pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: June 19, 2013
Date of Near Fatal Incident: November 29, 2013
Date of Oral Report: November 29, 2013

FAMILY KNOWN TO:

Carbon County Children and Youth

REPORT FINALIZED ON:

08/10/2015

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(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. Carbon County was not required to convene an Act 33 review team meeting due to the report being unfounded within 30 days.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	June 19, 2013
	Mother	[redacted] 1997
	Father	[redacted] 1994
	Paternal Grandfather	unknown
	Paternal Grandmother	unknown

Notification of Child Near Fatality:

On November 29, 2013, the agency received a report from [redacted] alleging non-accidental trauma to the victim child. The child was brought to the hospital by his father who reported that he was carrying the child down the stairs when he fell. [redacted] physician certified the child to be in critical condition as a result of non-accidental trauma. It was reported that, according to the father, the victim child landed on his back so that the father's story was not consistent with the child's injuries as the child should not have [redacted]

The child was transferred to Lehigh Valley Children's Hospital for further treatment the same day.

Summary of DPW Child Fatality/Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. The agency was not required to convene an Act 33 review team meeting for this case due to it being unfounded within 30 days.

Children and Youth Involvement prior to Incident:

A referral was received by the agency on December 7, 2011 alleging that the father (age 17 at the time) smokes cigarettes on the porch of the home, smokes pot and there is a lot of arguing between the child (father of victim child) and his parents. The referral was screened out the same day.

There were no other referrals received by the agency regarding this family.

Circumstances of Child Near Fatality and Related Case Activity:

On November 29, 2013, Carbon County Children and Youth received a report [redacted] regarding the victim child's injuries. The child was brought to the hospital by his father. The father reported to the hospital that he was carrying the child down the stairs and fell with him. The physician certified the child to be in critical condition as a result of non-accidental trauma as it was reported that the father's story was not consistent with the child's injuries which included [redacted] The father was named as the alleged perpetrator.

When interviewed, the father reported that he was getting the victim child ready for breakfast. When he was carrying the victim child down the stairs, the father slipped on the steps from his bedroom leading downstairs. The father reported that he fell backwards and the victim child slid underneath his arms and he dropped the victim child. The father did not know exactly how many steps the alleged victim fell but the father reported that he believed he was halfway down the stairs. The father reported that the victim child fell to the bottom of the steps. The victim child had a cut on the back of his head which was bleeding. The father reported that he immediately took the victim child to the emergency room.

Two witnesses in the home reported hearing a thump and father say "oh my god and (the victim child's name)". The steps in the home were determined to be steep, narrow and uncarpeted. After hearing the account of the incident, the physician determined that the victim child's injuries were consistent with being dropped down steps.

On December 8, 2013, as a result of the CPS investigation, the case was given an unfounded status.

Current Case Status:

The police completed their investigation and determined that the child's injuries were caused accidentally.

After the completion of the CPS investigation, the agency determined that the family was not in need of services and the case was closed.

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

The county agency was not required to convene an Act 33 review team meeting as the CPS investigation was unfounded within 30 days.

Department Review of County Internal Report:

The county agency was not required to convene an Act 33 review team meeting as the CPS investigation was unfounded within 30 days.

Department of Public Welfare Findings:

- County Strengths:

  The agency interviewed all relevant parties and presented their findings to the physician to determine whether the victim child's injuries were consistent with the agencies findings in regards to the account of the incident and the physical layout of the steps.

  The CPS investigation was concluded timely.

- County Weaknesses:

  Although the agency did seek the opinion of [redacted] physician at Lehigh Valley Hospital, they did not present their findings to the physician at St. Lukes' Miner's Hospital. The physician at St. Luke's Miner's Hospital initially certified the child to be in critical condition as a result of non-accidental trauma because the father's story was not consistent with the victim child's injuries.

- Statutory and Regulatory Areas of Non-Compliance:

  There were no regulatory deficiencies identified as a result of this review.

Department of Public Welfare Recommendations:

- Prior to making determinations in CPS Fatality/Near Fatality cases that do not concur with the initial determination by the physician that certified the child to be in critical condition as a result of suspected child abuse, the agency should present their findings to the physician to determine if the victim child's injuries are consistent with the agency's findings.