



REPORT ON THE FATALITY OF:

Tamara Arnette

Date of Birth: 7/5/11
Date of Death: 6/5/15
Date of Report to ChildLine: 6/6/15
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT
OR WITHIN THE PRECEDING 16 MONTHS:**

Lehigh County Children and Youth Services

REPORT FINALIZED ON:

11/10/2015

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. Section 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Lehigh County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on June 18, 2015 and a follow-up review on August 20, 2015.

Family Constellation:

| <u>First and Last Name:</u> | <u>Relationship:</u> | <u>Date of Birth:</u> |
|-----------------------------|----------------------|-----------------------|
| Tamara Arnette | Victim Child | 7/5/2011 |
| ██████████ | Sibling | ██████ 2010 |
| ██████████ | Biological Mother | ██████ 1987 |
| ██████████* | Biological Father | ██████ 1987 |
| Resides in ██████████ | | |

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

OCYF/Northeast Regional Office (NERO) commenced preliminary Fatality Review of the Tamara Arnette case on June 6, 2015, by means of collateral contact with Lehigh County ██████████ supervisor. Case specifics secured and review of county agency's safety assessment of the victim child's sibling was discussed.

On June 18, 2015 and August 20, 2015, OCYF/NERO personnel participated in the county agency's Act 33 Fatality Review at Lehigh County Children and Youth Services.

A site record review was conducted by OCYF/NERO on July 18, 2015. In addition to case file review, OCYF/NERO program representative interviewed the assigned ██████ caseworker and supervisor responsible for the ██████ investigation.

On September 15, 2015 Lehigh County Children and Youth administrative personnel submitted the County Internal Report to DHS/OCYF/NERO for review. Report reviewed and accepted.

Children and Youth Involvement prior to Incident:

Lehigh County Children and Youth Services has no record of service activity with this family either at the time of referral or in the past.

Circumstances of Child Fatality and Related Case Activity:

Lehigh County Children and Youth Services received a referral on June 6, 2015, following the fall of Tamara Arnette from the window of a fourth floor apartment unit in the city of [REDACTED]. The victim child died as a result of the blunt force trauma caused by the fall.

Tamara was playing with her older sister at the time of the incident. [REDACTED]

[REDACTED] The biological mother of the victim child is a single parent currently in a nursing program at a local college.

Lehigh County Children and Youth Services commenced an investigation into the incident in conjunction with the Allentown City Police Department.

Interviews were conducted with the alleged perpetrator and various individuals associated with the family. The county agency also conducted a safety assessment of the victim child's sibling and determined that [REDACTED] was an appropriate caretaker and no safety threats were found.

Following a review of the circumstances with the law enforcement agency investigating the incident and the Lehigh County Coroner's Office, it was determined that the victim child died as a result of an accidental fall. No culpability on the part of [REDACTED] was found and no criminal charges were filed.

On August 3, 2015, Lehigh County Children and Youth assigned [REDACTED] to the case. The case was closed by Lehigh County Children and Youth Services as no protective services were determined to be needed. The family was provided with information regarding [REDACTED]

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

Strengths

- Lehigh County Children and Youth Services consistently meet the timeframes and statutory requirements under the Child Protective Service Law (CPSL). This investigation demonstrated a timely and thorough assessment. Additionally, there is documentation within the case file that supports a collaborative investigative effort with the law enforcement agencies investigating this incident.

Deficiencies

- OCYF/NERO has determined that there were no deficiencies regarding statutory or regulatory issues. Lehigh County Children and Youth Services followed all required case practice [REDACTED] involving this investigation.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse

- N/A, this case was determined to be of an accidental nature and not directly related to child abuse or neglect.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies

- DHS/OCYF/NERO has no recommendations associated with this case that impact changes at either the state or local level relating to monitoring/inspection functions.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse

- The recommendations set forth in the Lehigh County Children and Youth Fatality Review Report advocate for increased education and public awareness of window safety especially as it relates to the safety of children are supported by the OCYF/NERO.
- It is further recommended that increased education/training be made available to the various social service agencies that routinely come in contact with children/youth in their own homes.
- Additional collaboration with the various zoning/code enforcement jurisdictions within the county regarding window safety regulations/standards would also aid in the promotion of safer home environments. This collaboration could occur in a number of forms such as education/public service announcements, cross training of zoning/code enforcement staff and

child care staff and more concerted efforts on the part of housing staff to educate tenants of young children in window safety.

Department Review of County Internal Report:

Department of Human Services, Northeast Regional Office of Children, Youth and Families (DHS/OCYF/NERO) received the completed County Internal Report from Lehigh County Children and Youth Services on September 15, 2015. DHS/OCYF/NERO has accepted the county submission as an accurate summary of the investigation of the Tamara Arnette fatality. DHS/OCYF/NERO accepts and concurs with all of the recommendations set forth in the September 15, 2015 report.

Department of Human Services Findings:

- County Strengths: The county agency conducted a timely and thorough investigation of the incident. A corroborative investigative process occurred. There was consistent and free sharing of case specific data during all facets of the investigation process. Lehigh County Children and Youth Services continue to have a very active and broad based participation in the Act 33 Fatality/Near Fatality case reviews. Near Fatality and Fatality Reviews are conducted in a timely and consistent manner.
- County Weaknesses: There has been a recent lack of attendance of select law enforcement jurisdictions in the Act 33 Review process.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency: There were no statutory or regulatory areas of non-compliance related to this investigation.

Department of Human Services Recommendations:

The Department of Human Services concurs with the findings and recommendations of the Lehigh County Fatality Review team that an increased educational and awareness campaign advising of the dangers associated with child play in the vicinity of open windows.

Additionally, it is recommended that county children and youth agencies afford line staff additional training in the areas of household safety and identifying potential safety hazards of open windows especially in living units that are multi-level.