criminal charges were filed against the mother and her paramour.

On February 22, 2007 the victim child's mother gave birth to her second child, the victim child's half-brother. The natural father of the half-brother is the paramour referenced in this report. A family group decision making conference was held prior to the birth to develop a plan to assure the safety of the half-brother and address a supervised visitation plan for the natural father. The half-brother would remain in the care of his mother; a visitation schedule between the victim child and his half-brother began on February 26, 2007. The victim child in this report remained in foster care. The half-brother's contact with the natural father was to be supervised at all times. An approved third party must ensure supervision. The person to provide supervision would be either an agency caseworker or any person who had prior approval of the agency to provide the supervision. The natural mother was not to be the one supervising the visitation between child and natural father. This stipulation was referenced in the family service plan; both parents were in agreement and signed the safety plan.

On March 5, 2007, the county agency received a referral concerning the mother allowing the natural father to have contact with the half-brother without someone approved by the agency to providing supervision during the contact. The agency caseworker discussed the allegation with the natural mother during a scheduled visit with the natural mother. The agency could not substantiate the report due to the mother's denial of the allegation and the agency had not witnessed the natural father in the home without supervision.

On March 8, 2007, the county agency, in an effort to return the victim child back with his mother, began unsupervised visitation between mother, victim child and his half sibling. The visitation began in February 2007 around the time the victim child's half sibling was born and release via hospital to the natural mother. This would provide an opportunity for the victim child to visit with his newborn half sibling. The visits were held twice a week, on Mondays and Thursdays from 9:00 am to 5:00 pm. The mother completed a , parenting skills classes, along with attending . The mother agreed to a safety plan not to allow anyone in her home during visitation, unless approved by the agency prior to a scheduled visit. The mother was not to use any physical discipline and was to ensure all of the child's basic needs would be met while in her care. During all contacts, the agency caseworker was able to ensure the victim child's safety which was documented in the case record.

On May 1, 2007, a court review hearing was held at which time the victim child was returned home to live with his mother. The court gave physical custody to the mother with the agency retaining legal custody of the victim child. On May 21, 2007, Family Preservation Intensive Casework Services began working with the family in the home.

A family service plan review was completed on May 14, 2007. The plan mirrored changes in the actual case. The plan indicated the level of Risk for this case was high. The reason for the revision was that circumstances in the plan had changed. Physical custody of victim child was relinquished to the natural mother with the county agency retaining legal custody of the child. There now was another child the newborn half sibling living in the natural mother's home. [REDACTED]

[REDACTED] The half sibling's father is not to have unsupervised contact with either child. The parents were given objectives which were identified and agreed upon.

On November 8, 2007, both the victim child and his half-brother were placed into foster care by Northumberland County Children and Youth Services. The mother violated the terms of the family service plan and the victim child's safety plan. The mother had allowed unsupervised contact between the children and the half-brother's father. The agency caseworker found the mother and the children at his residence. The mother signed a voluntary entrustment agreement and the children were placed together in an agency approved foster home.

On January 28, 2008, the case was transferred to the county agency's foster care unit. Parent advocacy began working with the natural mother. The mother's cooperation with the service was inconsistent. The children were safe in their foster home.

On December 23, 2008, a scheduled review hearing was held; at this time the children were returned home. The physical custody of the children was returned to the mother while the county agency retained legal custody of the children. The county agency was not recommending a return home to the care of the mother at this time. The court determined that the mother had made substantial progress. She completed a parent nurturing skills class. In addition the court determined that since she filed a protection from abuse order (PFA), on the half-brother's father which would allow for no contact between respected parties, the children could return home. This decision was made in the judge's chambers with attorneys present. The county caseworker assigned to this case was not given the opportunity to voice concerns. In review of the case record, on several occasions prior to obtaining a PFA the mother was having contact with the half-brother's father which would have been a violation of the victim child's safety plan. In addition the natural mother's visitation with her children was inconsistent during the time period.

