pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT OF THE NEAR FATALITY OF:

[redacted]

**Date of Birth: 09/16/2017**
**Date of Incident: 09/28/2017**
**Date of Report to ChildLine: 09/28/2017**
**CWIS Referral ID:** [redacted]

**FAMILY NOT KNOWN TO LEHIGH COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

**REPORT FINALIZED ON:**
03/21/2018

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.

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(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 not convened a review team in accordance with the Child Protective Services Law related to this report. The case specifics were reviewed with agency legal counsel and the law enforcement agency on 10/02/2017. At that time it was determined that the incident was of an accidental nature and would be assigned an Unfounded status. However, the county did not submit the Unfounded status until 11/15/17. An Act 33 review was required due to the fact that the case was not Unfounded within the 30 day timeframe as required by statute.

**Family Constellation:**

| First and Last Name: | Relationship: | Date of Birth |
|---|---|---|
| [redacted] | Child/Victim | 09/16/2017 |
| | Biological Mother/AP | |

* 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:**

OCYF/NERO conducted preliminary review of the Near Fatality investigation on September 28, 2017 through collateral phone consultation with assigned CPS intake caseworker. Safety plan was proposed at that time that involved the utilization of the maternal grandmother as a resource pending outcome of the CPS investigation.

**Children and Youth Involvement prior to Incident:**

There is no record of service activity with this family prior to the Near Fatality allegations.

**Circumstances of Child Near Fatality and Related Case Activity:**

On September 28, 2017 Lehigh County Children and Youth Services received a referral from Childline involving head injuries sustained by a three week old infant. Specifically, the Child/Victim presented in the emergency room of a local medical facility with bruising to the head area. Medical assessment revealed a skull fracture and bleeding to the brain.
The incident was assigned as a Near Fatality to Lehigh County Children and Youth Services naming the biological mother as alleged perpetrator of serious bodily injury.

Lehigh County Children and Youth immediately commenced the CPS investigation with interviews of the biological mother, biological father and the attending medical personnel. There was no evidence of safety threats as the information secured from the parties was consistent with the medical data. The family cooperated throughout the investigation and allowed the agency complete access to the family home.

The county agency in conjunction with the law enforcement agency conducted an investigation into the incident and determined that the injury was of an accidental nature when the AP accidentally dropped the Child/Victim on a hard wood floor. Following a review by the law enforcement agency and the medical professionals it was determined that the case was accidental in nature. Lehigh County Children and Youth assigned an Unfounded Status determination the incident on November 15, 2017.

**Summary of 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.

  N/A The county agency did not conduct an Act 33 Near Fatality Review.

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

N/A The county agency did not conduct an Act 33 Near Fatality Review.

- 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 The county agency did not conduct an Act 33 Near Fatality Review.

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

N/A The county agency did not conduct an Act 33 Near Fatality Review.

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

N/A The county agency did not conduct an Act 33 Near Fatality Review.

**Department Review of County Internal Report:**

Lehigh County Children and Youth Services did not empanel an Act 33 Near Fatality Review on this case.

**Department of Human Services Findings:**

- County Strengths:

OCYF/NERO case file review and interviews with assigned CPS intake caseworker evidenced a timely and thorough assessment of all allegations. There was also evidence of an immediate conjoint investigation with the law enforcement agency. Information was freely shared and case decisions were made in conformity with the conjoint investigative process.

Case file review also documents a timely decision making process that involved supervisory oversight regarding status determination. Case documentation clearly outlines the case rationale for assigning an Unfounded status determination to the incident.

- County Weaknesses:

Despite the case documentation of the data which supported an unfounded status determination to the incident within the first 30 days of the CPS investigation, the case was not formally closed until November 15, 2017.
There was clearly a supervisory oversight in resolving the case within the first 30 days of assignment. This also resulted in the county agency failing to meet the

statutory requirement of completing an Act 33 Near Fatality Review on the case as the case was not resolved prior to the 30 day timeframe.

Lehigh County Children and Youth

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

The county agency did not conduct an Act 33 Near Fatality Review on this case as required by statute. The case was not assigned an Unfounded status within 30 days of referral thus necessitating a formal Near Fatality Act 33 case review and the submission of a formal written report by the county agency on the case.

OCYF/NERO has issued an LIS relating to this violation of the CPSL:
6365 (d) (1)
6365 (4) (v)

## Department of Human Services Recommendations

N/A