



**REPORT ON THE NEAR FATALITY OF:**



**BORN: 3/23/11**

**DATE OF INCIDENT: 7/28/12**

**DATE OF ORAL REPORT: 7/28/12**

**FAMILY KNOWN TO: Lehigh County Children and Youth**

**REPORT FINALIZED ON: 5/3/13**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Lehigh County has convened a review team in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Mother (caretaker of VC)	██████/89
██████████	Mother's paramour (Alleged Perpetrator)	██████/82
██████████*	Victim Child (VC)	3/23/11
██████████*	Father	██████/89
██████████*	Paramour's daughter	age 3
██████████*	Paramour's daughter	age 10

\* not a member of the household at the time of the incident.

**Notification of Child Near Fatality:**

On July 28, 2012 mother and her paramour brought child into the Lehigh Valley Hospital (LVH) emergency room. The child was having ██████████ he had to be ██████████. He had a ██████████ on the left side of his head, which ██████████. This ██████████ required ██████████. The child also had various bruises and redness over his face, chest, back and scrotum. The child was listed in critical condition. The hospital reported that mother was very upset but paramour had a flat affect ██████████ called the report into ChildLine as a near fatality. The Northeast Regional Office of Children and Youth (NERO) and Lehigh County Children and Youth were notified by ChildLine of the report. Lehigh County Children and Youth Services (LCCYS) also notified NERO. The Pennsylvania State Police of Fogelsville were notified by LCCYS.

**Summary of DPW Child Near Fatality Review Activities:**

The NERO Human Service Program Representative (HSPR) met with the Child Protective Services Supervisor, Caseworker, Manager, and Director to discuss this case. The HSPR had obtained and reviewed the entire file regarding this family. The NERO HSPR also participated in the County Internal Fatality Review Team meeting on October 24, 2012.

**Summary of Services to the Family:**

At the time of the incident the family was open on a General Protective Services Intake with LCCYS.

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

This family was known to LCCYS. On June 5, 2012 LCCYS received an anonymous General Protective Services referral. The referral source stated that mother [REDACTED]. The referral source stated the VC was not being changed, bathed, or fed properly and was confined to his playpen most of the day and cannot walk. Additionally, it was reported the house was dirty and trash was strewn everywhere. On June 6, 2012 LCCYS made an unannounced home visit in response to the referral. No one was home, the caseworker left a note stating she would be back to see the mother and VC on June 7, 2012. The mother called on June 7, 2012 and stated she was unavailable to meet on that date. LCCYS called the mother on June 12, June 13, and June 14, 2012 and left voice mails requesting her to call LCCYS. No calls were returned. On June 19, 2012 the caseworker made an unannounced home visit and the mother and VC were present. The home environment was appropriate and clean. The VC appeared to be healthy and developmentally on track and was able to walk. The mother denied [REDACTED]. The [REDACTED] Mother stated she felt the referral source was a former babysitter who she fired for [REDACTED] in the home while she was babysitting the child. On June 26, 2012 the case was closed.

On July 26, 2012 a second referral was received from [REDACTED] who stated the mother [REDACTED] in front of the VC. The referral source stated the mother [REDACTED]. It was also reported that the mother does not supervise, feed or bathe the VC properly. The VC was [REDACTED] on July 26, 2012 because he had [REDACTED]. (It was later confirmed child had [REDACTED] and was in the hospital from July 23 to July 26, 2012). On July 26 and 27<sup>th</sup> 2012 LCCYS made unsuccessful unannounced home visits. A note was left both times requesting the mother contact caseworker.

LCCYS also had two brief service involvements with the alleged perpetrators two children. On March 23, 2010 a referral was received regarding concerns of [REDACTED]

[REDACTED]. The family was open for general protective services and then closed on July 2, 2010. On November 28, 2011 LCCYS received a referral due to alleged domestic violence in the home.

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

When LCCYS interviewed mother she stated she noticed bruising on VC's cheek and chest on July 26, 2012. She did not know how his cheek got bruised but felt his chest got bruised when he was in the hospital from July 23-26 due to [REDACTED]. She felt the bruising may have occurred when they [REDACTED]. Mother had stated the VC seemed fine on July 27, 2012 when she had taken him to day care. On this date the daycare called and asked the mother about the "finger marks" on the VC's head and chest. The mother told the daycare that she felt it occurred while the VC was in the hospital. (Daycare did not call report into ChildLine because mother's explanation seemed plausible). The mother stated she picked the VC up at daycare on July 27, 2012 and then picked her paramour up and they went to his mother's home to visit his two daughters [REDACTED]. The paramour lives with his mother on and off. He stays there when he is not with [REDACTED]. When his children visit they go to his mother's residence and he usually stays there. He has no restrictions regarding visitation of his children. The mother stated while they were there the VC seemed cranky but felt he was just tired. They returned home and she put the VC to bed around 9:30pm. The mother and paramour fell asleep on the sofa watching television. On July 28, 2012 the mother left for work at 7:00am; she did not go into the VC's bedroom to check him before leaving. The VC was left in the care of the mother's paramour. At about 8:00 am the paramour began texting the VC's mother (caseworker saw texts.) They exchanged communications regarding the VC's eating, diaper changes, etc. The paramour reported via text that the VC was "fine and moving his arms." Then it appeared that the paramour became anxious and stated to the mother that "if the kid died, it would be on her." He also made a statement about the VC being unresponsive. The mother left work and went home. The mother and paramour took the VC to the LVH. It was reported by hospital staff that mother was tearful and her paramour had a flat affect. On July 28, 2012 [REDACTED]. The hospital reported that the mother and her paramour brought the VC to the emergency room on this date and the VC was unresponsive and had a low heart and low respiratory rate; he was also having [REDACTED]. It was also observed that child had various bruises and redness to his [REDACTED] in different stages of healing. His [REDACTED]. On July 29, 2012 it was determined that the VC had [REDACTED]. On August 8, 2012 the VC was [REDACTED] to have a CT scan. It was discovered that child sustained [REDACTED]. The VC also had significant [REDACTED]. On August 20, 2012 the VC was transferred to the [REDACTED]. He [REDACTED]. Prior to that child had to wear a protective helmet.

