



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

BORN: [REDACTED] **2012**

DATE OF INCIDENT: 11/19/2012

DATE OF ORAL REPORT: 11/19/2012

FAMILY NOT KNOWN TO:

Lehigh County Children and Youth

REPORT FINALIZED ON:

6/18/2013

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. 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:

Name:

Relationship:

Date of Birth:

[REDACTED]

Mother
Father (Alleged Perpetrator-AP)
Victim Child (VC)
Sibling
Sibling
Cousin-not HHM
Cousin's daughter-not HHM

[REDACTED]/79
[REDACTED]/74
[REDACTED]2012
[REDACTED]/05
[REDACTED]/10
unknown
unknown

Notification of Child Near Fatality:

The VC was brought to the Lehigh Valley Hospital (LVH) Emergency Department (ER) by Emergency Medical Services (EMS) on 11/19/2012. The AP reported that the VC had difficulty breathing, was turning blue and that the VC's eyes were shaking. The VC had [REDACTED] during the transport to the hospital. The [REDACTED] continue once the VC arrived at the hospital. The VC did not have any external signs of trauma. A CT scan of the VC's brain revealed [REDACTED]. A relative informed the reporting source that the AP likes to throw the VC up in the air and as a result the VC may have hit her head on the ceiling. The VC was admitted to the [REDACTED]. The VC was certified by 2 [REDACTED] but was expected to live. [REDACTED] and deemed a near fatality by the Childline supervisor. The Northeast Regional Office (NERO) was contacted by Childline.

Summary of DPW Child Near Fatality Review Activities:

The NERO Human Service Program Representative (HSPR) met with the Lehigh County Children and Youth (LCCYS) 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 Act 33 Review Team meeting on January 16, 2013. At the time of the ACT 33 meeting, NERO recommended that LCCYS revisit their investigation of the case. Once the case was revisited, all 3 children were [REDACTED].

Summary of Services to the Family:

At the time of the VC's near fatality, the family was not known to any children and youth agency.

Children and Youth Involvement Prior to Incident:

This family was not known to LCCYS prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/20/12, the assigned caseworker, [REDACTED] received the information from Childline and the on-call caseworker. The caseworker subsequently visited the VC at the LVH. Caseworker requested to see the VC in the [REDACTED] and was initially informed that there was not a child by the name of victim child. The hospital case manager reported that there was a child with injuries, but the child's name was [REDACTED]. The Caseworker then provided the nurse with the correct identifying information for the family including names. The hospital case manager reported that only minimal information was available when the VC was admitted due to the family only speaking Vietnamese. No [REDACTED] [REDACTED] was needed and no external injuries observed. The VC was stable and was not near death. The VC was [REDACTED] at that time. [REDACTED] [REDACTED] The VC did not have a history of [REDACTED]. After the CT scan of the VC's brain revealed [REDACTED] [REDACTED], medical records reported that the AP denied any history of head trauma to the VC or shaking of the VC. Medical professionals report that the VC's injury would be consistent with "shaking" the VC, not hitting his head on the ceiling as reported by a family member or falling off the sofa as reported by the AP. According to medical professionals the injury appears to be non-accidental and is consistent with "shaking". Medical professionals have also ascertained that the history provided by the AP is not consistent with the injury sustained by the VC. Medical records indicate that the VC suffered from [REDACTED] secondary to non-accidental head trauma.

The caseworker asked if parents were at the hospital. Hospital case manager responded that AP was there the entire time and the AP's niece for about a 2 hour period. The caseworker asked how they were communicating with the parents and they stated that they use the blue phone. The caseworker entered the room and present were the AP and his cousin's daughter, [REDACTED]. The Nurse set the caseworker up on the blue phone so that the caseworker could speak with the AP. The caseworker connected with the interpreter and identified herself to the AP. The caseworker then asked the AP why

the VC was here. The AP stated that the VC was on the chair in living room (described what sounded like a couch) and the he was doing dishes in kitchen and the VC started crying. The AP entered the room in which the VC was located and saw the VC was on the floor. The VC was shaking and very pale. The AP then called 911. The mother was at work at a Nail Salon. The caseworker advised the AP that the VC's injuries were non-accidental and explained what this meant. The caseworker advised the AP that photos would need to be taken and explained why this was necessary. The caseworker then completed a safety plan with the AP. The caseworker advised the AP that he was not to be alone with the baby until the investigation was completed. The AP understood and signed plan. The caseworker advised the AP that he would need to identify other individuals to supervise his contact with the VC in addition to the mother. The AP pointed to [REDACTED]. The caseworker then spoke with [REDACTED] and asked some additional info. [REDACTED] is 15 years old and is home schooled. She recently moved to Easton with her mother, [REDACTED] and resides at [REDACTED]. [REDACTED] advised that [REDACTED] works and will not be able to supervise, but would she would be able to assist in the supervision.

