pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/29/2017
Date of Incident: 11/07/2017
Date of Report to ChildLine: 11/07/2017
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:
June 19, 2018

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 Office of Children and Youth Services 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]	Victim Child	09/29/2017
[redacted]	Biological Mother	[redacted]1981
[redacted]	Biological Father	[redacted]1978
[redacted]	Non-relative household member, alleged perpetrator	[redacted]1988
[redacted]	Mother's cousin	04/03/1990

* 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 Office of Children, Youth and Families, Northeast Regional Office (NERO) Program Representatives attended the county Act 33 team meeting held on 11/30/2017, to discuss the case. Attendees included county caseworkers and supervisor, medical provider, law enforcement, as well as a clinical social worker from [redacted] who participated via telephone.

- The medical records of the victim child (VC) from [redacted] were reviewed.

- As a result of a subsequent investigation, NERO received and reviewed additional medical records and additional follow-up from Monroe County in the week following the Act 33 team meeting.

Children and Youth Involvement prior to Incident:

The family was not known to the Lehigh County Office of Children and Youth Services (LCOCYS) prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/07/2017, LCOCYS received a report of suspected child abuse which was identified as a near fatality regarding the VC. It was reported at that time that the mother brought the VC to the emergency department at [redacted] due to a feeding difficulty the VC was having for two days in a row. While the VC was being examined, the VC's body on the left side was moving and the VC was gazing towards the right which referral source states is "Clinically seizing." Treatment medication was provided and the VC was resuscitated with IV fluids. A CAT scan was performed and subdural, Gyriforom, and Petechial Subarachnoid hemorrhages were found. The VC also has a tight bulging Fontanelle (soft part of the skull). On the VC's left forearm it looks like there was an old bruise that resembles a bite mark. A skeletal survey was also completed but the results were not available at that time. The referral source stated the VC's injures were life threatening. The referral source stated the mother seemed appropriately concerned and did not speak of any past trauma. There is a past case of the father being abusive towards the mother [redacted] as reported by the mother to the attending physician. The referral source does not know if the father and VC have contact with each other. The physician certified the VC to be in serious or critical condition based on the suspected abuse or neglect. The child was taken to [redacted] hospital to receive specialized care for these serious injuries. The referral source said the VC was expected to survive, but not without limitations. The mother was not able to provide a story of what happened to the VC but the referral source was not suspicious of the mother's story at that time. The referral source was suspicious as he stated, “Someone has clearly shaken or dropped the child. There is clearly trauma. We do not know who, but there are suspicions that the child has been in the father's care which mother allows. There is a past history of

domestic violence towards the mother by the father. We don't know who did this to the child but I don't think it was the mother."

The mother denied that she or the father had hurt the VC. She explained that the VC's father had not seen the VC for about three weeks. She reported leaving her son with her cousin's boyfriend, the alleged perpetrator (AP), on 11/06/2017 for approximately 45 minutes around 1 pm that afternoon, while she walked her dogs. The mother described that the alleged perpetrator had texted her a picture of the VC napping. It was after the VC woke up from that nap, about 3:00 pm that afternoon, that she noticed that he was not acting like himself. She called and waited for her sister to arrive home to take the VC to the ER around 6:30 pm. Mother agreed to not allow the alleged perpetrator to have contact with the VC at this time.

On the same day, 11/07/2017, the [redacted] Social Worker, reported that the mother appeared appropriate in her interactions with the VC and that the mother had remained consistent in the history of the VC's injuries. On 11/08/2017, [redacted] staff confirmed that the VC was diagnosed with retinal hemorrhages from their Child Protection Medicine Team, consistent with shaking. An MRI was scheduled for that afternoon. No discharge date had been set, and although the VC was expected to survive his injuries, the VC was stated to have significant brain damage with long term effects being unknown.

On 11/08/2017 the alleged perpetrator left a voicemail for LCOCYS CPS caseworker stating "there is no need for an investigation because he did it." His voicemail said he "power bombed" the VC but did not mean to hurt him. He said he wanted to come clean and not lie about the situation and make it worse. The Caseworker immediately informed Law Enforcement of the voicemail. This same day, the social worker for the Child Protection Team, at [redacted] called the LCOCYS caseworker and stated that alleged perpetrator had confessed to the mother's cousin, stating he had "picked up *VC* by the feet and may have caused whiplash." She said [redacted] had not heard from anyone from Allentown Police Department and so she would be contacting Philadelphia Police Department. On 11/08/2017 the alleged perpetrator was criminally charged and detained by the Allentown Police Department..