ChildLine listed the report as a near fatality. The mother's paramour was listed as the alleged perpetrator and was interviewed briefly on July 31, 2012 by Lehigh County Children and Youth. The purpose of this meeting was to sign the safety plan which he did but he did not respond to any questions regarding the investigation. He denied causing any injury to the VC. He stated he would take a polygraph but has not taken one. He retained an attorney and has refused to speak with LCCYS.

**Current Case Status:**

LCCYS indicated the paramour for the abuse of the VC. The mother took a polygraph regarding her involvement and/or knowledge of the abuse. The mother passed. Fogelsville State Police have not arrested the paramour and no criminal charges have been filed. The investigation is still open with the Fogelsville State Police. The paramour will not cooperate with the investigation. The VC was discharged from LVH [REDACTED]. He remained there for three months until he was discharged to his mother's care. The mother currently resides with her parents. On September 26, 2012 the safety plan was lifted because child's mother demonstrated the capacity to care for and protect the child without a safety plan. The AP currently has no contact with the VC. The VC is currently receiving [REDACTED] Services. He also receives services [REDACTED]. He has made some progress but still has [REDACTED]. The long term prognosis is undetermined. LCCYS is also providing general protective services to the family.

Currently LCCYS has no involvement with AP's biological children. During the investigation LCCYS opened the family. A safety plan was put in place, stating AP will have no contact with his children. The safety plan was lifted on August 15, 2012 and the case was closed. It was determined that their mother was able to care and protect her children without agency services.

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

Act 33 of 2008 requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. LCCYS County has convened a review team in accordance with Act 33 of 2008 related to this report; however the meeting was not held within the 30 day time requirement.

Strengths: LCCYS received the ChildLine report on July 28, 2012 they made a determination that the case would be indicated and filed the CY48 on September 26, 2012. LCCYS met time frames and made an appropriate determination regarding this case.

LCCYS established a safety plan on July 28, 2012 for child and also did a separate safety plan regarding alleged perpetrators two children that reside with their mother. These plans stated there would be no contact between alleged perpetrator and children.

No deficiencies were noted.

No recommendations at this time.

**Department Review of County Internal Report:**

On October 24, 2012 LCCYS conducted their Act 33 review of the near fatality. The NERO HSPR attended this review. NERO recieved a written report summarizing their review.

**Department of Public Welfare Findings:**

County Strengths: A safety plan was put into place for the VC. A separate safety plan was developed regarding the paramour's two children which reside with their mother. A thorough investigation was completed and the agency made a determination after collecting all of the information. The CY 48 was submitted within the time frame. LCCYS obtained all medical documentation. LCCYS was supportive of the mother and VC throughout the investigative process. LCCYS conducted an internal review in accordance with Act 33 of 2008.

County Weaknesses: LCCYS County has convened a review team in accordance with Act 33 of 2008 related to this report; however the meeting was not held within the 30 day time requirement.

Another concern is regarding the referral LCCYS received on June 5, 2012. LCCYS made an attempted home visit on June 6, 2012, but no one home so they left a note stating they would be back on June 7, 2012. On June 7, 2012 mother called and stated she would not be home. LCCYS called mother on June 12, 13, and 14 and left messages however she did not return LCCYS calls. On June 19, 2012 LCCYS made another unannounced home visit and was able to speak to mother and see child. It is NERO's opinion that more attempts to make contact with the family should have been made. Five days elapsed between two of the attempts (6/7/12 -6/12/12: 6/14/12-6/19/12). Contact was made fourteen days after LCCYS received the report. This would have also given mother plenty of time to get the home in order and get [REDACTED].

Statutory and Regulatory Areas of Non-Compliance: None.

**Department of Public Welfare Recommendations:**

The LCCYS services should consider automatically scheduling Act 33 meetings upon receipt of fatality/near fatality reports to ensure they occur within the mandated 30 days.