Simultaneously, on 11/20/12, LCCYS caseworker, [REDACTED], made an unannounced visit to the [REDACTED] home to complete a 24 hour safety check on the VC's siblings. The mother was at home with victim child's siblings, [REDACTED]. [REDACTED] utilized Language Service Associates to communicate with the mother. She was cooperative in providing demographics and stated that she had been in the current home for the past 3 years since in the country. She stated her husband had been in the country for several years. The children appeared happy and adjusted and no issues were observed or reported. The mother was advised of LCCYS involvement and the safety plan of no unsupervised contact between her husband and the VC.

On 11/28/12, phone contact was made with the hospital and it was learned that the skeletal survey and [REDACTED] of the VC were normal. The CT scan revealed [REDACTED] [REDACTED] was within normal limits.

On 11/29/12, the caseworker returned to the [REDACTED] at LVH and learned that the VC was moved on 11/23/12 to the [REDACTED] as the VC did not meet criteria for [REDACTED]. The VC also did not meet criteria for inpatient at [REDACTED] following discharge from LVH. [REDACTED] evaluated the VC and planned to discharge the VC from the hospital on 11/29/12. A follow-up visit for the VC was scheduled for 12/6/12.

The mother was at the hospital on 11/29/12 and through an interpreter the mother provided the following history. The mother reported that the VC fell according to what her husband told her. The mother was at work at the time of the injury. The mother works until 8:00 pm. At 7:00 pm the AP called and said that the VC was going to the hospital and didn't know what happened to the VC. The mother subsequently left work and went to the house to care for the other children. The caseworker advised the mother of the safety plan in effect in which the AP could not have any unsupervised contact with the VC. The mother stated that she will be home with the VC. The caseworker advised her that AP was supposed to meet with Allentown Police Department, but failed to do so.

The mother stated that the AP told her he met with police. The caseworker advised the mother that another interview with the Allentown Police Department for the AP and probably the mother would be rearranged.

The VC was discharged from hospital to the parents on 11/29/12 with a safety plan in place for the AP to have only supervised contact with the VC and translation services to meet with the family in subsequent home visits. A referral was also made to [REDACTED] and an appointment with the availability of a translator was scheduled for 1/7/13.

An interview was scheduled for Wednesday, December 5, 2012 with the parents by Detective [REDACTED] through an interpreter. The parents did not show for the interview on that date.

On 12/6/12, the VC was evaluated at [REDACTED] by [REDACTED]. The VC was alert, gained weight and was developmentally on target. AP was accompanied by his niece to this appointment and was appropriate. A 4 month check was scheduled at that time to insure VC continues with progress.

Unsuccessful home visits were attempted by the caseworker on 12/7/12, 12/14/12, and 12/27/12.

An emergency pre-placement meeting was held on 1/18/13 in consideration of the new information from the Near Fatality Review. It was determined that [REDACTED] in consideration of the unexplained non-accidental head trauma and injuries consistent with possible multiple incidents, rather than one single incident.

Current Case Status:

The CY-48 for Childline report [REDACTED] was submitted with an Indicated status. The CPS investigation established substantial evidence to support the allegations of physical abuse as per CPS law and regulations. According to medical professionals the injury appears to be non-accidental and is consistent with "shaking". According to the medical professionals, the history provided by AP is not consistent with the injury. The AP was the sole caregiver at the time of the injury resulting in the VC being admitted to the hospital and has been the primary caregiver the VC.

On 1/18/13, the VC was [REDACTED] home of paternal cousins of AP. The VC remained in this home until 1/25/13 at which time she transitioned to foster home through [REDACTED]. The decision was made with the caregiver to move the VC as the caregiver only spoke Vietnamese, indicated she was a short term resource only, and was unable to provide transportation for any routine or medical emergency medical care. On 1/29/13 [REDACTED] presented herself as a placement resource for the VC. LCCYS Kinship care worker completed a home assessment of [REDACTED] and discussed her ability,

availability, and commitment to care for the VC as her primary caregiver until reunification with the parents is possible. [REDACTED] indicated that she was available to be a full-time caregiver. Although she is employed two days a week, her schedule is flexible. She had no limit on the length of time she can care for the VC and is open to frequent visitation between the VC and her parents. She was willing to work with the agency and any services the VC needs. She was also able to drive the VC to any appointments and has accompanied the AP on past appointments to translate. She speaks both Vietnamese and English.

