REPORT ON THE FATALITY OF:

Adrian Kurtz

Date of Birth: 08/28/2015
Date of Death 01/12/2016
Date of Report to ChildLine: 01/15/2016
CWIS Referral ID: [redacted]

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

Lebanon County Children and Youth

REPORT FINALIZED ON: 08/05/2016
Completed by State Reviewer

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:

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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.

Lebanon 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 02/02/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Adrian Kurtz	Victim child	08/28/2015
	Biological Mother	1985
	Biological Father	1979
	Half Sister	2006
	Sister	2009
	Twin Brother	2015

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region office of Children, Youth and Families participated in the County Internal Fatality Review Team on 02/02/2016. Prior case history, medical reports were obtained and meetings with staff were held.

Children and Youth Involvement prior to Incident:

04/16/2013- The agency received a report of inappropriate discipline involving the mother against the victim child's half-sister. Both were interviewed and both admitted that the mother hit the child on her mouth for talking back. The child stated that she caused her lip to bleed by biting her lip. The bleeding was not caused by the mother. The case was closed and no services were provided to the family.

09/11/2013- The agency received a report of physical abuse by the mother against the victim child's half-sister. The allegation

was that the mother bit the child on her arm causing pain. When interviewed, the child couldn't remember if she was bit or hit. The child had no bite mark or bruise on her arm. The case was [redacted] on 09/24/2013 [redacted] No services were provided to the family.

10/02/2015- The agency received a [redacted] report of physical abuse by the father against the victim child's half-sister. There was a domestic dispute between the father and mother and the child attempted to intervene. Based on interviews conducted by the agency, at no time was the child hit or sustained any injury. The case was [redacted] and the [redacted] sent 11/03/2015. No services were provided by the agency.

11/23/2015- The agency received a [redacted] regarding the parents physically disciplining the children and screaming at the twin boys. This information was given by [redacted]
The caseworker met with the children who disclosed that the parents yell at the infants and there is domestic violence in the home. The parents denied yelling at the infants but admitted to some domestic violence in the home. There was no record of any interview with [redacted] even though [redacted] reported to the reporting source that she witnessed the mother, while putting one of the twins in his car seat, getting into the child's face and scream "Shut the ---- up and stay still." This referral was screened out and closed. No services were recommended for the family.

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

Police were dispatched to the victim child's home after receiving a 911 call by the parents due to the victim child being unresponsive. Police arrived and interviewed both parents. The father was the sole caretaker for both the victim child and his twin brother while the children's mother was at work from 3 pm until 9:30 pm. At approximately 6:15pm, the father fed both of the boys. The victim child was fussy after the feeding. At 7:45pm, the father swaddled the victim child in a heavy blanket and placed the victim child head first onto his swing with his head turned to his left. At 8:00pm the father left the home to go to a bar and left the twins with their 6 and 9 year old siblings. The father returned at 8:20pm but did not check on the twins. At 9:30pm the mother came home from work, saw the victim child in the swing facing the wrong way but did not move the victim child. She went upstairs to watch a television show and came down to give the boys their next feeding. At that time she found the victim child unresponsive and called 911. The victim child was pronounced dead at the scene and transported to Hershey Medical Center. Preliminary report was that the victim child died from asphyxiation [redacted] At this time, the parents had no explanation for the victim child's injuries.

The hospital believed that the asphyxiation was the result of the child's head being in close proximity to the side of the back of the swing and unable to move as a

result of the swaddling. All of the victim child's siblings were placed in foster care on 1/27/2016. [REDACTED] The 6 and 9 year old girls were placed together in a foster home. The victim child's twin brother was placed in a different foster home.

Lebanon County Children and Youth investigated the report and found that the victim child's parents were the sole caretakers for the victim child when the death occurred. [REDACTED] was submitted on 03/09/2016. [REDACTED] as perpetrator by commission and [REDACTED] as perpetrator for omission.

Criminal charges against the parents are pending the final autopsy report. Kinship resources are being explored by the agency for the siblings placed in foster care. [REDACTED] The current Child Permanency Plans require the parents to: identify and complete parenting classes; be able to demonstrate learned skills to ensure the welfare and safety of their children; [REDACTED]

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 investigation complied with regulations and response times as required.

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

  The county agency's report did not reference any specific identified deficiencies.

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

  The county agency's report did not reference any specific changes or recommendations at the state or county level.

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

  The county agency's report did not reference any specific changes or recommendations at the state or county level.

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

  The county agency's report did not reference any specific changes or recommendations at the state or county level.

Department Review of County Internal Report:

The Multi-Disciplinary Team report was received on 03/07/2016. There were no issues or concerns regarding the content of the report. The agency director was verbally notified of the acceptance of the report by the Department.

Department of Human Services Findings:

- County Strengths:

  Upon review of the documents associated with this particular case, there appeared to be a positive working collaboration between law enforcement, medical facilities and the county agency.

- County Weaknesses:

  The referral of 11/23/2015 was in regard to inappropriate discipline. The agency received a [redacted] regarding the parents physically disciplining the children, screaming at the twin boys. [redacted] The caseworker met with the children who disclosed that the parents yell at the infants and there is domestic violence in the home. The parents denied yelling at the infants but admitted to some domestic violence in the home. There was no record of any interview with [redacted] even though [redacted] reported to the reporting source that [redacted] witnessed the mother, while putting one of the twins in his car seat, getting into the child's face and scream "Shut the ---- up and stay still". This was screened out and closed. No services were recommended for the family. This did not meet the definition of a screen out. The reporting source, [redacted] was never interviewed and based on the mother informing the caseworker that she does not yell at the children, the caseworker closed the case.

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

  The agency was issued a Licensing Inspection Summary due to citations related to a previous referral received by the agency regarding this family on 5/25/2016. The citations were as follows: As per 3490.232(g) ██████ ████████ was not interviewed during the 11/23/2015 screen out. Also, 3490.232 (i) during the same screen out, the agency did not provide or arrange appropriate services to assure the safety of the child although the mother admitted to domestic violence occurring within the home.

Department of Human Services Recommendations:

The agency must develop a plan to monitor cases assigned as screen outs to assure that those cases clearly meet the definition of a screen out. All parties mentioned in the report must be interviewed and services should be arranged or provided regardless if the agency feels the family will not cooperate.