pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/08/2000
Date of Incident: 11/05/2017
Date of Report to ChildLine: 11/06/2017
CWIS Referral ID: [redacted]

FAMILY NOT 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:
May 1, 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 11/30/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1978
	Father	[redacted]1981
	Victim Child	05/08/2000
	Sibling	[redacted]2002
	Sibling	[redacted]2011
	Adult Half-Sibling	[redacted]1993
	Mother's Paramour/ Perpetrator	[redacted]1965

* 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 Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations. The NERO reviewed the current Child Protective Services (CPS) referral file. NERO staff participated in Act 33 Fatality / Near Fatality meeting on 11/30/2017.

Summary of circumstances prior to Incident:

The family had seven previous involvements with the county agency. The reports were General Protective Services (GPS) referrals and concluded within the sixty-day timeframe with the exception of one. That referral was open for a four-month period in late 2007 through early 2008. Each prior contact is summarized below:

-There were two reports for allegations of a child not being picked up at school, the first on 09/14/1999 and the second on 11/11/1999. These incidents involved the mother's oldest child, an adult half-sibling to the victim child. Both referrals were resolved by the agency in less than 60 days with no services provided.

-On 08/09/2000, the agency received a referral concerning lack of supervision for the half-sibling child. The victim child had just been born in May of that same year, therefore also involved in the intake assessment. Referral was closed in that same month.

-On 10/11/2007, the agency received a referral for truancy, housing, and concerns about an inappropriate caregiver. At that time, the half-sibling was 15-years-old [redacted]. She was not going to school and had been residing with a different caregiver. The case was accepted for services. The half-sibling began attending school and utilizing [redacted] services that were available to her through school allowing for the case to close on 02/29/2008.

-The fifth referral was received on 09/03/2008 for concerns of insufficient food, lack of caregiver, and parenting skills. The half-sibling had her own child by this time as she was born in July of that year. The case was closed around 30 days.

-Truancy continued to be a concern for the half-sibling and the agency received the sixth referral on the family on 04/07/2009. The half-sibling had concern about others watching her infant daughter while she attended school. Her interest was to obtain her GED. She did have a supportive family to watch her child and did continue with school. Her school attendance in the eighth grade improved during the six-week involvement. The case was closed on 05/21/2009.

-The seventh referral was received on 05/01/2015 for a concern of inappropriate discipline. This referral outcome determination was invalid. The case was closed on 06/25/2015.

Circumstances of Child Near Fatality and Related Case Activity:

A referral was received on 11/06/2017. In the late-night hours of 11/04/2017, into the early morning hours of 11/05/2017, the Perpetrator, mother's paramour, was in the home with victim child, her two siblings, and their mother. The mother reportedly was yelling and cursing at the Perpetrator and then he left the home. When the Perpetrator returned he told the mother how he felt disrespected and that he was there to get his belongings. At that time, the mother struck him. Perpetrator then shot at her five times. The victim child was struck by one of the bullets. The victim child's mother died in the incident; the victim child was transported to [redacted].

The victim child was admitted and remained in the hospital for approximately 10 days. She was admitted to the hospital on 11/05/2017 for assault with a gunshot wound. She was intubated. It was determined that she was shot in the left buttock with the exit wound in the abdomen. The victim child was determined to

have a left iliac fracture with bone and metallic fragments as well as lactic acidosis. She underwent exploratory laparotomy and was found to have bruising to the left colon. By 11/06/2017, she was extubated, walking, and had the best possible score of 15 on the Glasgow Coma Scale. The victim child had care through neurology, pulmonology, and gastroenterology. She underwent a computerized tomography (CT) scan of the chest/abdomen/pelvis on 11/05/2017. She was discharged on 11/16/2017. Discharge recommendations were for follow up with the trauma team on 11/30/2017 and 12/08/2017. She was [redacted] her biological father.

