pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/03/07
Date of Incident: 04/24/16
Date of Report to ChildLine: 04/25/16
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:
November 10, 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 05/19/16.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	04/03/07
	Mother	[redacted]/82
	Father	[redacted]/81
	Maternal Grandmother	Unknown
	Half sibling	[redacted]/99
	Half sibling	[redacted]/02
	Sibling	[redacted]/06

Summary of OCYF Child Near Fatality Review Activities:
The Department of Human Services, Office of Children, Youth and Families, Northeast Regional Office (DHS/OCYF/NERO) conducted a preliminary case review of the incident by means of a collateral contact with the assigned Child Protective Services (CPS) Intake supervisor at Lehigh County Children and Youth Services (LCCYS) on 04/25/16. Background data and preliminary assessment of the family was discussed. Safety assessments relating to the victim child's siblings were also discussed.

DHS/OCYF/NERO program representative conducted a site visit to LCCYS on 04/27/16 and conducted a preliminary review of the case file and interviewed the CPS Intake supervisor. At this time, the Preliminary Notification Report of Near Fatality and a copy of the county child welfare agency case files was provided to DHS/OCYF/NERO program representative.

DHS/OCYF/NERO program representative and supervisory personnel participated in the Act 33 review at LCCYS on 05/19/16.

DHS/OCYF/NERO program representative conducted a LCCYS site visit on 06/21/16. The agency's CPS case file was reviewed and the CPS supervisor and assigned CPS investigator were interviewed at this time. The case was reviewed with agency

administrative and legal personnel and authorized status determination of Unfounded was made.

Children and Youth Involvement prior to Incident:
Lehigh County Children and Youth had multiple periods of service activity with this family starting in 2002. The initial involvement with the county agency involved family homelessness. The family was referred to a local shelter at this time.

The agency again became involved with the family in April, 2003 when the biological mother was selling and using drugs. There was an agency general protective assessment and assignment of the case at his time. The agency worked in tandem with local law enforcement authorities. The oldest sibling of the victim child was referred for [redacted] programming. The biological mother successfully completed [redacted]
The case was closed in September, 2003.

In April 2008 the family again came to the attention of LCCYS when allegations were investigated relating to sexual abuse of an older sibling of the victim child by a male friend of an extended family member. At the conclusion of the CPS investigation, services were arranged for the family. The family was linked to [redacted] services and closed.

In August 2009 LCCYS investigated allegations of substandard housing and possible service needs associated with the victim child's developmental delays. The agency offered ongoing supportive services to the family. However, the family was already receiving [redacted] services for the victim child through the [redacted] and also [redacted] services for an older sibling of the victim child. Following the agency's assessment of the case at the Intake level it was determined that there were no safety issues relating to parental capacities and no involuntary interventions were necessary. As the family was compliant and declined agency services, the case was closed.

In February 2010 LCCYS received a referral alleging that the older sibling of the victim child was violent towards the victim child. Concerns were also raised that the victim child required [redacted] During this period the family was again linked to multiple in-home service providers. Following an assessment by the county children and youth agency, it was determined that the family was cooperating with all recommended [redacted] services and the agency closed the case on 07/16/10.

In November 2013 LCCYS received a referral regarding truancy related issues involving an older sibling of the victim child. Following an assessment, the case was referred to a truancy diversionary program and closed at the GPS intake level 12/19/13.

LCCYS assessed the family again on 02/03/14 following a truancy referral on an older sibling of the victim child. At this time there was also JPO involvement with

the identified child so conjoint interventions were conducted. Multiple [redacted] services were set in place. [redacted] regimens were implemented and the case was closed at the GPS intake level on 03/19/14.

Truancy referrals regarding the victim child began in 07/24/15. During the agency's Intake assessment, it was determined that the victim child was experiencing multiple issues in the home. It was becoming increasingly more difficult for the biological mother to meet the [redacted] needs of the victim child. At this time, the biological mother reported difficulties in addressing the victim child's nutritional needs. It was determined that services were needed due to the victim child's [redacted] issues. Once linkages to local social service agencies and compliance with referrals were established, the county agency again closed the GPS in September 2015.

Circumstances of Child Near Fatality and Related Case Activity:
On 04/25/16, LCCYS was notified of a Near Fatality case alleging the biological mother was negligent in securing the necessary medical treatment for and meeting the basic nutritional needs of the victim child. At the time of agency's current involvement, the victim child was referred for [redacted]

At the time of the referral, the victim child was hospitalized at a local medical facility undergoing an evaluation to rule out multiple medical conditions [redacted] During this time period the agency conducted interviews with service providers, parent and also assessed the family home to determine if there were any outstanding safety issues. Coordination of services with the educational and medical community were also completed during this time frame. A referral was made to the local law enforcement agency at this time as well.

