pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF: [redacted]

Date of Birth: 7/25/13
Date of Incident: 9/17/2013
Date of Oral Report: 9/19/2013

FAMILY NOT KNOWN TO:

Luzerne County Children and Youth

REPORT FINALIZED ON:

09/02/2014

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 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, DPW 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. Luzerne County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]/91
	Father	[redacted]/86
	Child	[redacted]/13
	Babysitter	[redacted]/81

Notification of Child (Near) Fatality:

On September 19, 2013, Luzerne County Children and Youth Services (LCCYS) received a referral regarding 7 week old [redacted]. According to the referral, on September 17, 2013, the natural mother, [redacted], took [redacted] to his pediatrician, Dr. [redacted] because the child was vomiting. Dr. [redacted] sent natural mother to [redacted] Geisinger Wyoming Valley Hospital. While at the hospital the child began experiencing [redacted] and was found to have [redacted]. The child was admitted to the hospital. The VC was transferred to Geisinger Medical Center in Danville where further testing revealed he had [redacted] Physician, Dr. [redacted] determined the injuries were consistent with non-accidental [redacted]

Summary of DPW Child Near Fatality Review Activities:

The Northeast Region Office of Children (NERO), Youth and Families obtained and reviewed all of the current case record pertaining to the [redacted] family. [redacted] was obtained and reviewed. Follow up interviews were conducted with the Caseworker [redacted] and the Supervisor [redacted] on October 15, 2013 and November 4, 2013. The

NERO also participated in the County Internal Fatality Review Team meeting held on October 15, 2013.

Summary of Services to Family:

This case was not active with Luzerne County Children and Youth Services at the time of the report.

Children and Youth Involvement prior to Incident:

There was no prior involvement with LCCYS for this family. Three prior referrals were received regarding [redacted], the babysitter, regarding her family and her home. The referrals were all General Protective Service incidents regarding minor lack of supervision and unclean living conditions. All three incidents were closed at the intake level.

Circumstances of Child (Near) Fatality and Related Case Activity:

On September 19, 2013 LCCYS received a referral regarding 7 week old [redacted]. It was reported that on September 17, 2013 the natural mother took the child to the Pediatrician, Dr. [redacted], because [redacted] was vomiting. Dr. [redacted] sent the child to the [redacted] Geisinger Wyoming Valley. The child was admitted to Geisinger Wyoming Valley hospital for [redacted]. The child was also having [redacted] at the hospital. [redacted] was transferred to Geisinger Medical Center in Danville for further evaluation. It was determined that the VC had both [redacted]

The natural mother and natural father were both interviewed. They both reported that they were the primary caregivers for the VC except on 3 occasions when [redacted], a babysitter took care of him. All three caregivers were named as alleged perpetrators.

The natural parents underwent voice stress analysis. The natural mother's test showed some deception and she was non-compliant with a second interview by law enforcement. The natural father showed no deception on the voice stress analysis and has been compliant with law enforcement and LCCYS. The babysitter [redacted] has also been compliant.

[redacted] He was originally placed in a foster home and then on October 2, 2013 he was moved into the Kinship home of his maternal uncle.

Current Case Status:

At this time the VC remains in the care of his maternal uncle and is doing well. He appears to be functioning normally and continues to [redacted]

The natural parents have become involved in a parenting program through Time Limited Family Reunification. They have been referred [redacted]. They have also maintained safe and stable housing and have been cooperative with LCCYS. They have nine hours of [redacted] supervised visitation with the VC each week.

The status of the CPS investigation remains pending the outcome of the criminal investigation.

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

Strengths:

*CPS responded to the report immediately and appropriately.
*All parties involved were interviewed.
*Child's medical records were obtained and reviewed.
*No regulatory deficiencies were identified.

Deficiencies:

*No deficiencies were noted

Recommendations for Change at the Local Level:

*Provide education on Shaken Baby Syndrome to the public.
*Collaborate with local colleges to produce Public Service Announcements about Shaken Baby Syndrome.
*Explore funding sources for the education program.
*Compile and maintain statistical information on infant abuse.

Recommendation for Change at the State Level:

*No recommendations identified.

Department Review of County Internal Report:

On October 15, 2013 LCCYS convened a review team in accordance with Act 33 of 2008. The report was received by the NERO on December 11, 2013. The Northeast Regional office attended this meeting and concurs with the findings.

Department of Public Welfare Findings:

County Strengths:

*Luzerne County Children and Youth responded immediately to the CPS referral, and conducted a thorough investigation.
*They held the Act 33 meeting within the appropriate time frame.
*The Act 33 team members included two Physician Assistants which was very beneficial in regards to the medical information presented.
*The agency was responsive to NERO's requests for Child Death Data Collection tool and contents of the file.

County Weaknesses:

*No deficiencies were noted.

Statutory and Regulatory Areas of Non-Compliance:

*There were no areas of non-compliance.

Department of Public Welfare Recommendations:

The NERO concurs with LCCYS, in that a determination is pending upon completion of the law enforcements investigation.