REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 05/05/17
Date of Incident: 05/18/17
Date of Report to ChildLine: 05/18/17
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 Children and Youth Services

REPORT FINALIZED ON:
01/11/2018

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))

Office of Children, Youth, and Families, Northeast Regional Office
100 Lackawanna Ave, Scranton, PA 18503 | 570-963-4376 | Fax 570-963-3453 | www.dhs.pa.gov

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 meeting was conducted on June 1, 2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Child/Victim	05/05/2017
[redacted]	Half Sibling	[redacted] 2009
[redacted]	Half Sibling	[redacted] 2010
[redacted]	AP/Mother	[redacted] 1982
[redacted]	Father	[redacted] 1978

Summary of OCYF Child Near Fatality Review Activities:

OCYF/NERO program representative conducted preliminary review of Lehigh County CPS investigation of incident and conducted collateral interview with CPS intake supervisor at county agency on May 22, 2017.

On May 19, 2017, OCYF/NERO received and reviewed Lehigh County Children and Youth agency submission of Initial Notification of Near Fatality Due to Suspected Child Abuse document. Agency's current safety plan discussed.

Collateral interview with assigned Lehigh County Children and Youth CPS caseworker conducted on May 26, 2017. Safety plan and current status of CPS investigation reviewed.

Act 33 Near Fatality Review conducted at Lehigh County Children and Youth Services on June 1, 2017. OCYF/NERO program representative and supervisory personnel attended Act 33 Review.

Lehigh County Children and Youth Services submitted a CY 48 on June 22, 2017 assigning an Unfounded status determination to the near fatality investigation. The

county agency in collaboration with the investigating law enforcement entity concluded that the incident was accidental in nature.

Summary of Circumstances Prior to Incident:

Lehigh County Children and Youth Services had no record of prior involvement with this family. The child, siblings and family have no record of private social service activity within Lehigh County as well.

Circumstances of Child Fatality and Related Case Activity:

Lehigh County Children and Youth Services received a report [redacted] on May 18, 2017 alleging that an infant was [redacted] the Lehigh Valley Hospital Emergency Room on May 18, 2017, for severe burns to 12% of her body. The Child/Victim was transported to the medical facility by her biological mother and paternal grandmother. At the time of initial contact with the family, it was unclear as to the etiology of the burns. [redacted] As the Child/Victim was admitted to the hospital in serious condition and there was suspicion that the injuries were of a non-accidental nature the case was registered as a Near Fatality as per Act 33 protocol.

The county agency immediately commenced an assessment of the allegations associated with the Child/Victim and assessed the safety of the two siblings of the Child/Victim who also reside in the care/custody of the biological mother and her husband. A major contributing factor and barrier to the investigation of the incident was the fact that the biological mother had a limited knowledge of the English language as she was a recent immigrant from Greece. A safety plan was initially developed placing the care and supervision of the siblings of the Child/Victim with extended family. Family members were also utilized in ongoing translation efforts.

Following a conjoint investigation with the [redacted] Police Department it was determined that the injuries sustained by the Child/Victim were the result of an accident that involved the biological mother bathing the Child/Victim in a sink. The case was subsequently assigned an Unfounded status and the criminal investigation was closed with no criminal charges filed.

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;

The agency conducted a timely and thorough investigation into the incident under investigation. The allegations include a complex review of circumstances surrounding the burning of an infant. The investigation was hampered by several factors: the victim was an infant and there was a language barrier associated with interviewing the alleged perpetrator as she communicated primarily in the Greek

language. There was evidence in the case record as well as information shared during the Act 33 Review that indicated law enforcement and the county children and youth employed multiple interview techniques in an attempt to ascertain an accurate assessment of the case circumstances. This entailed multiple conjoint interviews as well as a re-enactment of the incident.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  N/A

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

- 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.
  N/A

Department Review of County Internal Report:

OCYF/NERO received a copy of Lehigh County Children and Youth Services near fatality internal report on August 15, 2017. The report accurately reflects the information reviewed and shared during the June 1, 2017 Act 33 Review. DHS/OCYF/NERO has reviewed the report in its entirety and accepts the report as submitted.

Department of Human Services Findings:

- County Strengths:

  The county agency commenced a timely and thorough investigation of the allegations of serious bodily injury to an infant. The investigation was conducted conjointly with the [redacted] police department. The agencies cooperated throughout the life of the case freely sharing and collaborating on the investigation.

- County Weaknesses: and
  N/A

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  N/A

Department of Human Services Recommendations:

DHS/OCYF/NERO recommends that the county agency continue to conduct CPS investigations consistent with the quality evidenced in this case. The thorough case analysis that drew upon medical experts and law enforcement collaboration in this investigation is lauded and worthy of emulation.

OCYF/NERO also recommends that the county agency utilize professional impartial translation services in case specific circumstances where investigative needs require additional assistance. In this case the county agency relied on family members to assist in the translation/interpretation of various documents and the actual investigative process.