pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/19/2016
Date of Incident: 06/10/2016
Date of Report to ChildLine: 06/11/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

The Lehigh County Office of Children and Youth Services

REPORT FINALIZED ON:
01/05/2017

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 related to this report but the county review team was convened on 07/21/2016, which was later than the 31st day following receipt of the oral report and outside the timeframe required by the Child Protective Services Law. Part of the Act 33 protocol for the county agency is to convene the review team on the third Thursday of every month and the county agency decided to adhere to their protocol instead of convening the Act 33 review team earlier during the month of July 2016. Lehigh County did report that a Multi-Disciplinary Team meeting was held on 06/29/2016 and the case information was discussed at that time; however, the members of the Act 33 review team were not present at that meeting.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	03/19/2016
	Biological mother	[redacted]1991
	Biological father	1994
	Paternal grandfather	Unknown
	Paternal grandmother	Unknown
* [redacted]	Paternal aunt	Age 16
	Paternal great-aunt/Kinship Caregiver for victim child	[redacted]1964
* [redacted]	Paternal great-uncle/Kinship caregiver for victim child	[redacted]1962
* [redacted]	Maternal Grandmother	Unknown

* 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 Near Fatality Review Activities:

The Northeast Regional Office of the Office of Children, Youth and Families (NERO) communicated with the agency via phone upon receipt of the report to review initial referral and allegations.

The NERO participated in the Act 33 meeting on 03/10/2016. A site record review was conducted by DHS/OCYF/NERO. In person interviews were conducted with the assigned Child Protective Services (CPS) caseworker and supervisory staff. Background information was secured regarding prior case involvement and the status of the criminal investigation. Current case documentation was secured and reviewed.

Children and Youth Involvement prior to Incident:

There is no prior agency involvement with this child or family.

Circumstances of Child Near Fatality and Related Case Activity:

Late in the evening on 06/10/2016 the victim child was brought into the Lehigh Valley Hospital [redacted] by Emergency Medical Services (EMS). EMS was reported to have been called by the family after the victim child "went limp" and was non-responsive while being held by his father. After examination, the victim child was certified to be in critical condition as a result of suspected child abuse. The victim child's prognosis [redacted] at the time of referral to the county agency on 06/11/2016 and he was admitted to [redacted] Lehigh Valley Hospital [redacted] The father was named as the alleged perpetrator for causing bodily injury to the victim child.

The victim child's case was consulted with the hospital's Child Protection Team, which is led by a physician who specializes in child abuse pediatrics. [redacted] which was also concerning for child abuse. The explanation provided by parents did not coincide with the victim child's injuries. The referral source reported that if the victim child [redacted] home, this would be a great risk to his life, as he experienced a life threatening event as a result of suspected child abuse which resulted in the certification of the child as having a near fatality.

On 06/11/2016 the county agency received the child protective services (CPS) near fatality report concerning the victim child. This was the first referral to the county agency concerning the victim child and his family members. The allegations stated the victim child was at the home of his paternal grandparents', where the victim child and his parents' resided, in the arms of his father, when the victim child became limp and unresponsive. The victim child was transported to Lehigh Valley Hospital by ambulance where he was found to have [redacted] These injuries are consistent with the victim child being shaken. There is a [redacted] which has required the county to submit a CPS investigation outcome of pending to ChildLine.

[redacted]

[redacted]

At the time of his placement it was learned that the victim child was behind on his immunizations as he missed his two-month well-baby check-up.

On 07/01/2016, approximately three weeks following the incident, the victim child attended a follow-up pediatric appointment [redacted] Paternal great-aunt/kinship caregiver described that the victim child's head size was increasing over the past two days and he had been vomiting. It was determined that the victim child's original injuries [redacted]

On 07/08/2016, the victim child [redacted] and returned to the kinship home of his paternal great-aunt and uncle. Since that time the victim child has had numerous follow-up medical appointments [redacted] to monitor his condition. He also receives [redacted] services and receives [redacted] In addition, the victim child attends [redacted]