On 11/16/2017 LCOCYS made a referral to Monroe County in anticipation of the mother's return there to reside with VC with his father. [redacted] was discharged from [redacted] into the mother's care on 11/17/2017. Monroe County Children and Youth Services (MCCYS) Supervisor confirmed that their caseworker had made successful contact with the family on 11/20/2017.

The mother called LCOCYS caseworker on 11/21/2017 to share that contact had been made with her by Monroe County, who had completed [redacted] with her the day before. She shared that the VC continued to wear a neck brace and that his follow up at [redacted] was on 12/20/2017.

On 11/30/2017 during Lehigh County's Act 33 meeting, it became known to the county children and youth agencies of Lehigh and Monroe that mother reportedly had not scheduled an immediate follow-up appointment for the VC's skeletal survey as advised by the pediatrician. Through the information sharing at the meeting, a subsequent report was made to ChildLine with concerns regarding medical neglect by both parents in the jurisdiction of Monroe County. The Act 33 team recommended the VC be seen immediately by [redacted] The mother was agreeable to this and stated that she had understood that she needed to talk with the VC's pediatrician about this but did not know there was a required time frame for this. The examination was held the following day as well as an evaluation by [redacted].

On 11/05/2017, LCOCYS submitted an outcome indicating the alleged perpetrator named in this case. The agency closed its case due to Monroe County having accepted the case for services. On 12/06/2017 the CPS caseworker attended AP's arraignment hearing where AP waived the hearing and bail was set. The next hearing was scheduled for 01/02/2018. The mother, father, and VC attended this hearing as well and met with LCOCYS caseworker outside the courtroom where the VC looked cared for. The mother had admitted to substance abuse and [redacted] LCOCYS was informed that MCCYS had been [redacted] of the VC because of concerns about parental substance abuse and multiple police reports of suspected domestic violence. A [redacted] was set for 12/11/2017. At the [redacted], the VC [redacted]. The father had moved out of the family home. The mother was reported to have been ordered to participate in a [redacted] and [redacted] for possible [redacted]. The father was ordered to participate in supervised visitation with the VC.

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;

- Lehigh County's Act 33 Team provided LCOCYS with recommendations for immediate action on behalf of the child, resulting in his quick admission into rehabilitation services.

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

- Act 33 team expressed concern that Lehigh County's referral to Monroe County Children and Youth may not have expressed clearly the urgency and severity of the issues of the child's family situation.

- Act 33 team expressed concerns that the transition of the family's case between two counties created a gap in follow through and monitoring for Leo's medical follow-ups, including corroboration with medical providers.

- Act 33 team expressed concerns that the child was discharged from inpatient hospital stay without specific medical appointments with identified providers for his follow up care.

- At mother's first visit to a local emergency room, child's serious condition was not understood and abusive head trauma was not suspected.

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

- Lehigh and Monroe county caseworkers should work together immediately to have child seen by [redacted]

- The child should be evaluated for inpatient rehabilitation services.

- The child's mother and father should submit to random, ongoing urinalysis

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

N/A

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

- Emergency Department staff would continue to benefit from ongoing training related to signs and symptoms of suspected child abuse.

Department Review of County Internal Report:

The county submitted the near fatality report on 04/06/2018 which was untimely as it was due on 02/28/2018, thereby shortening time available for thorough review.

The report did include details of the chain of events surrounding the incident and the parties involved. The record was provided to the regional office including medical information and running dictation.

Department of Human Services Findings:

- County Strengths:
    - Lehigh County's Act 33 Team has representatives of the medical community, law enforcement, community social and other support services agencies, along with active participation form the Regional OCYF.

    - The Act 33 meeting was held timely and LCOCYS responded to the team's recommendation with immediate action on behalf of the VC, resulting in his quick admission into rehabilitation services. The team is comprehensive with medical personnel, law enforcement, regional staff and other agencies involved.

    - Law enforcement was notified within 24 hours and there was ongoing communication between LCOCYS staff and the detective assigned.

- County Weaknesses:
    - LCOCYS's referral to MCCYS did not clearly express the urgency and severity of the issues of the VC's family situation.

    - The transition of the family's case between the two counties created a gap in follow through and monitoring for the VC's medical follow-up, including corroboration with medical providers and this could have been handled by closer follow through.

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

  Pursuant to the Child Protective Services Law, §6365 (d)(4)(v), LCOCYS did not submit the Act 33 team report to the regional office within the 90 day timeframe. There will be a Licensing summary issued.

Department of Human Services Recommendations:

The Department recommends that county children and youth agencies consider implementing or revising internal systems to facilitate timely submission of Act 33 reports to the Regional Offices. It is suggested that active reminders be put in place to alert persons assigned these cases of upcoming deadlines for

completion/submission of reports, forms and other documents required for the child fatality/near fatality review process.