The county agency interviewed victim child on 11/30/2017. She disclosed she was shot by the Perpetrator during an altercation between her mother and the Perpetrator. She shared that she was not in pain from her injuries during the 11/30/2017 interview. The biological father had been taking her to the trauma follow-up medical appointments. She declined for the caseworker to make a [redacted] referral for her, stating she was doing well and was looking forward to returning to school. The victim child had been connected with an advocate through [redacted] through the Lehigh County District Attorney's Office, who will remain in place to support her through the criminal court process. Due to the circumstances surrounding her injuries, she had received a [redacted] consult while she had been inpatient and was recommended [redacted]. The victim child has continued to refuse [redacted] throughout the time of agency involvement.

The siblings of the victim child [redacted] had maintained his relationship with his children over the years. The father does have a criminal background including a drug-related conviction in 2000 and a firearm conviction from 2013. He continues on supervision with state parole from that 2013 sentencing.

During interviews with each of the children, they reported that they loved their father and felt safe in his care. The father was working at the time of the incident, but reported to have lost his job because of so much absence from work due to being at the hospital with the victim child. He handled the funeral arrangements for the children's mother. The father has consistently refused in-home and [redacted] services throughout agency involvement. He knew that the mother had [redacted] and [redacted]. He denied having his own [redacted] difficulties and denied any domestic violence between him and the mother in the past.

The father has limited family support in Lehigh County. He does have a brother and sister that are local, but the paternal grandparents reside in Puerto Rico. The father has gone to the [redacted] and registered for [redacted]. He moved into the mother's home with the children, where family members have reported that the children prefer to be.

On 11/28/2017, a GPS report was received stating that on 11/28/2017 the father was observed grabbing the oldest sibling of the victim child by her neck and

forcefully pushing her towards his car when he came to pick her up from school. The [redacted] was deployed to the family the same day. At the caseworker visit with the sibling on 11/30/2017, she explained how her father had been angry, thinking she was skipping school, and had grabbed her arm and pulled her down the steps of the school. There were no injuries to the child and she described that he grabbed her arm, not her neck, and did not push her into the car. The father gave the same history as his daughter, denying that he had grabbed her neck, and explaining he also disciplined her by taking her phone, in efforts to hold her accountable to participating in school every day. [redacted], which is an intensive in-home service to support the family and address family-specific goals as well as engaging the family's wider kin-network for support tried repeatedly to work with the family, but the father refused and neither this child or the victim child were agreeable to working with the program or referrals for [redacted]. This GPS referral outcome was submitted on 01/30/2018 as Invalid.

An Indicated status for this near fatality Child Protective Services (CPS) investigation was submitted on 01/04/2018 naming the mother's paramour the perpetrator. The Agency closed its case at the end of January, having no concerns about the current care of the children, and having had offered services to the victim child and her family which were declined.

Allentown Police Department facilitated charges of homicide, attempted homicide, and aggravated assault in this case. The perpetrator reportedly turned himself in and gave a full confession. Perpetrator reportedly admitted to feeling disrespected by victim child and her mother. He reportedly fired five total shots. Perpetrator waived his preliminary hearing. There were no records of previous domestic violence between the mother and her paramour. The perpetrator reported to law enforcement that he owned the firearm because of his fear of the children's biological father, who does have a criminal record including a weapons charge and is currently on state parole.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

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

- Strengths in compliance with statutes, regulations and services to children and families;
    - The father stepped up immediately to care for his children full time at the time of their mother's death.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - The Agency did not deploy in home services to the family until 11/29/2017. Perhaps if services could have reached out to the family

sooner, there might have been more successful engagement with the family.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - None noted

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - None noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None noted

Department Review of County Internal Report:

NERO did not receive the Lehigh County Fatality Team Report in accordance to the bulletin. The report is due within 90 days of the Act 33 meeting which would have been 02/28/2018. The report was received on 04/01/2018. The report content and findings are representative of the discussion during the meeting on 11/30/2017. NERO notified the LCCYS director on 04/04/2018 of receipt and acceptance of the county report.

Department of Human Services Findings:

- County Strengths: The agency completed thorough investigations of all reports. The agency gathered information from service providers, law enforcement and medical professionals.

- County Weaknesses: None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. No areas of non-compliance

Department of Human Services Recommendations:

There are no recommendations.