On January 12, 2009 this case was transferred to the agency's Family Preservation Unit. A risk assessment was completed with a rating of high. According to the case record reviewed the agency caseworker met the family on two occasions in the month of January. A meeting was held with the family preservation worker, agency worker, and the mother to discuss concerns with mother's apparent lack of follow through with services. The mother assured the team she would fully comply with the preservation services. While services were in place, both the agency and the family preservation services worker experienced issues with the mother meeting expectations. At times she

would not return calls, missed scheduled visits, or would not answer her door. In addition, the mother failed to follow through with having the victim child attend recommended [REDACTED] were also missed. On June 3, 2009, during a scheduled court review hearing the agency requested to continue legal custody of the children. The case would be reviewed again in three months to determine progress. The mother's progress was minimal.

On November 3, 2009 a Permanency Review Hearing was scheduled. The agency continued to express concerns regarding the mother's progress and cooperation with the agency. Physical custody remained with the mother and the agency continued to maintain legal custody of the children. The agency continued to monitor the case and work with the family.

On January 2, 2010 the agency received a [REDACTED] alleging the victim child in this report was hospitalized with a blood alcohol level of .368. The child's half-brother was placed in foster care. The victim child was placed in the same foster home as his sibling [REDACTED]. The foster home placement was the same home the victim child was placed in during his first placement episode.

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

On January 1, 2010 the victim child complained to his mother of having abdominal pain. The mother reported she had the victim child lie down and watch television after which she gave him eggs and toast. He appeared to be feeling better and played with his half-brother both in the house and outside throughout the day with no additional signs of abdominal pain. The victim child ate dinner without complaining of pain. Some time after dinner, the victim child again complained to his mother about having abdominal pain. The victim child went to bed between 8:00 and 9:00 pm. [REDACTED] around midnight the victim child had an emesis while sleeping, which mother described as green in color without blood. The mother cleaned him up and turned him on to his stomach. The mother indicated she was concerned after this episode so she decided to set her alarm every hour to check on her son.

The mother indicated that between the first two bed checks the child appeared to be sleeping fine in bed. Around the 3:00 am bed check the mother did not find the child in bed. His bedding was wet and she discovered the victim child sleeping on the bathroom floor. The mother was able to arouse him; the victim child thought he was in the kitchen getting a drink rather than in the bathroom. The mother placed the child back to bed and during her 4:00 and 5:00 am bed check he was resting fine. At 6:00 am the mother found the child lying awake in bed and he appeared fine, speaking and acting appropriately according to the mother. The mother reported she went back to sleep until 8:00 am at which time she went to wake the victim child. She was unable to get her child out of bed; he was limp, not moving, yet still breathing. The victim child was unresponsive to mother's attempts to awake the child. On the morning of January 2, 2010 the mother transported her son to the [REDACTED]. The clinic evaluated the child and

was unable to arouse the child. The evaluating doctor indicated the victim child's vitals were fine; however, the child would not respond to attempts to arouse him. [REDACTED]

[REDACTED] The victim child was transported via ambulance to the Geisinger Medical Center (GMC) for further evaluation. [REDACTED]

Upon admission to GMC Emergency Department, further medical testing was completed on the child. A CT scan was done on the head and abdomen which were found to be negative for trauma. The physical examination found marks on the victim child's body, including his arms, legs, upper back, and a bruise was found on the lower abdomen above the victim child's pubic region. The examination discovered the victim child had a blood alcohol level of .368 which is greater than three times the legal limit for an adult. [REDACTED]

The victim child's mother was unaware of how his blood alcohol level could have gotten so high. Upon reevaluation of events, the victim child's mother explained to hospital staff that there was a drink she had mixed with alcohol in the fridge. It contained vodka and an energy drink. The mother only drank a portion of the beverage and placed the rest in the refrigerator. She believes that is what the victim child must have ingested. She was unsure at that time if the beverage was still in the refrigerator. The victim child's mother indicated that other than the mixed drink in the refrigerator there was only a bottle of Kahlua in the entire house and a bottle of Nyquil. When the victim child's blood alcohol level was tested, the hospital staff made the determination that his blood alcohol level would have been equivalent to ingesting 8 oz of vodka, [REDACTED]

[REDACTED] The medical staff did indicate that his blood alcohol level and equivalent ingestion would have been higher since the test was performed a significant time after the child's ingestion.