[REDACTED] the VC was a victim of abuse by the AP [REDACTED], in regards to abuse investigated in Childline [REDACTED]. The CY49 was sent to Childline to change the status to Founded.

The VC's siblings remain in the home under a [REDACTED]. The VC is still in a Kinship placement. She is actually in her 3rd kinship home since 1/18/13.

An in-home service has recently started with the parents. They will be taking an interpreter with them when they meet with the parent(s). The VC is attending all medical appointments and has services through [REDACTED]. The case is being opened for ongoing services and will be going to [REDACTED] unit.

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:

- On 2/14/13 a follow up meeting was held with LCCYS, LVH personnel, [REDACTED] and [REDACTED], CPNP and the District Attorney's office to explore additional concerns and identify areas for improvement.
- LCCYS's response to NERO's recommendations were positive. The agency acted accordingly and revisited their investigation per NERO's recommendations.

Deficiencies:

- A major mutual concern noted was the lack of communication between LCCYS and hospital personnel during the VC's 10 day hospitalization.
- A further critical concern noted was the failure to receive hospital records in a timely fashion and the inability to interpret and summarize all documents in order to determine further case planning at LCCYS.

The agency did not have the caseworkers, [REDACTED], who were part of the case present at the meeting.

Recommendations for Change at the Local Level:

- It was determined that there will be a single point of contact at the hospital to discuss the medical condition and conclusions of all children admitted for a non accidental suspicious injury. This contact between LCCYS and the hospital will be critical to the discharge planning at the hospital and the case planning at LCCYS. The comprehensive list of concerns follows:
- Absence of comprehensive medical information prior to medical discharge of VC from hospital
- Lack of coordination and communication with hospital personnel regarding VC's medical condition
- Failure to obtain follow-up interviews with parents by LCCYS regarding history
- Failure to provide services in a timely fashion
- Absence of follow-up home visits to assure the safety of the children remaining in the home

Recommendations for Change at the State Level: None.

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 received a written report summarizing their review. NERO has accepted the report summarizing LCCYS review.

Department of Public Welfare Findings:

County Strengths: LCCYS's response to NERO's recommendations at the ACT 33 meeting held on 1/16/2013 were positive. The agency acted accordingly and revisited their investigation per NERO's recommendations.

County Weaknesses: After a thorough review of the case file, NERO outlined the following as county weaknesses which will need to be addressed regarding the ACT 33 protocols:

- On 11/12/12 LCCYS conducted a safety assessment. The agency did not identify threats associated with the children despite information indicating the AP's account of the incident was not consistent with VC's injuries. Therefore, diminished protective capacities were not identified. However the agency created a safety plan, despite the lack of an identified threat. Therefore the safety plan could not properly address the concerns necessary to ensure the children's safety. The mother is listed as a responsible party but does not sign the plan. The AP is listed as a responsible party which is unacceptable. Safety plan states AP will provide LCOCYS with an appropriate caregiver to supervise his contacts".

- Likewise, LCCYS conducted a safety assessment on 1/18/13. The agency found only one child to be unsafe, but again failed to identify a safety threat. Therefore, diminished protective capacities were not identified. The agency did not use the safety assessment process to accurately assess all the caregivers in the home; therefore a safety plan was created that did not protect the children. The agency needs additional training with the In-Home Safety Assessment Tool.
- 1/25/13 [REDACTED] after the act 33 meeting, regarding chronic injuries, old injuries, the dictation states the mother admitted to being the sole caretaker until she returned to work. Records states “another investigation” will be completed, [REDACTED] [REDACTED] listing the mother as a possible perpetrator for the old injuries. Nor is there evidence in the record these concerns were explored.
- Despite being given a high risk tag the children were not seen weekly.

Statutory and Regulatory Areas of Non-Compliance:

See Attached

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 in the mandated 30 days;
- The LCCYS should develop a plan to address agency deficiencies in the safety assessment process;
- The LCCYS should identify the reasons that a new investigation was not conducted, and take steps to ensure investigations are completed when new information becomes available;
- The LCCYS should identify systemic issues related to diminished gathering of information during investigation of referrals.