pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Chance Ortiz

Date of Birth: 08/05/2016
Date of Death: 06/29/2017
Date of Report to ChildLine: 06/26/2017
CWIS Referral ID: [redacted]

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

Lehigh County Office of Children and Youth Services

REPORT FINALIZED ON:
01/11/2018

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 07/06/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Chance Ortiz	Victim Child	08/05/2016
[redacted]	Biological Mother	[redacted]1988
	Mother's Paramour	Unknown
	Maternal Half-Sibling	[redacted]2013
	Maternal Aunt	[redacted]2005

Summary of OCYF Child (Near) Fatality Review Activities:
The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the [redacted] Investigation. NERO staff had a discussion with the investigating caseworker. NERO staff participated in the Act 33 meeting on 07/06/2017. The meeting included a review of agency file, review of medical records and a discussion related to the incident including medical overview and reports from law enforcement related to the status of the case.

Summary of circumstances prior to Incident:
The Lehigh County Office of Children and Youth Services (LCOCYS) had one prior referral on 01/17/2017, involving the mother and the victim child's maternal aunt. LCOCYS investigated allegations of child physical abuse. The case was [redacted] Services were offered to the family however the mother did not participate and the case was closed.

Circumstances of Child Fatality and Related Case Activity:
On 06/26/2017, emergency medical services (EMS) arrived at the home of the victim child. EMS found the victim child to be pulseless and not breathing. The victim child was found unresponsive and adjacent to the mother's paramour. The mother was at work at the time of the alleged incident. The victim child was transported to Lehigh Valley Health Network (LVHN) at Cedar Crest. The victim child presented to LVHN after cardiopulmonary arrest. [redacted]

[redacted]

On 06/26/2017, the mother arrived home from work at approximately 4:00 PM. Mother reports the victim child was fussy as he usually would be. The paramour left the home and the mother was alone with the children for approximately one hour. The mother cooked dinner and then went upstairs to shower and get ready for her second job. The mother left the victim child downstairs in his swing. When the paramour returned, the mother was still in the shower, he informed the mother that the victim child was crying. The mother came back downstairs gave the victim child a bottle. The mother took the victim child out of the swing and rocked him. When the mother got the victim child partly asleep, she placed him on the couch beside her paramour and left for work. The mother reports she left at approximately 7:45 PM and at approximately 8:05 PM she received a call from her paramour that the victim child was limp. The mother instructed her paramour to call 911 and she left work to go home.

The paramour reported that he did not live with the mother and the children but he did stay with the victim child and his sibling while the mother was at work. The paramour described that soon after the mother left for work he picked the victim child up from the couch to put him in his swing and found the victim child to be limp with a faint heartbeat. The paramour reports attempting CPR on the victim child. There was no explanation as to how the victim child's injury occurred either by the mother or by the paramour. On 06/27/2017 a safety plan was put in place that the paramour would not have any contact with the victim child, the victim child's sibling, or the victim child's maternal aunt. Mother agreed to and signed the safety plan. She also agreed to have a medical evaluation of the sibling [redacted] and it was determined there were no concerns regarding the siblings home care.

[redacted]

[redacted] On 06/28/2017, medical personnel talked with the mother [redacted] The mother stated she knew she needed to make a decision and that she did not want to see her child like this. On 06/29/2017, the mother took the victim child off of life support.

When the initial report was received the prime suspect in the case was the [redacted] On 07/06/2017, during the Act 33 Review, LCOCYS became aware that [redacted] had become the primary focus of the law enforcement investigation. Law enforcement was requesting to take the lead in the investigation of [redacted] and requested LCOCYS not interview [redacted] Based on this information a safety plan was put into place that the sibling and the twelve year old maternal aunt would remain in the care of the sibling's maternal aunt, and the mother would have no contact with either child. The mother agreed and signed the second safety plan. [redacted] The maternal aunt of the victim child transitioned to the care of her father on 0/8/31/2017.

The [redacted] investigation outcome of [redacted] was submitted on 08/23/2017.

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;

  Agency coordinated its investigation within child advocacy center approach including medical expert, law enforcement, and prosecution.

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

  No recommendations made.

- 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 made.

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

  No recommendations made

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

  Agency should continue to work closely with law enforcement and district attorney personnel to develop a timely plan for safety for the sibling [redacted]

Department Review of County Internal Report:

Lehigh County Office of Children and Youth Services submitted the County Review Team Report to NERO on 10/05/2017. NERO determined that the county internal report accurately reflected background case history and the status of the CPS investigation.

Department of Human Services Findings:

- County Strengths:

  NERO has determined that Lehigh County Office of Children and Youth Services commenced the [redacted] investigation of the victim child's case in a timely manner. Interviews were completed on all household members and all medical reports received. The agency worked in collaboration with the local law enforcement.

- County Weaknesses: and

  None

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

  There were no areas of statutory or regulatory non-compliance identified.

Department of Human Services Recommendations:

The Department concurs with the recommendations made by the Act 33 team and would recommend the following be included in relevant future reports:

- Community education to address safe haven for unwanted babies and shaken baby.
- Education for parents to help them to feel comfortable asking for help with parenting issues.