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**REPORT ON THE NEAR FATALITY OF**



**BORN: December 8, 2010**  
**DATE OF NEAR FATALITY: May 19, 2011**

**FAMILY WAS NOT KNOWN TO: Monroe County Children and Youth Services**  
**DRAFT DATED: October 3, 2012**

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, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. The bill became effective on December 30, 2008 and is known as Act 33 of 2008; Department of Public Welfare 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. Monroe County was required to have a review because the status determination via the CY 48 was not completed within 30 days.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED] 2010
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Maternal Grandfather	unknown
[REDACTED]	Paternal Uncle	[REDACTED] 1984
[REDACTED]	Father	[REDACTED] 1978

**Notification of Near Fatality:**

On May 18, 2011 Monroe County Children and Youth received a referral from Childline. The referral source was [REDACTED]. It was reported that the victim child had [REDACTED] due to [REDACTED]. On May 18, 2011 the victim child's mother was at work and her three children were left in the care of [REDACTED]. Also in the home at this time was maternal grandfather. The children's father does not reside in the home, but is involved with his three children. The report was [REDACTED] for [REDACTED]. [REDACTED] was listed as the [REDACTED] because the victim child and her siblings were in his care when the incident occurred. On May 18, 2011 the [REDACTED] and the Northeast Regional Office of Children, Youth and Families received the report of the near fatality.

**Summary of DPW Child Fatality Review Activities:**

The Northeast Regional Office of Children and Youth Human Service Program Representative met with the [REDACTED] Supervisor, Caseworker, Assistant Director and Director to discuss this case. The Program Representative had obtained and reviewed the entire file regarding this family.

**Summary of Services to the Family:**

No Services were being provided to the family by Monroe County Children and Youth Services or community agencies.

**Children and Youth Involvement Prior to Incident:**

This family was not known to the Agency.

**Circumstances of Child Fatality and Related Case Activity:**

On May 18, 2011 victim child's mother was at work and her three children were left in the care of [REDACTED]. He has babysat the children since they were born. At the time of the incident the oldest sibling was four years old; the other sibling was two years old; and the victim child was five months old. Also in the home at this time was maternal grandfather. The victim child's mother cares for her father and he resides with her. The children's father and uncle are brothers and they reside together at [REDACTED]. On May 18, 2011 paternal uncle called mother, at work and told her the victim child was vomiting and having difficulty breathing. Mother went home and noticed the victim child was "floppy" and not breathing correctly. She took victim child to

the Mountain Medical Center. Paternal uncle remained in the home to watch other two children. The victim child was treated for [REDACTED] but while at the Mountain Pocono Center it was noticed the child's [REDACTED] seemed to change. The hospital did a [REDACTED] and transferred the victim child to Lehigh Valley Hospital. It was determined the child [REDACTED]. The hospital stated the injury could be the result of a [REDACTED]. The [REDACTED] called Childline to file a report of [REDACTED]. The victim child was listed in [REDACTED] but expected to live. Monroe County Children and Youth Services went to the home and put a safety plan into effect, regarding the other two children. The safety plan stated that the children were not to be left in the care of [REDACTED] until the investigation was completed. [REDACTED] was listed as the [REDACTED] because the victim child and her siblings were in his care at the time of the incident. [REDACTED] denies harming the victim child. Lehigh Valley Hospital completed [REDACTED] and it was determined that the victim child had [REDACTED] which caused the child to have a [REDACTED]. The [REDACTED] caused the victim child's [REDACTED]. They stated the child was not a victim of child abuse, that the [REDACTED] was a [REDACTED]. Child's mother also has a [REDACTED].

**Current / Most Recent Status of Case:**

The case was [REDACTED] Monroe County Children and Youth determined the family was not in need of any services and closed the case. The [REDACTED] also closed their investigation, no charges were filed.

**Statutory and Regulatory Compliance:**

- \*Safety was accessed for all the children in the home.
- \*The investigation was conducted in a timely manner.
- \*All parties were interviewed and received rights letters.

Monroe County Children and Youth Services did not have an internal review in accordance with Act 33 of 2008.

**Findings:**

NERO concurs with the unfounded status determination of Monroe County Children and Youth Services.

**Recommendations:**

An internal review should have been conducted in accordance with Act 33 of 2008. This case required an internal review because the [REDACTED] went over 30 days. The Northeast Regional Office will meet with the Agency to go over guidelines of Act 33 of 2008.