pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/11/2015
Date of Incident: 07/21/2017
Date of Report to ChildLine: 07/22/2017
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 Children and Youth Services

REPORT FINALIZED ON:
01/09/2018

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))

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 not convened a review team in accordance with the Child Protective Services Law related to this report. Lehigh County Children and Youth Services was not required to convene a review team or prepare a report as the investigation was unfounded prior to 30 days.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	07/11/2015
	Mother/Alleged Perpetrator	[redacted]1986
	Brother	[redacted]2008
	Sister	[redacted]2011
[redacted]*	Victim Child's Father	[redacted]1984

* 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 Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the current Child Protective Services (CPS) referral file.

Summary of Circumstances Prior to Incident:

The family did not have history with Lehigh County Children and Youth Services (LCCYS), nor were any other service providers identified as providing services prior to this near fatality.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/22/2017, ChildLine received a report regarding the allegations of the victim child having an un-witnessed fall down stairs with loss of consciousness. Victim child was inconsolable and panicked during the medical exam. Victim child was unsupervised at home and had fallen down the stairs.

On 07/22/2017, the agency responded to the hospital. According to the mother/AP, she had left the victim child in the bathroom with his siblings while he was brushing his teeth. The victim child left the bathroom on his own at some point and had fallen down the stairs. The mother / AP stated that she went downstairs for a minute and was in the kitchen when this happened, so she did not witness the actual fall. However, she is theorizing that the victim child had fallen between the rods on the stairs as he was on the floor when she saw him.

LCCYS conducted hospital visits on 07/22/2017 and 07/24/2017 where the victim child had presented on target for a child his age. [redacted] The child was alert during the hospital visit.

[redacted]

On 07/25/2017, the victim child [redacted] hospital. LCCYS conducted a home visit on this same date. LCCYS identified some concerns regarding the home including no smoke detector and a spiral staircase with wide spaces between railings with no safety gates or safety measures in place. The LCCYS caseworker met with the mother and the landlord on 07/25/2017 to express the need to remedy these issues. LCCYS also notified the city's Code Enforcement.

[redacted]

On 08/04/2017, the case was unfounded. The case was closed and not accepted for services. LCCYS did have a Multi-Disciplinary Team (MDT) meeting regarding the case and had put services in to assist the family at that time with their immediate needs. [redacted] The

deficiencies in the building were rectified. New smoke alarms were installed in the home by the landlord and components were added to the staircase to make the home safer.

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

The case was unfounded in less than 30 days and the County was not required to convene a review team meeting; there was no County Internal Report thus, no further information to report.

Department Review of County Internal Report:

The County was not required to convene a review team meeting since the case was unfounded in less than 30 days, therefore they were not required to complete the County Internal Report. There is not a County Internal Report due for the department to review.

Department of Human Services Findings:

- County Strengths:

  LCCYS completed a thorough investigation of the report. The agency gathered information from medical professionals. The investigation status was submitted within the required time frame. LCCYS was able to quickly assess the family for their needs and offer appropriate services.

- County Weaknesses: and

  There were no County weaknesses identified.

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

  LCCYS has not submitted the Child Fatality / Near Fatality Data Collection Form that was due on 09/20/2017. NERO requested this be completed and updated regarding the completion of the Data Collection Tool on 10/20/2017 and 11/15/2017.

Department of Human Services Recommendations:

Every County should adhere to the requirements of the Implementation of Child Fatality and Near Fatality Review and Report Protocols as established in the ACT 33 of 2014 Bulletin. The Department should provide technical assistance through the Regional Offices and the Child Welfare Resource Center as needed to assist all of the counties in following these protocols. All counties should ensure that they adhere to the timeframes as designated in the bulletin, especially in regards to timeframes and information needed in relation to the decertification process.