It was determined that the multi issues related to the victim child's condition were not directly the result of parental neglect or abuse. Given the multiple medical issues compounded by the victim child's delays, there was clearly a need for more concerted multi-system response to addressing the victim child's needs. During this assessment period the county agency was able to link the various service providers from the medical, educational and [redacted] systems together to develop a plan that met the child's needs and provided the parental support necessary to maintain the child within the family home.

Lehigh County Children and Youth submitted an Unfounded status determination to ChildLine on 06/24/16.

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 accurately identified and arranged for services for the victim child in this case. The current Child Protective Services investigation was conducted in a timely and thorough manner. All due process assurances were provided as per the Child Protective Services Law.

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

  N/A

- 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 service providers to prevent child abuse.

The complexities of service delivery to the victim child and the multidisciplinary nature of this case posed a number of challenges for the public child welfare agency. While the county children and youth agency is not the sole agency responsible for providing services to this family, they do have an inherent responsibility to assure that services are implemented and maintained especially when the agency is involved due to allegations of parental neglect. In this specific circumstance, extensive prior agency case history documents a pattern of service delivery fraught with inconsistency. A case can certainly be made for minimal parental investment of an acquiescent quality. Agency case history also demonstrates a pattern of initiation of services and lack of parental resolve to maintain the recommended service. While case circumstances relative to this family are not routine, they certainly have precedents within Lehigh County. It would benefit the county children and youth agency to develop a formal means to track referrals, case progress and service provision in cases such as this to ensure that service delivery is maintained.

A more formalized countywide review mechanism for cases such as this would provide for a more systematic and reliable means to monitor and assure that

recommended services are made available, delivered and maintained. If there was such a review process already set in place, the service gaps and issues that presented in this case may have been identified earlier and been able to be remediated.

Department Review of County Internal Report:
Lehigh County Children and Youth Agency submitted the County Review Team Report to DHS/OCYF/NERO on 07/20/16. DHS/OCYF/NERO determined that the county internal report accurately reflected background case history and the status of the county agency's current Child Protective Services investigation.

Department of Human Services Findings:

- County Strengths:

Lehigh County Children and Youth conducted a timely and thorough Child Protective Services investigation. Case file review and interviews with agency personnel evidenced an investigation that drew upon all available medical data, information secured from various service providers and the investigating law enforcement agency. There was also evidence of consistent supervisory oversight and contemporaneous case documentation.

The county agency continues to utilize a very broad based and large representative pool for the Act 33 review process. The team is vocal and very engaged in the review process.

- County Weaknesses:

It is evident from review of the prior record of service activity by the county agency with this family that many of the current case circumstances had foundational elements established much earlier than April 2016. There is clearly a pattern of service intervention, family engagement and subsequent lapses of service provision that are documented in Lehigh County Children and Youth's case files. Given the extensive service needs and array of services offered and provided to this family in the last ten years, the primary weakness evident in this case lies in the county agency's inability to track and assure that all necessary services were implemented and maintained. This case, on the merits of prior agency contacts, would have benefited from ongoing case management services implemented by the county child welfare agency. As the multiple referrals suggest, services beyond an intake assessment were warranted.

There was a breakdown in the monitoring and implementation of services to this family by multiple entities. This weakness should not be viewed as solely the county child welfare agency's issue but as a responsibility that includes the various social service providers, the medical community as well as the educational system. As the case history reflects, there is multi-system involvement with this family that spans a full decade. Concomitant with this involvement is a shared responsibility

by all providers to ensure that services are arranged, implemented and maintained so that the needs of all the children within this family are met.

It would certainly benefit the victim child and all the agencies that have/will provide services to this family to have a formal means to assess the progress and needs of the victim child and family. The provider service community involved with this case is large and spans many disciplines.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There are no statutory or regulatory areas of non-compliance. The agency completed a timely, thorough and complete assessment of the allegations according to the regulatory requirements of the Department of Human Services and the Child Protective Services Law. DHS/OCYF/NERO continues to recommend that the county agency initiate and complete Child Protective Services investigations in a manner consistent with the practice standards evidenced in this case.

Department of Human Services Recommendations:

As has been outlined previously, DHS/OCYF/NERO has determined that the primary area of concern relating to this case derives from the circumstances surrounding assessment of needs, authorization/linkage of services and the family's consistent participation in the recommended programming.

Lehigh County Children and Youth clearly identified the multiple needs for both the victim child and the parent in this case on multiple occasions. Case file documentation outlines the needs, recommended services and authorization of programming. However, agency case history also documents multiple service needs for the victim child and parent that cross multiple disciplines including medical, educational and financial.

DHS/OCYF/NERO recommends that the county agency explore a more systematic method to identify service and track progress for cases that are of similar complexity and cross multi-disciplinary fields. Participation and involvement of the larger provider community within Lehigh County is essential to the success of this endeavor.