The victim child's mother did not have an exact explanation regarding the bruising on the child's body. She believes the bruises on the arms and legs could have been from sledding, playing outside or from the family's dog. Regarding the mark on the child's back, mother did report an irritated area and she applied cream to that area. The victim child's mother did not notice the bruise on the lower abdomen area until at the hospital; again she said it may have come from sledding or playing outside.

During the [REDACTED] investigation conducted by Northumberland County Children and Youth Services, county agency staff interviewed the mother, maternal grandmother, victim child's biological father, the victim child, as well as hospital staff from Geisinger Medical Center. Medical records were obtained and both children were given a physical exam conducted by the Child Advocacy Center. The victim child's half-brother was placed in foster care and the victim child was placed in the same foster home upon discharge from the hospital. [REDACTED]



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The victim child's half-brother's father was provided parenting classes through [REDACTED].

[REDACTED]

The victim child's half-brother's father was recommended to complete [REDACTED] classes, which he did not complete.

The victim child's mother, father, and half-brother's father completed an [REDACTED].

The victim child's father was offered active parenting classes and [REDACTED] classes through Common Sense Parenting. He did attend and completed in November 2007.

Adult Probation Office in Columbia County provided supervision for father.

*It should be known that the natural father was incarcerated throughout most of the time period pertaining around this incident, upon his release goals were established for him to complete.*

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:**

The county's report indicated that Northumberland County Children and Youth Services provided a plethora of helpful services to support the family. The county agency

provided services to the family in an effort to assure the safety of the minor children and to strengthen the parenting skills of the mother and fathers of both minor children. In addition the community was very supportive to the family as well as the foster family, the family support center, and other community services which were offered to the family.

**County Recommendations for changes at the Local Levels as identified by Fatality Report:**

Agency- after an in depth review of the court process at the county level, it became evident that communication between the solicitor and the children and youth agency could be improved especially while court is in session. Should there be a sidebar conversation between the Judge and Counsel, caseworkers should be briefed and provide input if agreement goes beyond the scope of the agency's recommendations.

Court- after review of the court transcripts, the county review team found use of a protection from abuse order as a resolution out of context in this case. The issue of domestic violence was not prevalent in this case. It was noted that the caseworker in this case was given but a brief opportunity to express concerns regarding the need for continued placement to assure the safety of the minor children. An increased level of respect for the social workers would be relevant in assuring the safety and well being of the adjudicated minor children.

**Recommendations for changes at the State Level:**

None reported in the county's review.

**Central Region Findings:**

The county agency provided adequate and appropriate services to this family. The agency caseworkers monitored this case along with being supportive to the natural parents. The children may have benefited from the county agency filing a petition for physical custody of the children due to mother's lack of compliance and follow through with the family service plan.

After review of the county child near fatality report, CROCYF would recommend that the county agency meet with the county agency solicitor to discuss the agency's need to provide input into any agreements made which go beyond the scope of the county agency's recommendation in the dependency and review hearings.

**Statutory and Regulatory Compliance issues:**

The case was transferred to the county agency family preservation unit on January 12, 2009 at which time the case was given a high risk tag. According to the case record reviewed the mother was not seen weekly by the county agency caseworker. The children were seen weekly.

The county agency will be cited for the failure to meet the following regulation:

Section 3490.61 (c) (1) *When a case has been accepted for service, the county shall monitor the safety of the child and assure that contact are made with the child, parents, and service providers. The contacts may occur either directly by a county agency worker or through purchase of service, by phone or in person but face to face contacts with the parent and the child must occur as often as necessary for the protection of the child but no less than:*

*(1) Once a week until the case is no longer designated as high risk by the county agency.*