pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/08/2016
Date of Incident: 04/09/2017
Date of Report to ChildLine: 04/09/2017
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:
11/27/2017

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))

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 04/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Child/Victim (C/V)	12/08/2016
[redacted]	AP/Father of C/V	[redacted]1992
[redacted]	Mother of C/V	1979
* [redacted]	Sibling of C/V	[redacted]2007
* [redacted]	Paternal 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 Office of Children Youth and Families (OCYF), Northeast Regional Office(NERO) program representative conducted a preliminary review of Lehigh County Child Protective Services (CPS) investigation of the incident and conducted collateral interview with the intake supervisor at the county agency on 04/17/2017. Prior record of service activity and current status of agency safety assessment of C/V was also reviewed.

The County Act 33 Near Fatality Review was conducted at Lehigh County Children and Youth Services on 04/20/2017. OCYF/NERO program representative and supervisory personnel attended the Act 33 Review.

OCYF/NERO conducted a site visit to Lehigh County Children and Youth Services on 05/09/2017. Interview of assigned CPS caseworker by NERO/OCYF program representative was completed on this date. Current status of CPS investigation was also reviewed.

Collateral interviews by OCYF/NERO were conducted with Lehigh County CPS caseworker and supervisor on 06/08/2017. Discussion centered on case file documentation, investigation procedures and service provision to family.

OCYF/NERO program representative conducted a follow up interview with assigned CPS caseworker on 08/23/2017. Status of the case assignment and ongoing services was reviewed.

Lehigh County Children and Youth Services completed the CPS investigation on 06/06/2017 and assigned an unfounded status to the investigation. The agency concluded that there was not sufficient evidence to conclude that actions of alleged perpetrator (AP) were abusive as per Section 6303 of Child Protective Services Law (CPSL).

OCYF/NERO received a copy of the agency Near Fatality Data Collection Form on 07/03/2017.

Children and Youth Involvement prior to Incident:

Lehigh County Children and Youth Services was initially active with this family in December 2016. A referral was made to the county agency on 12/08/2016. The case was assigned for a General Protective Services (GPS) intake assessment following the birth of the Child/Victim when the infant tested positive for marijuana [redacted] There were concerns that the biological mother was using [redacted] drugs. At the time of this writing the biological mother and biological father of the Child/Victim have been reticent in actively engaging in [redacted] initially proposed by the county agency.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/09/2017 Lehigh County Children and Youth Services received a report alleging that a three month infant was severely injured when he was left on a store shelf in [redacted] while in the care of his biological father. The Child/Victim fell from the shelf and sustained [redacted] from the incident. Upon admission to a local pediatric facility, the incident was assigned a Near Fatality status as the Child/Victim was admitted in critical condition.

Lehigh County Children and Youth Services and the [redacted] Police Department commenced a conjoint investigation of the incident. There were initial concerns raised regarding the rationale for the biological parents traveling to [redacted] at such an early time frame (approximately 3:00 AM). There were also concerns raised due to the biological father's belligerency directed towards EMS staff attending to the Child/Victim initially as well as questions as to his capacity to care for the Child/Victim at the time of the fall.

Following interviews with various individuals associated with the referral, law enforcement review of store video surveillance, agency requested testing of the

biological father and consultation with medical personnel, it was determined that the incident was of an accidental nature.

The case was Unfounded by Lehigh County Children and Youth Services on 06/06/2017. The law enforcement investigation was also closed at this time with no criminal charges being filed. The incident was ruled as an accident.

Given the agency prior involvement with this family and the outstanding issues relating to stable housing and family supports it was determined that ongoing general protective services were necessary. The family has been opened for ongoing support to address issues of household stability/budgeting and parenting, and ensuring that the parents maintain participation in [redacted] services and overall case management. Lehigh County Children and Youth has also implemented an [redacted] service to assist the family with various matters associated with child care and support.

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;

  Child/Victim received appropriate emergency medical attention due to incident under investigation.
  Child/Victim remained in care/custody of biological parents.
  There was a coordinated investigative effort between [redacted] Police department and Lehigh County Children and Youth Services.

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

  Agency involvement in January 2017 with family was terminated prematurely.
  In home diversionary services recommended by county agency were not sufficiently engaged/employed by biological parents of Child/Victim.

- 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.

  Lehigh County Children and Youth Services should implement a more consistent QA mechanism to review referrals made to community agencies. Particular attention should be paid to referral compliance and adequacy of service delivery.

Department Review of County Internal Report:

Department of Human Services, Northeast Regional Office of Children, Youth and Families has received and reviewed the County Act 33 Near Fatality submission. While the report accurately reflects the discussions and recommendations set forth at the 04/20/2017 meeting, OCYF/NERO has determined that the agency's initial investigative efforts were not sufficient given the multiple unknown variables associated with this case. The rationale for this determination by NERO/OCYF are set forth in the following section.

Department of Human Services Findings:

- County Strengths:
  The county agency commenced a conjoint investigative effort on this case with the Lehigh County District Attorney's Office. Interviews were conducted collaboratively and information was freely shared between all parties.

- County Weaknesses:

There were multiple issues associated with this case that warranted additional attention. The agency investigation of the Child Protective Services investigation was not initiated in a circumspect manner. Nor was there ample case documentation outlining the agency case decision making or assessment of the safety issues associated with the family during the initial stages of the CPS investigation process.

