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REPORT ON THE DEATH OF

ANDREW HENGEVELD

BORN: 08/02/2008
DATE OF FATALITY: March 17, 2009

FAMILY NOT KNOWN TO: Lehigh County Children and Youth Services

REPORT FINALIZED: February 11, 2010

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1979
Andrew Hengeveld	Victim Child	08/02/2008

Notification of Fatality :

[REDACTED] The incident occurred on March 17, 2009 at the daycare home. The child was napping and fell off the bed and suffocated between the bed and the wall. It was reported that the child was checked regularly but the last time he was checked he had turned blue. 911 was called and the police arrived within minutes. The child was at the hospital within twenty minutes. [REDACTED]

[REDACTED] The child was sleeping on a bed rather than a crib. The degree of supervision was unknown. The victim child was deceased when Lehigh County Children and Youth Services received the report. [REDACTED]

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families reviewed the [REDACTED] [REDACTED] file of Lehigh County Children and Youth Services. This included medical and police reports. The Northeast Regional Office Program Representative spoke with the Lehigh County [REDACTED] Supervisor and Manager regarding the case. The Program Representative also discussed this case with the Northeast Regional Office of Child Development and Early Learning.

Case Chronology:

03/17/2009 [REDACTED] report received by Lehigh County Children and Youth Services
03/18/2009 Safety assessment completed at [REDACTED] daycare home.
Safety plan signed.
03/18/2009 Lehigh County phone conversation with Regional Office of Child Development and Early Learning

03/18/2009 CY 104 sent to Law Enforcement
03/19/2009 Lehigh County conversation with law enforcement
03/19/2009 Phone contact with Lehigh Valley Coroner
03/19/2009 Caseworker spoke with [REDACTED]
04/01/2009 Lehigh County Internal Review completed
04/27/2009 Caseworker requested medical records
05/11/ 2009 Receipt of medical records
05/14/2009 [REDACTED] Risk Assessment completed.
06/04/2009 MDT held
Data Collection Tool completed
Risk Assessment completed

Previous Children and Youth Involvement:

This family was not known to Lehigh County Children and Youth Services. The incident occurred in a daycare home and not in the mother's home. [REDACTED] had no prior involvement with Lehigh County Children and Youth Services.

Circumstances of the Child's Fatality:

On March 17, 2009, the mother took the victim child to the daycare home on a day that she was off from work and not a regularly scheduled day for the child. The mother said that she called the daycare provider and asked if she could watch the child for a few hours as the mother just needed some time for herself. The mother reported that she dropped him off at around 2:45 or 3:00 pm. that day. She reported that the daycare providers called her before the time that she was to pick up the child and said that the child was not breathing and was turning blue.

The cause of the child's death was determined by the coroner to be depressed suffocation as the child was pinned up against the wall and not being able to get air. It was reported [REDACTED] that the victim child arrived at the home around 2:30 pm and she fed the child and he fell asleep in her arms. She said that she put the victim child in her ten-year-old daughter's bedroom and put pillows around the victim child so he would not roll off the bed. She stated that she sent her ten-year-old daughter to check on the victim child at 6:00 pm because she had to leave the home at 6:30 pm. She stated that her daughter found the child between the bed and the wall at the head of the bed. She then said that her daughter put the victim child in the middle of the bed and called for her. She said that she saw that the victim child was not breathing and turning blue.

Current / Most Recent Status of Case:

[REDACTED]
Neither [REDACTED] was able to provide a credible history of adequate supervision of an infant the victim child's age, during the time the victim child

was in the care of [REDACTED]. The investigation also established that [REDACTED] did not personally check on the victim child for a period of at least two hours. In addition, the victim child was placed in an unsafe and inappropriate sleeping environment for a child of the victim's age. Clear and convincing evidence has been established that [REDACTED] actions of placing the child in an unsafe sleeping environment and not supervising the child adequately in an unsafe sleeping environment, resulted in the child's death. Neither biological daughters (ages 10 and 11) were of the age where they could be considered employees of the daycare, thus ruling them out as having been able to provide supervision of the victim child during the alleged times that they checked on the victim child. [REDACTED]

[REDACTED] The Northeast Regional Office of Child Development and Early Learning is in the preliminary stages of attempting to revoke the daycare operator's certificate of registration. Thus, the daycare home is still operating under appeal.

Lehigh County Children and Youth Service have continued to provide services to [REDACTED] as they continue to operate a daycare home. The safety plan that was initially established was that the family would not serve as a childcare provider for any children other than their own during the [REDACTED] investigation. The safety plan also addressed that [REDACTED] ensure adequate care of their own children at all times. The concern was also to offer services to [REDACTED]

There were no criminal charges filed on this case by law enforcement.

Statutory and Regulatory Compliance:

All pertinent parties were interviewed. The investigation was completed within sixty days. The CY 104 was sent to law enforcement on March 18, 2009. The risk assessment was completed on June 4, 2009 which per 3490.321 (h) (1). The periodic assessments of risk shall be completed by the county agency at the conclusion of the intake investigation, which may not exceed 60 calendar days. The risk assessment was completed with [REDACTED] who were caregivers of the child at the time and the victim child's mother. The ratings are reflective of the [REDACTED] daycare environment at the time of the incident. A safety assessment was also completed in compliance with regulatory requirements.

Findings:

- 1** Neither family was known to the county agency.
[REDACTED]
- 4** [REDACTED] are currently operating their daycare home under appeal as the Northeast Regional Office of Child Development and Early Learning has taken preliminary steps to revoke their certificate of registration.
- 5** Criminal charges were not filed against [REDACTED].

- 6 The Risk Assessment was completed at the end of the [REDACTED] Investigation as per regulation.
- 7 The case was closed as the mother of the victim child had no other children in her household. She was referred [REDACTED].
- 8 [REDACTED] was also referred [REDACTED].

Recommendations:

The Northeast Regional Office of Children, Youth and Families recommend that although [REDACTED] were appropriately listed on the risk assessment, it was a household to which the victim child was not residing. Therefore, it would clarify the difference in households if the county completed two distinct risks (one for the victim child's home and one for [REDACTED] household.).

The statewide risk assessment tool was used by the county to assess the risk to the victim child. [REDACTED] were included on the tool appropriately, however; the county agency assessed [REDACTED] household as if the victim child had resided there. Thus, the county needed to do two separate risk assessment tools: one for the victim child's household and one for [REDACTED] and their family to distinguish between the two households. The victim child had only been at [REDACTED] home in the capacity of a daycare provider.