pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON NEAR FATALITY OF:

[redacted]

Date of Birth: 07/13/2012
Date of Incident: 02/27/2013
Date of Oral Report: 03/01/2013

FAMILY NOT KNOWN TO:

Berks County Children and Youth

REPORT FINALIZED ON:

November 7, 2013

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. Berks 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]**1980**
	Father	[redacted]**1976**
	Victim Child	**7/13/2012**
	Sibling	[redacted]**2005**
	Maternal grandfather	[redacted]**1948**
	Maternal grandmother	[redacted]**1951**
	Father [redacted]	[redacted]**1978**

Notification of Child (Near) Fatality:

Berks County Children and Youth Services was notified on March 1, 2013 that a report of [redacted] was made regarding 7 month old [redacted]. The report indicated that the date of the incident was between 2/27/2013 and 2/28/2013. The child victim was taken to the [redacted] Lehigh County and [redacted] seizures. The victim child was at a day care home [redacted]. A CAT scan performed at the hospital [redacted] that the victim child fell off a couch two days ago [redacted]

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office review included a review of the record, interviews with the caseworker, the casework supervisor and the intake department manager. The Regional office reviewed the safety assessment completed by the agency and the subsequent Safety Plan that was implemented. Since the victim child was in the hospital in Lehigh County, Regional Office verified communication and contact between both counties. The record contains appropriate documentation.

Summary of Services to Family:

Berks County Children and Youth Services was not active with the family prior to the incident.

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

The victim child was believed to have been injured either late in the evening on 2/27/2013 or early in the morning on 2/28/2013. The victim child presented to the Emergency room at [redacted] Hospital located in Lehigh County via ambulance from the day care home she was attending. [redacted] was then taken to the emergency room. The child [redacted] began to cry several minutes after arrival at the hospital. A CAT scan was administered and was [redacted] At this time, [redacted] the mother responded that the child fell onto the floor in her home which she described as being thinly carpeted and hardwood. [redacted] The mother, who was listed as the alleged perpetrator, [redacted] left her on the couch for a few minutes as she went into the kitchen and heard her fall to the floor.
Berks County Children and Youth Services contacted Lehigh County Children and Youth Services to request a courtesy interview of the victim child while she was in the hospital. Documentation in the record confirms that the counties did in fact communicate and proceed as requested. The Berks County caseworker worked on contacting the mother, who was at the hospital, in order to formulate a safety plan for both children. The mother [redacted] and agreed to meet with the caseworker at her home. The mother presented as being very [redacted]. Additionally, the hospital staff were alerted and her room was next to the nurse's station. [redacted] about her child.

Current Case Status:

The victim child has been returned to the mother who [redacted] and sibling. The victim child did not have a skull fracture and no obvious signs of trauma. [redacted] attentive and appropriate with the child. The victim was subsequently discharged from the hospital [redacted] The victim child did not have any [redacted] any signs of abuse. [redacted] occurred as [redacted] reported. [redacted] The victim child has [redacted]

[redacted]

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

County Strengths:

The County acted promptly in response to the Childline report. No Title 33 meeting was held due to the fact that the case was unfounded within the 30 day limit.
The County went to the home of the grandparents and made an assessment in an efficient manner and developed an appropriate safety plan.

County Weaknesses:

No County weaknesses were identified.

Recommendations for Change at the Local Level:
No recommendations for change on the local level were identified as a result of the investigation.
The county agency responded immediately and held appropriate interviews with everyone involved.
Established protocols were followed.

Recommendations for Change at the State Level:

No recommendations were made.

Department Review of County Internal Report:
The county agency did not hold a Title 33 review since the case was unfounded within 30 days. However, the intake team, consisting of caseworkers, supervisor and manager of intake did hold meetings to update each other on the progress of the case. An integral part of the review process was also the hospital and staff working with the victim child and her family. Their input was critical to case decision making. Attempts to speak with fathers was also evident in the case history.

Department of Public Welfare Findings:

County Strengths:

Berks County Children and Youth Services responded in a timely and appropriate manner to the allegations related to the [redacted] near fatality. The agency completed a review and investigation of the case in response to the information received regarding the near fatality. Consistent supervisory reviews were conducted and caseworkers assigned were provided

support and direction. Also evident in the record is consistent collaboration with law enforcement, hospital staff, and family members, including fathers.

County Weaknesses:

Statutory and Regulatory Compliance:

A Department of Public Welfare record review was conducted and it was determined that the county agency had completed all necessary regulatory requirements for the investigation of this case.

Department of Public Welfare Recommendations:

The agency case file was complete and well documented. Efforts to interview everyone involved in the case were done swiftly, yet with good practice standards. The child victim was considered first and her safety was assured, as was her older sister. Fathers involved were part of the plan and informed of CPS regulation and requirement. The county agency demonstrated sound practice standards and should continue in this endeavor. The CPS case and its circumstance held serious, sensitive issues, as many do, but the agency's swift approach and collaboration assisted with a timely outcome that serves the need of all family members.