



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: [REDACTED] **2007**
DATE of near-fatality: **July 15, 2011**

FAMILY KNOWN TO:

Berks County Children and Youth

REPORT DATED: 10-4-12

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 child near-fatality as a result of suspected 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.

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]	Victim Child	[REDACTED] 2007
[REDACTED]	Mother	[REDACTED] 1985
[REDACTED]	Father	[REDACTED] 1984
[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Sibling	[REDACTED] 2008

Notification of Fatality/Near Fatality:

The [REDACTED] case came to the attention of Berks County Children and Youth on 07/02/2011 [REDACTED]. The allegations were that the victim child was very thin, laying in a crib and eating only blended foods. [REDACTED] Additionally, it was reported that the victim child had three other siblings living at home with him and his parents. [REDACTED]

[REDACTED] seemed to be very thin also. A response time of 7 days was assigned at this point. A caseworker from Berks County Children and Youth went to the home on 07/08/2011 to assess the allegations; however, there was no one home. A note was left to notify the family of the caseworker's attempt to evaluate. The caseworker went over the allegations with the parents on 07/11/2011, but was told by the parents that the child was being followed medically and that he had an upcoming medical appointment. The parents further stated that the child [REDACTED]. The parents then stated that they take all of the children to [REDACTED] but that they did not have a car now and wanted to change to [REDACTED] in Berks County where it would be easier to obtain medical care for the children. The family was told to have the child seen by a physician. The family was notified that Berks County Children and Youth would be monitoring and assisting them with obtaining medical care for all the children; especially the victim child. Medical appointments were secured by the [REDACTED].

The victim child was to be seen on 07/19/2011 and [REDACTED]. After reviewing the case with the supervisor, the caseworker was instructed to get an earlier appointment. The opinion of the agency at this time was that the family was not able to get an appointment in a timely manner and the child needed a medical evaluation. Subsequently, the victim child was taken to the emergency room of the [REDACTED] 07/14/2011. The victim child was determined to be grossly underweight, malnourished, and weighed only 19 pounds at age 4. He was unable to walk or talk without using grunting as his method of communication. He was admitted to the hospital for further evaluation. He had not been seen by a physician or a dentist since birth. [REDACTED]

[REDACTED] perpetrators. [REDACTED]

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office conducted a complete review of the files pertaining to the [REDACTED] family, which included the referral, the assigned response time, the safety assessment, the risk assessment and all case notes and associated contacts. The Department also conducted interviews with staff involved with the case, which included the Intake Administrator, Supervisors involved in the case, and caseworkers who have worked with the [REDACTED] family. [REDACTED] was interviewed and the medical condition of the victim child was discussed during the interview. The Northeast Regional Office attended the Act 33 case review held on 02/07/2012.

Children and Youth Involvement Prior to Incident:

This family was referred to Berks County Children and Youth on July 7, 2008 due to [REDACTED] to meet the demands of their growing family.

This family was referred to Berks County Children and Youth on July 7, 2008 due to REDACTED, to meet the demands of their growing family. REDACTED, enforcement issue. REDACTED. The family had no electricity but this was quickly rectified as it was a REDACTED. However, it was determined that the family could benefit REDACTED. However, it was referred to REDACTED in September

[REDACTED] the father. [REDACTED] and referred to [REDACTED] on September 8, 2008. [REDACTED]. The services recommended were [REDACTED] to [REDACTED] given to the [REDACTED]

[REDACTED] and have a polygraph completed. The family was very cooperative with all services which included follow through with [REDACTED]

[REDACTED] not need supportive services for this issue. The father received [REDACTED]

[REDACTED] was supportive during this time and assisted the family. The agency held a review of the case status on December 4, 2008 and determined that services were no longer needed. The case was closed December 11, 2008.

Circumstances of Child's Near Fatality and Related Case Activity:

[REDACTED] case came to the attention of Berks County Children and Youth again on July 2, 2011 as a [REDACTED] report. The allegations were that the victim child was very thin, laying in a crib and eating only blended foods. He was reported to be 4 years old. His arms and legs were thin. It was reported that there were three other children in the home, [REDACTED]

[REDACTED] thin also. The Berks County caseworker went to the home on 07/8/2011 unannounced but found no one at home. On 07/11/2011 the caseworker was contacted by the father who stated that the caseworker could stop by around 6:30pm when the mother would be home from work. The caseworker went to the home and did find the victim child to be very thin, rocking back and forth in a rocker, not speaking, using only grunting sounds. The parents reported that the victim child is unable to eat solid foods and receives his nutrition through blended foods placed in a bottle. The mother also reported that the victim child had not been to a doctor since birth and stated that she feared something was wrong with him and she feared knowing the diagnosis. The other three siblings were seen [REDACTED] the household and were active and alert. They did not appear to be underweight. [REDACTED]

