pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY

[redacted]

Date of Birth: 01/30/2011
Date of Incident: 02/05/2016
Date of Report to ChildLine: 02/05/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lehigh County Children and Youth Services

REPORT FINALIZED ON:
07/21/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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 the Child Protective Services Law related to this report. The county review team was convened on March 17, 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim/Child	01/30/2011
[redacted]	Mother	[redacted]1991
[redacted]	Step-father	[redacted]1990
[redacted]	Half-sibling	3 years old
[redacted]	Half sibling	2 years old
[redacted]	Step grandparent Household member	age 59
[redacted]*	Biological father of Victim/Child	32 years old

*Incarcerated

Summary of OCYF Child Near Fatality Review Activities:

Department of Human Services, Northeast Regional Office of Children, Youth and Families (DHS/NERO/OCYF) commenced near fatality review of case on 02/09/2016 by means of collateral contact with assigned Lehigh County Children and Youth Child Protective Services intake supervisor. Background information reviewed and current status of investigation discussed. Agency safety plan relating to siblings of victim child reviewed.

DHS/NERO/OCYF received and reviewed county agency's Preliminary Report/ Regional Notification of a Child Near Death on 02/09/2016. All relevant background data and casefile history was requested by DHS/NERO/OCYF at this time.

A site visit to Lehigh County Children and Youth was conducted by DHS/NERO/OCYF on 02/12/5016. Preliminary record review of case file was completed. Collateral interviews were also conducted with assigned CPS caseworker and CPS supervisory personnel.

DHS/NERO/OCYF supervisor and program representative participated in the Multi-Disciplinary Team meeting convened by Lehigh County Children and Youth on 02/24/2016.

Representatives from DHS/NERO/OCYF also attended the Near Fatality Review at Lehigh County Children and Youth Services on 03/17/2016.

DHS/NERO/OCYF Program Representative conducted site visit to Lehigh County Children and Youth Services on 04/05/2016. Interviews with CPS Intake supervisor and caseworker were completed. CPS case file was reviewed and overall case disposition was discussed.

DHS/NERO/OCYF received a completed summary of the Act 33 review from Lehigh County Children and Youth Services on 06/15/2016. The submission was reviewed and accepted for incorporation into the Department's report.

Children and Youth Involvement prior to Incident:

Lehigh County Children and Youth Services had two prior referrals on the family. Both referrals were related to General Protective Services concerns associated with victim child's high lead levels and lack of weight gain. The first referral was investigated by Lehigh County Children and Youth Services in 01/2014. In this circumstance, victim child, who was three years old at the time, was alleged to have a high lead level that required medical follow-up which the family did not complete. During the time of the county agency's involvement with the family, case documentation reflects the agency provided assistance to the family in scheduling a pediatric follow-up for victim child and linkage of the family to the [redacted] Health Bureau for household lead remediation. Case file documentation also includes Lehigh County Children and Youth Services' referral of the family to in-home/diversionary services funded through the county agency's budget and contract with a local private social service, Pinebrook Services. Services were provided for an approximate six month time period with family evidencing compliance with all recommendations. Case was subsequently closed on 05/10/2014.

The second General Protective Services referral on victim child was received by Lehigh County Children and Youth Services on 01/22/2015. The concerns raised at this point involved allegations that the child, then age four, was again losing weight, had irregular follow-up with [redacted] and may require [redacted]

[redacted] hospitalization. Agency involvement at this time included case worker contact with the biological mother at the family residence and assistance in securing medical appointments and referrals for [redacted]. Agency case file documentation includes a second referral for in-home diversionary services and closure at the General Protective Services Intake level.

It should be noted that a referral for diversionary services was completed prior to Lehigh County Children and Youth Services closing the General Protective Services Intake. The county agency authorized the in-home diversionary expenditure for this case. However, there is no record of the family engaging in this programming.

Circumstances of Child Near Fatality and Related Case Activity:

Lehigh County Children and Youth Services received [redacted] on 02/05/2016 alleging that victim child, now five-years-old, was malnourished and required hospitalization due to a body mass index of 1%. [redacted] Referral source alleges parental neglect in follow-up with medical recommendations.

Lehigh County Children and Youth Services commenced a Child Protective Services investigation by in-person contact with victim child and parents on 02/06/2016. The county agency also secured consultation from [redacted] provider and also requested background [redacted] data on child and parental involvement in child's [redacted]

There is significant case history involving this family that suggests victim child requires multiple services due to her developmental and medical issues. [redacted]

The family has a record of service activity with multiple service providers within Lehigh County due to victim child's needs. The biological mother was active with [redacted] Pinebrook Family Services [redacted]

Due to the complexities associated with investigating the Child Protective Services allegations, Lehigh County Children and Youth Services convened a Child Advocacy Center Multi-disciplinary Team case review in order to determine [redacted] This review was conducted on 02/24/2016.

Lehigh County Children and Youth Services also referred the case to the Lehigh County District Attorney's Office due to the severity of the allegations.

During the timeframe that the county agency assessed the allegations and reviewed the circumstances of victim child's current weight loss, it was determined that a number of programmatic needs were underutilized. [redacted]

[redacted]

The CPS investigation also determined that the biological mother did in fact possess significant knowledge of victim child's medical needs and appeared to be doing the best that she could. Given the complexities associated with victim child's medical condition and the intricacies of [redacted] services, Lehigh County Children and Youth Services determined that there was no evidence to support willful neglect on the part of the parents. [redacted] the case was assigned an Unfounded Status on 04/05/2016. The case has been open for ongoing services to assure that all of the services and recommendations for victim child are secured [redacted]. The family has been cooperative throughout the investigation.

