



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 8/5/13
Date of Incident: 10/3/14
Date of Oral Report: 10/4/14

FAMILY NOT KNOWN TO:

Lehigh County Children and Youth Services

REPORT FINALIZED ON:

January 23, 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, DHS 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. Lehigh County has not convened a review team in accordance with Act 33 of 2008 related to this report as the case was assigned an unfounded status within 30 days.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child/Victim	8/5/13
[REDACTED]	Biological Mother of C/V	[REDACTED]/94
[REDACTED]	Biological Father of C/V (not involved/current whereabouts unknown)	Unknown
[REDACTED]	Paramour of Biological Mother	[REDACTED]/93
[REDACTED]	Maternal Grandmother of C/V	[REDACTED]/66
[REDACTED]	Paramour of Maternal Grandmother	Unknown

Notification of Child Near Fatality:

The [REDACTED] contacted Lehigh County Children and Youth Services on November 4, 2014 with a report of serious physical injury relating to a female infant transported to [REDACTED] Saint Luke's Hospital by her biological mother. Child/Victim was admitted with a [REDACTED]

Upon admission to Saint Luke's Hospital the biological mother could not provide an explanation for injuries, and the case was assigned a Near Fatality status as the attending physician alleged the incident to be the result of non-accidental trauma.

Child/Victim was subsequently transferred to the [REDACTED] at Lehigh Valley [REDACTED] where she was admitted and treated for the [REDACTED]

Summary of DHS Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) commenced a review of the Near Fatality of [REDACTED] on October 8, 2014 by means of a collateral contact with Lehigh County Children and Youth Child Protective Services Intake Supervisor, [REDACTED]

██████████. Background data and preliminary case specific information was secured at this time and the Preliminary Report was prepared and submitted by OCYF/NERO.

Lehigh County Children and Youth Child Protective Services Intake Supervisor forwarded all relevant supporting case documentation to OCYF/NERO on October 15, 2014.

OCYF/NERO conducted site interviews with assigned caseworker and supervisory staff at Lehigh County Children and Youth Services on October 21, 2014. Case status and completed Child Protective Services case file was reviewed for compliance with Department of Human Services Regulation and Child Protective Services Law.

Children and Youth Involvement prior to Incident:

There is no record of service activity to either parent or Child/Victim by any public child welfare agency since the birth of Child/Victim in August, 2013.

Circumstances of Child Near Fatality and Related Case Activity:

On October 4, 2014 this case was referred to Lehigh County Children and Youth Services as a Near Fatality due to medical professionals at Saint Luke's Bethlehem ██████████ suspecting that Child/Victim sustained ██████████ due to non-accidental means while in the case of her biological mother.

At the initial point of contact with this family, it was unclear as to the exact jurisdiction of the allegations. Preliminarily a referral was made to the Northampton County Children and Youth Agency. Contact was made with the Child/Victim and biological mother by Northampton County Children and Youth on October 4, 2014. When it was determined that the allegations associated with this incident related to a location in Lehigh County, the ██████████ reassigned a report to Lehigh County Children and Youth Services. The case documentation initially developed by the Northampton County Children and Youth office was utilized by Lehigh County Children and Youth in the assessment of the incident.

Review of agency case files revealed documentation of collaboration with law enforcement and ██████████ throughout the course of the investigation. Lehigh County Children and Youth Services secured medical consultation from the agency's ██████████ consultation with medical personnel at Lehigh Valley Hospital. Additional information secured by assigned Child Protective Services intake worker from the biological mother indicated that Child/Victim fell from a bed to a hardwood floor.

Lehigh County Children and Youth completed the Child Protective Services investigation on October 15, 2014 assigning an Unfounded status determination to the incident.

Current Case Status:

Lehigh County Children and Youth Services completed the Child Protective Services investigation on October 15, 2014 and concluded that the injuries sustained by Child/Victim

were of an accidental nature and not the result of child abuse or neglect. The family was totally cooperative with county agency's investigation from the onset. The biological mother was also fully engaged in [REDACTED] regimen and medical recommendations made by the hospital. The county agency has determined that the incident was of an accidental nature. This conclusion was also supported by the criminal investigation conducted by the Lehigh County District Attorney's Office and the [REDACTED] Police Department.

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

N/A

Department Review of County Internal Report:

N/A as the county agency was not required to conduct a full Act 33 Near Fatality Review as per Statute.

Department of Human Services Findings

County Strengths:

The Northeast Regional Office of Children, Youth and Families determined that the county agency conducted a thorough and comprehensive investigation of the [REDACTED] case. The investigation was timely. There was evidence that the investigation was coordinated with the law enforcement agency assigned. Case file was well documented and [REDACTED] were afforded all parties.

County Weaknesses:

The Northeast Regional Office of Children, Youth and Families determined that there were no areas of weakness relating to the agency assessment of this case.

Statutory and Regulatory Areas of Non-Compliance:

OCYF/NERO determined that the county agency was in full compliance with all applicable Department of Human Services regulations.

Department of Human Services Recommendations:

The county agency is encouraged to continue investigating Child Protective Services cases in the manner evidenced in this case. Case file documentation reflects a thorough analysis of the data relevant to the case under investigation. There is also case documentation that supports timely supervisory review as well as evidence of multi-disciplinary consultation and collaboration.