[REDACTED] The family was instructed to make a medical appointment for the victim child within the week. However, on 07/14/2011, after a discussion with the supervisor of the case, a decision was made to secure an earlier appointment as the mother reported that she obtained one for 07/21/2011. If the child could not be seen sooner, the family would have to take him to the emergency room. [REDACTED] assigned for immediate assistance to the family, [REDACTED] hours of contact two times per week, [REDACTED]. On 07/14/2011 the [REDACTED]

caseworker [REDACTED]

On 07/15/2011, the caseworker was notified that the child would remain in the hospital. The child was in need of [REDACTED]

[REDACTED] The victim child also was observed to have [REDACTED]. He was able to eat from a spoon. His father had come to visit but the mother was working. The agency received information from the [REDACTED] 07/17/2011 [REDACTED]

On 07/19/2011, the agency completed the [REDACTED] victim child's condition. The victim child was expected to have [REDACTED] and the agency needed to seek [REDACTED]

On 07/21/2011, the victim child was transferred to [REDACTED]. He left the hospital with the [REDACTED]. The child was seen on 07/25/2011 at the [REDACTED] hospital by the caseworker and the assigned detective [REDACTED]. He was doing better, gaining weight, interacting with staff and sitting up. The mother visited once. [REDACTED]

The victim child was [REDACTED] 08/25/2011 [REDACTED] foster parents from [REDACTED] were able to deal with his delays. He remains in this placement.

[REDACTED]. When the parents were arrested and incarcerated on 09/21/2011 home. [REDACTED]

Current/Most Recent Status of Case:

Both parents have been named [REDACTED] victim child. [REDACTED]. Even though they have been provided [REDACTED] it didn't impact them enough to help them change to become better [REDACTED] parents. At the time of placement, [REDACTED]. Berks County promptly assessed their suitability for placement for the children. Family Group Decision Making sessions were held [REDACTED]

[REDACTED] Both parents participated in [REDACTED] evaluations and bonding evaluations. The victim child has been visiting with a [REDACTED] who is determining if she feels comfortable trying to meet his special needs. He does remain with his original foster family and continues to make progress. The [REDACTED] The older two children [REDACTED] However, [REDACTED] He can presents challenges to the [REDACTED] sometimes be [REDACTED]

had been visiting at the agency, however, the agency is planning children.

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

The Act 33 near fatality meeting identified several strengths that the panel believed to be evident in the case. The fact that ChildLine was notified and a prompt investigation ensued, as well as the admitting physician recognizing abuse and promptly reporting it. The fact that the agency has worked closely with relatives of the children and supportive services had also been identified as strengths. The victim child was treated promptly which provided all the necessary requirements for recovery including medical, social, educational and nutritional opportunities.

The review also determined that law enforcement was notified and the services provided were necessary and collaborative.

Areas of concern included that fact that the family came to the attention of the agency in 2008 and the focus seemed to be on the father, with little information provided about the children. At this time, the medical condition of the children was not assessed. Information that was provided by the parents during the recent investigation did not seem to indicate that the parents were providing factual information yet the county did not act to evaluate the information quickly enough. The child's condition upon first contact should have alerted the caseworker. There was also concern and discussion around the mother's lack of prenatal care with . This was identified at St. Joseph's Medical Center when she presented in labor. There was no follow up to assure pediatric care was provided.

County Recommendations for Changes at the Local (County or State) Levels as Identified in County's Near Fatality Report: None

Department of Public Welfare Findings:

County Strengths:

- The ChildLine report was filed and the county responded promptly. The agency assisted the family by offering in home services and assuring that the victim child received the medical care he required.
- The agency offered appropriate services to the family
- The agency worked well with law enforcement to assess the social and criminal content of the case. The CY-104 was filed and a joint visit to the hospital was made by the county caseworker.
- Berks County Children and Youth provided weekend visits to check the safety of the other children and the youngest child was removed when his medical and nutritional needs were not met.
- The agency filed all administrative paperwork within the required time frames.
- The agency utilized family finding in order to get family members involved and Family Group Decision Making was used appropriately.
- Older siblings were removed and placed in appropriate placements.
- Supervisory oversight led to good decision making to get the victim child to be medically evaluated and start his medical care.
- Supportive services were initiated promptly.

County Weaknesses:

- The victim child was identified as grossly underweight, unable to walk or talk at age 4 and without medical care on 07/11/2011. The family did not provide the caseworker with sufficient information to make a determination of safe in this household.
- With the prior history on this family and the allegations at intake, an immediate response time could have been given, assuring that county casework investigation would commence quickly.
- The initial referral on this family was in July 2008 at which time the father's criminal history was made evident. The victim child was 14 months old. None of the children's medical histories were investigated at intake, as is necessary when assessing families at intake. No inquiry of medical history of the children is evident.
- The agency did not conduct an adequate assessment of the siblings in the family. Observation of the children and their interaction on initial contact is insufficient to provide an accurate assessment of the overall health of a family.

Statutory and Regulatory Compliance Issues:

All required statutory and regulatory compliance was met. Law enforcement was notified by CY-104 and all follow up contacts were completed. Work was done in collaboration with medical and supportive services.