The law enforcement agency investigating this case has closed its case. No criminal charges will be filed.

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

Strengths in compliance with statutes, regulations and services to children and families:

- Lehigh County Children and Youth initiated and conducted the Child Protective Services investigation in a thorough and timely manner. Case file documentation was clear and consistent with DHS regulatory guidelines.
- DHS/NERO/OCYF review of CPS intake case file evidenced full compliance with [redacted] the Child Protective Services Law (CPSL).

Deficiencies in compliance with statutes, regulations and services to children and families:

- [redacted]The Act 33 report did not identify any statutory or regulatory deficiencies. However, a recommendation was made that a more coordinated effort by local social service agencies and medical practitioners be established to ensure concerted follow-up of cases similar to this one. Collaboration of service providers and assistance of this family in securing and maintaining programming for victim child. There is significant case history and medical background information that would suggest a more formalized tracking of victim child's medical and social development to insure consistent provision of services to child victim and family. [redacted]

[redacted]

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

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

N/A

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

There was discussion that Lehigh County Children and Youth Services in conjunction with local social service agencies begin to identify a countywide forum where cases similar to this be discussed. There was consensus that a more systematic review should be established.

Department Review of County Internal Report:

DHS/NERO/OCYF received the County Review Team Report on the Near Fatality of victim child on 05/11/2016. DHS/NERO/OCYF reviewed the county agency submission at this time.

The Act 33 Report completed by Lehigh County Children and Youth Services accurately reflects the discussions and recommendations set forth at the Act 33 Near Fatality Review conducted on 03/17/2016.

Department of Human Services Findings:

- Lehigh County Children and Youth Services completed a timely and thorough Child Protective Services investigation of the near fatality of victim child. All statutory and regulatory requirements were met. The county agency conducted the CPS investigation in collaboration with the local law enforcement agency. Information was shared consistently.

- DHS/NERO/OCYF also determined that the county agency sought and secured input from medical professionals that had current and prior involvement with the victim child. Various medical professionals were actively involved in the assessment/validation of the allegations associated with the incident under investigation.

- The primary shortcoming identified both in the Lehigh County Children and Youth Act 33 Report and the case analysis conducted by DHS/NERO/OCYF

relates to the county agency's resolution of prior General Protective Services allegations that came to the agency's attention both in 2014 and 2015.

- In 2014 the county agency accurately identified a need for ancillary supportive services for the family relating to the multiple needs of victim child and referred the family for in home diversionary programming funded through Lehigh County Children and Youth Services contract with a local social services agency. This service was appropriate and met the varied needs of the victim child and parent. However, the county agency was once again involved in a similar allegation in 2015 that has no case documentation that service provision or referral to ancillary programming was completed. Given the significant case history and documented array of needs [redacted] of victim child, it certainly would have been more prudent to follow this family in a more consistent and formalized manner. Lehigh County Children and Youth Services does not have a consistent quality assurance safeguard to ensure that cases such as these are formally tracked for service provision and actual compliance.

- While there is a concern regarding the county agency's lack of case documentation of diversionary service provision, the prior General Protective Services assessment completed in 03/2015 identified valid issues and offered an appropriate case remedy. The primary issue centers on the agency's referral process and service provision. There appears to be an organizational need to ensure that cases such as these receive a more formalized tracking to ensure that the recommended services have been implemented. In this case, a more definitive process for referral to diversionary services could have assisted in service provision to victim child and her family. Lehigh County Children and Youth Services should develop a more structured mechanism to track service delivery and actual provision of services in those cases where the agency has determined a need for enhanced services that the county will fund.

Department of Human Services Recommendations:

DHS/NERO/OCYF concurs with the service recommendations and ongoing case plan established by the county agency for the victim child and her family. Lehigh County Children and Youth Services conducted a thorough and timely investigation into a case that was replete with medical issues and service provision complications given the victim child's extraordinary needs. DHS/NERO/OCYF recommends that the county agency continue to conduct CPS investigations in a similar fashion.

As has been previously discussed, DHS/NERO/OCYF recommends that the county agency develop an administrative vehicle to review cases of similar circumstance in a more formal manner. This is especially important when the agency has identified bona fide service needs that may not be categorically the responsibility of the public child welfare system but in the best interest of the children and families served. In this case, there was an organizational administrative deficiency in assuring that services recommended and fiscally authorized were actually implemented. Serious

consideration should be given to maintaining cases such as this within one of the county agency's ongoing protective services units. In reviewing the current case status and family functioning with the active ongoing caseworker, there is ample evidence to suggest this case benefitted from the active engagement of a child welfare caseworker. Case history and case file review by DHS/NERO/OCYF determined that the county agency recommended diversionary in-home services for this family subsequent to the General Protective Services referral of January, 2015. While there was fiscal authorization for the service and case closure documentation indicating the service was set in place, there is no evidence that the family or the service provider were apprised of this recommendation. DHS/NERO/OCYF has determined that Lehigh County Children and Youth Services administrative personnel should establish a mechanism that would track actual referrals and disposition of cases where diversionary services are recommended. In this case, there appeared to be a systemic break in tracking. It is, therefore, recommended that Lehigh County Children and Youth Services administrative staff develop a working protocol for tracking and follow up on cases referred for agency funded services. It is especially important to implement procedures that would track cases that are closed out of the agency intake system.

The DHS/NERO/OCYF also recommends that a closer critical analysis of cases similar to this one be conducted. This is especially relevant to larger child welfare agencies that purchase in-home diversionary services such as the ones involved with this case. If there was an established mechanism in place to identify and track the progress of this family, there may not have been any service gaps that resulted in the public welfare agency becoming re-involved with this family.