pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/16/2014
Date of Incident: 10/25/2017
Date of Report to ChildLine: 10/25/2017
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 & Youth Services

REPORT FINALIZED ON:
April 5, 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 - 11/16/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	09/16/2014
[redacted]	Biological Mother	[redacted]1988
[redacted]	Biological Father	[redacted]1987
[redacted]	Sibling	[redacted]2006
[redacted]	Sibling	[redacted]2008
[redacted]	Sibling	[redacted]2010
[redacted]	Sibling	[redacted]2012
[redacted]	Sibling	[redacted]2017

Summary of OCYF Child (Near) Fatality Review Activities:

The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective Services (CPS) Investigation. NERO staff had a discussion with the investigating caseworker and her supervisor. NERO staff participated in the Act 33 meeting on 11/16/2017. The meeting included a review of the agency file, medical records and a discussion related to the incident.

Summary of circumstances prior to Incident:

The Lehigh County Office of Children and Youth Services (LCOCYS) had received one prior General Protective Service's referral concerning this family on 07/06/2017. The referral alleged the mother was depressed and obsessed with religion on YouTube. The children were reportedly not supervised, the eight year old male sibling was alleged to have been pushed through a glass door by the ten year

old sibling and that the four year old sibling was made to clean up the glass. It was alleged the four year old sibling cut his hands on the glass. It was also alleged the six year old sibling was washing cars and his parents would not allow him to keep the money he earned. LCOCYS made a home visit on 07/07/2017. The mother and all of the children were seen during this visit. The family had recently relocated to Lehigh County from [redacted]. There was no evidence to suggest there was a broken window or injuries to any of the children. The mother did disclose the ten year old sibling did push her brother and that this child was [redacted] The mother acknowledged the family is religiously devout. The allegations were determined not valid and the case was closed.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 09/29/2017 the parents brought the victim child and all of her siblings for a medical appointment to a local pediatrician. The mother reported all of the children had been coughing for two to three weeks. None of the children had been vaccinated. [redacted] The mother initially stated she did not want to treat the children with [redacted] but would prefer to quarantine them at home. However it was verified the mother did provide the children with the [redacted] On 09/30/2017 the nine year old sibling was hospitalized [redacted] of a local hospital due to [redacted]

On 10/18/2017 the father contacted the pediatrician's office and requested a follow up visit for the victim child as her condition had worsened. The father was offered a same day appointment however he declined this appointment and scheduled an appointment for 10/25/2017. The family brought one of the victim child's sibling into the pediatrician on 10/24/2017 and never told the provider that the victim child had not been able to get out of bed, was in severe pain and that the victim child had not been eating or drinking for two days.

On 10/25/2017 the father brought the victim child to the pediatrician. The victim child was critically ill. [redacted] observed the victim child's distended abdomen, swollen face, and lack of eating, drinking and mobility. The father stated the victim child had been like this for a week and a half. The pediatrician was concerned as the parents had the other children to compare symptoms with and their condition had improved. The parents did not schedule the recommended follow up appointment for the children after the initial appointment. The pediatrician was concerned with the father's complacency with the victim child's condition.

The pediatrician directed the father to bring the victim child immediately to the local hospital emergency department. The victim child had [redacted]

[redacted] The victim child was admitted [redacted]

[redacted]

On 11/11/2017 the victim child was transferred to a children's specialty hospital [redacted]

The victim child became very withdrawn during her hospitalization, making few vocalizations even to her mother. [redacted] At [redacted] the victim child was more vocal with staff.

The victim child was [redacted] to her parents on 12/15/2017. [redacted] There would also be visiting nurse services in the home until 12/22/2017.

On 10/26/2017 the father did participate in an interview with the CPS caseworker. The father stated that the nine year old sibling had been [redacted]

The father stated the children did not receive routine medical care however the parents would take the children to the doctor when they were ill. The father reported that the victim child became ill approximately one month ago and that he

and the mother began to look for a doctor. The father reports the children were given the [redacted]. The father reports contacting the pediatrician in reference to the victim child's [redacted]. The father stated the pediatrician told him that [redacted] can take months to recover from. The father stated the pediatrician told him that if the victim child turned blue or had trouble breathing to bring her into the office. The father states he contacted the doctor's office on 10/22/2017 as the victim child's symptoms were getting worse and the office scheduled him for an appointment three days later. The father stated the pediatrician directed them to go to the hospital. Father stated they practice in the Catholic faith and that he would do whatever needed to be done for the children. The mother refused an interview for her or the children on the advice of her attorney.

On 10/31/2017 the parents did follow through with medical exams for all of the siblings. The family has extended family visiting to help support them through this time. The caseworker was able to determine there was no prior involvement with [redacted] CPS.

The family was referred to the [redacted] to ensure the family was following through with medical treatment for all of the children as well as to observe child care and parenting to aid in the assessment of family functioning. The parents were non-compliant with the service. The parents would not allow LCOCYS caseworker access to the siblings or to their home. [redacted]

On 12/21/2017 LCOCYS submitted an unfounded investigation outcome due to conflicting medical evidence regarding whether there was a delay in treatment and that the possible delay in treatment did not exacerbate the victim child's condition.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:</u>

Information in this section is copied directly from the county report.

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

  [redacted]

The Family is utilizing their familial supports.

CPS coordinated the input of three physicians at the Act 33 meeting [redacted] Additionally, CPS also included the victim child's [redacted] in the meeting.

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

  LCOCYS cannot fulfill its obligation to visit the victim child and her siblings to determine child safety and risk factors due to parents' refusal.

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

  LCOCYS should explore Dependency due to parent's poor judgement in not providing medical intervention when the victim child was reportedly suffering pain and impairment.

  [redacted] who is seeing the victim child and her siblings will notify LCOCYS of any concerns. This [redacted] currently has no concerns regarding the family's care of the victim child and follow through with medical care.

  The family's ties to religion might lend itself to their seeking support through their church community, including a parish nurse if one is available.

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

  None

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

  None

Department Review of County Internal Report:

LCOCYS submitted the County Review Team Report to NERO on 03/05/2018. 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:

  LCOCYS conducted a timely CPS investigation. LCOCYS followed all established protocols for referral to law enforcement.

- County Weaknesses:

  NERO acknowledges LCOCYS collaboration with the different medical professionals involved with the victim child. However, the determination made was based on the victim child's [redacted] and that the delay in treatment did not exacerbate the victim child's disease. The initial report identifies concerns surrounding the amount of pain the victim child was experiencing as well as her inability to stand, to eat or drink and the possibility of the victim child [redacted]. The NERO does agree the parents cannot be held responsible for the victim child's [redacted] however if the parents had followed up with medical care the victim child would not have experienced the pain and suffering that occurred for a week and half before being seen by the physician.

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

  LCOCYS was not able to fulfill its obligation to ensure all of the children's safety. NERO does acknowledge appropriate actions were taken by LCOCYS to remedy this.

Department of Human Services Recommendations:

The Department recommends that education be provided to medical providers, social workers to assist in developing their understanding of the role of the child welfare professional in working with families surrounding medical neglect.