REPORT ON THE FATALITY OF:

Felix Robinson-Geist

Date of Birth: 11/09/16
Date of Death: 02/10/17
Date of Report to ChildLine: 02/16/17
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:
07/27/2017

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))

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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 conducted on 03/09/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Felix Robinson-Geist	Victim child	11/09/2016
	Brother	2012
	Biological Mother	1985
	Biological Father	1990
	Paternal Grandfather	age 55
* Resides in Bucks County	Biological Father of Sibling	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 Fatality Review Activities:

The Northeast Regional Office (NERO) conducted a preliminary review of Lehigh County's investigation of the incident and conducted a collateral interview with the intake supervisor at the county agency on 02/23/2017. The prior record of service activity and the current status of the agency safety assessment of the victim child's sibling were reviewed.

An Act 33 fatality review was conducted at Lehigh County Children and Youth Services on 03/09/2017. The NERO program representative and supervisory personnel attended the Act 33 review meeting. The NERO representative interviewed the assigned caseworker and reviewed the current status of the investigation on this date.

The NERO conducted site interviews and case file reviews at Lehigh County Children and Youth on 04/26/2017.

Children and Youth Involvement Prior to Incident:

On 08/21/2016, Lehigh County Children and Youth Services received a report for allegations of drug use by the victim child's biological father following an alleged overdose. The biological mother was pregnant with the victim child at the time the allegations were made. Concerns were raised for the supervision of the victim child's sibling and home environment. The case was assessed and maintained by the [redacted] intake department, as the concerns did not rise to the level of child abuse. The agency requested that the parents submit to urine screenings due to the allegations on the report. The father tested positive for marijuana and the mother's urine screen was negative. Services were offered but declined by the family. The case was closed on 09/15/2016.

Circumstances of Child Fatality and Related Case Activity:

Lehigh County Children and Youth Services conducted a [redacted] investigation for allegations of physical abuse to the victim child's 4-year-old sibling on 02/15/2017. Due to the physical abuse allegations, the county agency arranged for a medical examination of the victim child's 4-year-old sibling on 02/16/2017. [redacted] information was secured alleging the victim child, who died on 2/10/2017, died as a result of being struck by a shoe that was thrown by the victim child's [redacted] These allegations resulted in the re-evaluation of the circumstances surrounding the victim child's death, previously listed as accidental.

After a review of the autopsy results with the Lehigh County Coroner's Office and the District Attorney's Office, it was concluded that the cause of death was determined to be SIDS. On 03/07/2017, Lehigh County Children and Youth completed the CPS investigation and assigned an [redacted] status to the investigation.

From the commencement of the initial investigation in February 2017 to the conclusion of the investigation in May 2017, a safety plan was developed for the victim child's sibling. The caseworker assigned to complete the [redacted] investigation met with the victim child's biological mother and developed a safety plan that transferred primary custody and responsibility of the victim child's sibling to his biological father in Bucks County. Lehigh County Children and Youth secured the assistance of Bucks County Children and Youth with this arrangement and assessment of the father's home. The biological father of the victim child's sibling provided full time care and supervision for the sibling in his Bucks County home. Once the case disposition was determined to be [redacted] the initial safety plan was withdrawn and the victim child's sibling was returned to the full time care and custody of his biological mother. Lehigh County Children and Youth recommended and arranged [redacted] for the biological parents and sibling of the victim child. Following this recommendation the agency closed the case within the public child welfare system.

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

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

  Lehigh County Children and Youth Services has not submitted a written summary of the Act 33 fatality review. However, there were no recommendations made during the review applicable to this area.

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

  The county's internal report due on 5/17/2017, has not been submitted to the NERO as of the writing of this report.

- 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; and

  N/A

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

  N/A

Department Review of County Internal Report:

As of the writing of this report the county agency has not submitted the county internal report to the NERO.

Department of Human Services Findings:

- County Strengths:
  The county agency conducted a timely and thorough ███ investigation. Lehigh County Children and Youth Services collaborated with the investigating law enforcement entity to complete the investigation. Information was freely shared between agencies and the collaboration was evident.

  The county agency ensured the due process of all involved individuals and compiled an accurate record of all agency actions.

- County Weaknesses: and
  While the NERO was able to ascertain information regarding the status determination and data review that was conducted through interviews with agency personnel, case documentation of this information was not clearly demonstrated in the agency case file. A more consistent method of case documentation should be established to document the justification and approval of case dispositions especially when investigations involve multiple investigating entities and complex medical reports.

  Lehigh County Children and Youth Services has not submitted the county internal report as of the writing of this report. The final report was due on 05/17/2017.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  Lehigh County Children and Youth Services has not submitted the county internal report according to the time frame established by the CPSL. The NERO has determined that this is a regulatory violation and has prepared a licensing and inspection summary (LIS) for submission to the county agency requesting a plan of correction.

Department of Human Services Recommendations:

Lehigh County Children and Youth has established a deliberate and comprehensive multi-disciplinary approach to the review of near fatalities and fatalities within the county. Act 33 reviews are always well planned with ample participation by the various agencies serving children and families within Lehigh County. However, given the recent administrative changes and agency re-organization it may benefit the agency to consider dedicating administrative support staff to be responsible for the timely submission of case documentation as per the Act 33 statute. It appears that agency administrative personnel are responsible for multiple roles concurrently. This has encumbered the current staff complement resulting in multiple overdue Act 33 submissions.