



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: 04.13.12**  
**Date of Incident: 03.06.14**  
**Date of Oral Report: 03.06.14**

**FAMILY NOT KNOWN TO:**

**LEHIGH COUNTY CHILDREN AND YOUTH SERVICES**

**REPORT FINALIZED ON:**

**March 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, 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. Lehigh County had no statutory requirement to convene a review team in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child/Victim	04.13.2012
[REDACTED]	Biological Mother of Child/Victim	[REDACTED] 1983
[REDACTED]	Biological father of Child/Victim	[REDACTED] 1976
[REDACTED]	Sibling of Child/Victim	[REDACTED] 2004
[REDACTED]	Sibling of Child/Victim	[REDACTED] 2009
[REDACTED]	Sibling of Child/Victim	[REDACTED] 2010

**Notification of Child Near Fatality:**

[REDACTED] contacted Lehigh County Children and Youth on March 6, 2014 with a report alleging that Child/Victim sustained multiple skull fractures and facial injuries due to an incident whereby a television fell onto the Child/Victim. [REDACTED] certified this case as a Near Fatality due to allegations that the biological mother failed to provide adequate supervision of the Child/Victim at the time of the incident.

[REDACTED] the medical facility Child/Victim was treated for facial bruising, fracture of the [REDACTED], fracture of the [REDACTED], fracture of the [REDACTED] and fracture of [REDACTED].

Lehigh County Children and Youth commenced a Child Protective Service (CPS) investigation with mother listed as the alleged perpetrator on March 6, 2014 in conjunction with investigating personnel from the [REDACTED] Police Department. Medical records were secured from the medical facility and interviews were conducted by agency personnel with both the medical staff

as well as the biological mother of Child/Victim on March 6, 2014. Additionally, Lehigh County CPS caseworker reviewed medical reports with a pediatrician providing agency with consultation on complex child abuse cases.

A safety assessment of the all siblings of the Child/Victim was conducted on March 6, 2014 by Lehigh County Children and Youth. In collaboration with the investigating law enforcement entity a determination was made that all three siblings of Child/Victim were safe in the care of their biological father while the county agency conducted the CPS investigation relating to the incident. As preliminary CPS assessment evidenced the accidental nature of the incident the county agency did not prohibit the AP from access to either Child/Victim or siblings of Child/Victim.

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

The Northeast Regional Office of Children, Youth and Families (OCYF/NERO) commenced review of the Near Fatality of [REDACTED] on March 7, 2014. A site visit to Lehigh County Children and Youth was conducted on this date. Preliminary data collection and interviews with Child Protective Services intake supervisor and assigned caseworker were completed at this time. Background data and case specific information was secured at this time and the Preliminary Report was prepared and submitted by OCYF/NERO.

Lehigh County Children and Youth supervisor had collateral contact with OCYF/NERO on March 11, 2014 regarding the status of the case.

Lehigh County Children and Youth conducted a clinical case review of the Near Fatality on March 12, 2014. A representative from the OCYF/NERO participated in this case review.

On April 4, 2104 OCYF/NERO conducted a case file review at Lehigh County Children and Youth Services. The assigned supervisor was interviewed during site visit. Completed CPS case file was reviewed for compliance with Department of Public Welfare Regulation and Child Protective Services Law (CPSL).

OCYF/NERO reviewed the county agency's submission of the Child Death Data Collection tool on April 21, 2014.

**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 prior to this contact.

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

On March 6, 2014 this case was referred to Lehigh County Children and Youth as a Near Fatality due to medical professionals alleging that Child/Victim's biological mother failed to provide adequate supervision of Child/Victim. Due to this act of omission Child/Victim sustained life threatening injuries as the result of a television falling from a dresser onto Child/Victim. Child/Victim was admitted to Lehigh Valley Hospital where she was treated for multiple facial injuries and fractures of facial bones. The child/Victim remained at Lehigh Valley Hospital for three days. She [REDACTED] the care and supervision of her parents and was referred for follow up with her family pediatrician and an [REDACTED]. Child/Victim evidenced minor residual effects from the injuries and it is projected that she will fully recover.

Lehigh County Children and Youth completed the CPS investigation on March 26, 2014 assigning an Unfounded Status to the case. Both the county child welfare agency and law enforcement agency determined that the injuries sustained by the Child/Victim were accidental in nature and not the result of any acts or omissions by the biological mother. The county agency did not find any abuse or neglect issues related to the care of either Child/Victim or any of the siblings.

**Current Case Status:**

Lehigh County Children and Youth Services completed the Child Protective Services investigation on March 26, 2014. Following the agency's completion of the CPS investigation outreach was established with the Health Department of the City of [REDACTED] in an effort to explore potential informational outreach to families within the city that may also be utilizing television sets of similar vintage. A recommendation that derived from the agency's internal Near Fatality Review process focused on the need to offer information/public service announcements alerting families to the potential dangers of improper securing of older model televisions on "makeshift" stands.

Lehigh County Children and Youth has closed its case on this family.

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

Lehigh County Children and Youth did not conduct a Near Fatality Review on this case at it was Unfounded within 30 days of assignment. However, the agency did staff the case from a clinical perspective at the request of the medical practitioner providing consultation to Lehigh County Children and Youth. Primary impetus for this review stemmed from the medical professionals questioning the rationale for labeling the case as a "Near Fatality". It was the consensus of the group that the case should be more accurately evaluated from the perspective of avoidable household accidents than parental culpability. As a result of this meeting the committee set forth a recommendation to promote community awareness of the dangers associated with household accidental injuries due to improper/inadequate positioning of household appliances. The

recommendation included public service outreach in an attempt to engage local health care providers and community health professionals in a public information effort to warn parents of the dangers relating to storing and usage old televisions/appliances.

**Department Review of County Internal Report:**

N/A as Lehigh County Children and Youth had no statutory obligation to conduct Act 33 review as case was assigned an Unfounded status within 30 days.

The Northeast Regional Office of Children, Youth and Families does concur with the agency's internal clinical case review as it relates to informational outreach and enhancing public health outreach on proper use/securing of televisions/appliances.

**Department of Public Welfare 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 instant case. Case file was well documented and all [REDACTED] were afforded all parties.

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

Lehigh County Children and Youth have demonstrated a very proactive approach in evaluating the circumstances surrounding this Near Fatality. While the county agency had no statutory obligation to convene a review team on this case they proceeded to a full review of the case.

It was also quite evident from the agency's review of this case that Lehigh County Children and Youth exhibits an awareness of the various overarching contributing factors to childhood household injuries as they pertain to infants/toddlers growing up in impoverished circumstances.

County Weaknesses:

No areas were identified.

**Department of Public Welfare Recommendations:**

OCYF/NERO recognizes the quality and procedural mechanisms currently in place with in Lehigh County as they relate to the assessment and investigation of CPS cases and recommends their continuation.

The OCYF/NERO also commends the county child welfare agency in its collaborative relationship with this office in compiling case specific data and evaluating the overall process of

Near Fatalities/ Fatalities in an effort to promote consistent, quality services to the children, youth and families involved in this aspect of public child welfare service delivery.