Parents have provided differing and changing histories of the circumstances around the victim child's injuries to different professionals throughout the CPS investigation. The parents stated they were visiting maternal grandmother in New Jersey on 06/10/16. Initially they stated no concerns with the victim child during the drive back from New Jersey to the home of paternal grandparents in Pennsylvania. The mother stated that the victim child was "nasally" sounding during the drive, but acting normally. Later, both parents changed this history and described the victim child as "fussy" during the car ride. On 06/10/2016, upon arriving at the home of paternal grandparents in Pennsylvania, the victim child was reportedly left in the car seat inside the home until the paternal aunt changed his diaper and made him a bottle. The mother said that when the victim child is "gretzy", she gives him to paternal grandmother. The paternal grandfather reportedly remained in the basement during the time of the incident and had no contact with the victim child. The mother reportedly was preparing food for herself and the father and they ate together while the victim child remained with paternal grandmother and paternal aunt. The mother stated after eating, she went to take a shower and the father went upstairs to their bedroom. Mother offered varying lengths of time that she spent in the shower. Mother and father both stated that they heard paternal grandmother yell at the victim child, "why don't you just shut up!"; although father later stated this did not occur. Paternal grandmother then called for the father to take the victim child, which he did. The victim child remained in his parents' bedroom and father made a bottle. According to father, he

began feeding the victim child the bottle and after about 1 to 2 minutes, the victim child went "limp" in his arms. Parents also provided a history that the victim child had been put down to sleep, but when they picked him up he went "limp" for a short time. Another different history that the parents provided was that father put the victim child into his baby swing and the victim child started making "weird noises" heard by the father and mother. The father said he rushed to get mother, who was exiting the shower, when he heard these noises. When the mother got to the victim child, his eyes "were rolled back in his head and he was limp." Together, the mother and father called for other family members present in the home to call 911.

The mother's story about the incident changed several times. She at one point provided information during the investigation that her adult friend may have hurt the victim child while the family was visiting maternal grandmother in New Jersey. Mother also reportedly named maternal grandmother as having caused [redacted] injuries.

The mother took a polygraph on 07/11/2016 and failed. Father has been offered a polygraph by law enforcement but cancelled the appointment and stated his attorney has advised him against participating.

[redacted] Mother reported that she and the victim child's father are still a couple, but father has denied this.

[redacted] Father is encouraged to attend follow up medical appointments for the victim child.

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;

  The county agency Near Fatality Report submission presents a very detailed analysis of the investigation of the incident. Criminal investigators and county child welfare personnel have worked conjointly throughout the investigation. In addition, the county agency was able to place the victim child with a relative resource.

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

The county agency needs to follow up with a referral for the victim child to [redacted] Services and obtain his birth records from New Jersey. The county agency should also seek additional consultation with [redacted] to attempt to detail [redacted] and the corresponding timeline for occurrence.

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

  No recommendations were made.

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

  No recommendations were made.

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

  No recommendations were made..

Department Review of County Internal Report:

The NERO received the county agency report and requested clarification on 06/11/2016. The NERO had conversations regarding the report with LCCYS staff on 06/11/2016 and 07/21/2016. The NERO received the final report from the county agency on 09/27/2016 and does concur with the findings in the county agency report.

Department of Human Services Findings:

- County Strengths:

  NERO has determined that the county agency commenced the CPS investigation of the victim child's case in a timely and thorough manner. The county agency has followed all established protocols for referral to law enforcement agencies and collaboration established by statute and regulations. Site record review by NERO validated that there has been extensive collaboration and information sharing on the part of medical personnel, law enforcement and county child welfare personnel regarding this case. No statutory or regulatory violations were found.

- County Weaknesses: and

  The county agency did not convene a review team related to this CPS near fatality report until 07/21/2016, which was later than 31 days following receipt of the oral report and outside the timeframe required by the Child

Protective Services Law. Part of the Act 33 protocol for the county agency is to convene the review team the 3rd Thursday of every month and the county agency decided to adhere to the protocol instead of convening the Act 33 team earlier during the month of July 2016. The county agency did report that a Multi-Disciplinary Team meeting was held on 06/29/2016 and the case information was discussed at that time; however, the members of the Act 33 team were not present at that meeting.

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

  There were no areas of statutory or regulatory non-compliance identified. A discussion was held with the county regarding NERO's concerns with about using Multi-Disciplinary Team meetings in addition to Act 33 meetings when the scheduled date for the Act 33 meeting is 31 days past the date of receipt of the oral report.

Department of Human Services Recommendations:

The county agency needs to review their current Act 33 meeting protocol and determine if changes are needed to ensure the county review team is convened in accordance with the timeframes established by the Child Protective Services Law. If the county agency convenes an Multi-Disciplinary Team meeting in situations where the Act 33 meeting will be held past the 30 day mark, the county must ensure the Multi-Disciplinary Team meeting adheres to the criteria outlined in Bulletin #3490-15-01 entitled Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by Act 33 of 2008 and Act 44 o 2014.