OCYF/NERO record review and interviews conducted with casework and supervisory personnel evidence minimal attention to the initial agency case involvement with this family in December 2016. There were certainly significant issues raised by the referral source involving possible [redacted] drug usage/abuse by the biological mother. Given the fact that the initial referral involved a newborn the county agency could certainly have been more thorough in assessing the issues surrounding the care and supervision of an infant alleged to be in the care and custody of an alleged addict. Case file review determined that collateral outreach by the intake caseworker was minimally made. There was also no definitive assessment of the biological mother's [redacted] Primary data relating to this aspect of the referral was derived solely from information secured from the biological mother. Given the fact that the information secured from her was not able to be corroborated by

available medical information, the overall veracity of this information could be questioned. It is for this reason that additional public child welfare involvement at the intake level could reasonably be justified. While the agency did recognize a need for additional support services with the referral to [redacted] services, no formal agency follow up was made to ensure that the referral was accepted and maintained.

Case file review also evidenced cursory case documentation relating to the agency's attempts to secure information from the biological parents concerning family history and current living arrangements. There were appreciable gaps in the agency's attempts to assess the family living arrangements due to periods of homelessness and moves between multiple counties.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  OCYF/NERO case file review and interviews conducted with personnel at Lehigh County Children and Youth have evidenced case investigation and case practice deficiencies relating to the timeliness and adequacy of assessment of safety of this case. While there is an appreciation for the difficulties surrounding the location and cooperation of this family during the initial phases of the CPS investigation, it becomes all the more imperative for the county agency to attempt to locate and engage the family in the investigation. There is no clear delineation of the agency's efforts to engage this family absent intake caseworker contacts with the Child/Victim at the medical facility on 04/09/2017 & unsuccessful home visits on 04/19/2017 & 04/25/2017. The C/V and parents were interviewed on 05/02/2017 by the CPS intake caseworker. Given the circumstances surrounding the agency's involvement at this time, i.e. [redacted] of an infant, a more pronounced and nuanced approach to commencing the investigation was called for. Minimally, the case file requires a more well- documented rationale for the agency's inability to locate and assess the family.

  The safety assessment and risk assessment documentation contained in the CPS intake case record also does not sufficiently assess or rate the elements of risk and safety to this family from the initiation of the CPS investigation until the interview conducted on 05/02/2017. Case record documentation includes a preliminary safety assessment completed while the C/V was hospitalized on 04/09/2017. There is also a concluding risk assessment completed by the CPS intake caseworker dated 06/06/2017.
  As a result of the DHS/OCYF/NERO review of this case an LIS has been issued. OCYF/NERO has determined that there were regulatory violations in the following areas:

  3130.21 Responsibilities of county executive officers
  The executive officers shall ensure that the agency is operated in conformity with applicable Federal, State and local statutes, ordinances and regulations.

  3490.55 (I) Investigation of Reports of suspected child abuse

When conducting its investigations, the county agency shall visit the child's home, at least once during the investigation period. The home visits shall occur as often as necessary to complete the investigation and assure the safety of the child.

3490.321 Standards for Risk Assessment

The standards established for risk assessment shall include the following:

(a)(3) The application of the process, including the points at which the process shall be applied and the periodicity of application.

(f) The county agency shall rate each factor in subsection (e) and shall provide documentation in the record to support the identified level of risk and assure the child's safety.

(I) The county agency shall conduct a risk assessment as often as necessary to assure the child's safety.

(j) The county agency shall assess the safety and risk of the child when the circumstances change within the child's environment at times other than required under this section.

Department of Human Services Recommendations:

NERO/OCYF continues to recommend that Lehigh County Children and Youth Services promote the positive relationship and coordinated efforts that currently exist between the law enforcement agencies and the county child welfare agency. Case file documentation evidences conjoint visits to the AP's residence on multiple occasions.

There are several issues relating to the assessment of this case that require attention on the part of the county child welfare agency. As the primary concerns associated with this investigation relate to the care/supervision of an infant, it is incumbent upon the county child welfare agency to demonstrate a diligent and concerted effort to assess all aspects of the family functioning. Timely and comprehensive assessment of safety and risk factors are the primary concerns of the public child welfare agency. It is also imperative that the county agency case file clearly elucidate all efforts and barriers to this process. In this case circumstance there were several factors that served as deterrent to this process; namely the family's lack of housing and "county hopping". Due to these factors there are significant gaps in the agency's assessment and service delivery. While the overall disposition of this case was not affected by these issues, they are certainly core casework elements that require attention.

It would serve Lehigh County Children and Youth Services to ensure that in those cases where there are barriers to comprehensive assessment of cases, agency supervisory personnel are cognizant of the staffing complement and experience level of the staff. Additional training in case documentation and efforts to assess resistive clientele would benefit the agency.

Another issue that appears to pervade this case is the degree to which the agency can adequately assess and evaluate cases where there is a history of addiction. Cases that involve patterns of familial addiction have long posed dilemmas for child welfare staff attempting to assess safety and needs. In this case there is a history of prior addictive issues that also appear to impact the current array of services. It would also behoove the agency administrative staff to develop additional training for casework staff in the multi-faceted implications of active addiction and recovery patterns. Especially in areas of intake assessment and the development of sound safety plans and assessment of risk.