pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/22/2014
Date of Incident: 07/28/2017
Date of Report to ChildLine: 07/28/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lehigh County Children and Youth Services

Family Not Known To:
Schuylkill 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))

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 was convened on 08/17/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Child/Victim	10/22/2014
	Sibling of C/V	[redacted]2004
	Sibling of C/V	[redacted]2011
	Sibling of C/V	[redacted]2009
	Sibling of C/V	[redacted]2007
	Sibling of C/V	[redacted]2013
[redacted]	AP/biological mother of all children	[redacted]1987
*[redacted]	paternal grandfather	[redacted]1966
*[redacted]	paramour of F. Garcia	[redacted]1960
Currently providing Kinship care to [redacted]		
*[redacted]	Maternal cousin	[redacted]1964
Currently providing Kinship care for [redacted]		
*[redacted]	paternal grandparent	[redacted]1970
*[redacted]	Paternal grandmother	[redacted]1962
Currently providing kinship to grandson [redacted]		
*[redacted]	Father of C/V	Unknown
Currently caring for [redacted]		
*[redacted]	Father of [redacted]	Unknown
*[redacted]	Father of [redacted]	[redacted]1981
*[redacted]	Father of [redacted]	[redacted]1990
*[redacted]	Father of [redacted]	Unknown

* 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:

OCYF/NERO conducted preliminary case review with Lehigh County CPS caseworker assigned to the investigation on 07/28/2017. Case circumstances reviewed and safety plan reviewed.

OCYF/NERO conducted site visit to Lehigh County Children and Youth on August 2, 2017. Case status and case file documentation reviewed at this time. A copy of Lehigh County Children and Youth's prior case file secured at this time.

On 08/17/2017 OCYF/NERO human services program representative and supervisory personnel attended Act 33 Near Fatality meeting at Lehigh County Children and Youth Services.

OCYF/NERO human services program representative conducted a site record review on 10/27/17. The completed CPS investigative file was reviewed at this time. Additionally, interview of assigned CPS intake caseworker and assigned ongoing caseworker was also completed at this time.

OCYF/NERO received a copy of the county submission of the Near Fatality Report on 11/2/2017.

Children and Youth Involvement prior to Incident:

Lehigh County Children and Youth Services has had seven prior case involvements with this family starting in 2005 when sibling of C/V was an infant. Issues that were addressed at this time included inconsistent medical attention for Sibling of C/V's [redacted] and the parenting needs relating to an adolescent caring for a child. The case was carried short term at this point and closed by the GPS intake unit. Subsequent records of service activity to this family occurred in 2007, 2011, 2012, 2013 and multiple times in 2014. The prevailing issues again centered around inadequate parenting skills of the biological mother, stable housing, substance abuse and domestic violence. The county agency implemented a series of diversionary services to this family at various periods in 2012 and 2014. All of these services were voluntary and of short duration. There is no clear delineation of the outcome of these services.

On 02/26/2014 the family was referred to the county agency with allegations that a Tier 3 sex offender was residing within the home and there were also allegations of inappropriate discipline by the biological mother. The case was once again provided short term diversionary services and closed at the intake level.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/28/2017 the Child/Victim was brought to the emergency room of Lehigh Valley Hospital by his maternal grandmother and biological mother. [redacted] the caretakers indicated that Child/Victim fell from the second story window of the grandmother's residence. The medical professional certified that the Child/Victim's injuries were alleged to be the result of an egregious failure to supervise and the case was assigned as a Near Fatality investigation to the CPS intake unit at Lehigh County Children and Youth Services.

The Child/Victim was admitted [redacted] there was evidence of prior injuries to extremities and burn scarring on his wrists. In light of this Lehigh County Children and Youth [redacted] regarding the evidence of multiple old injuries.

[redacted] it was also determined that the provision of information by both maternal grandmother and biological mother was inconsistent and did not adequately explain the various injuries on the Child/Victim.

Upon reception of the case Lehigh County Children and Youth Services immediately commenced an assessment of the allegations relating to the Child/Victim. The agency also conducted an assessment of the safety of the siblings of the Child/Victim. Following interviews with various family members and the biological mother it was determined that all siblings required additional support and safety planning. As a result the county agency developed a safety plan that included the placement of all children from the biological mother's care and placed with relatives in the Lehigh County area. While all six children have different fathers, the county agency determined that none of them were viable emergency resources as there is no record of paternal involvement with the children.

The county agency completed the CPS investigation relating to the Near Fatality report associated with the fall of the Child/Victim on 09/25/2017. The case was assigned an Unfounded status at that time. The agency determined that there was insufficient evidence to conclude that the incident was the result of lack of supervision. However, during the assessment of the allegations derived from the Near Fatality referral the agency did determine that there was evidence that several of the siblings of the Child/Victim had evidence of old injuries that could not be explained by the biological mother. Following CAC interviews and [redacted] consultation the agency commenced CPS investigations relating to these injuries.

As of this writing Lehigh County Children and Youth Services continues to provide ongoing services to the Child/Victim and siblings. All children reside in formal kinship care placements with relatives.

Summary of 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 CPS intake caseworker conducted a thorough and timely assessment of the case.
  There was also evidence of collaboration with the CAC and medical provider in securing an assessment/evaluation of the Child/Victim and the siblings.

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

  None identified

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

  None identified

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

  None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  None identified

Department Review of County Internal Report:

OCYF/NERO received the Near Fatality Report prepared by Lehigh County on 11/02/2017. The county submission accurately outlines the current case circumstances and subsequent agency activity relating to the assessment and placement of Child/Victim and siblings. The county submission also accurately analyzes the current family dynamics and the multiple needs of the children as they relate to services and permanency planning.

However, the report is remiss in providing any semblance of justification for the agency's assessment of this family throughout its record of service activity. A myriad of issues have been raised by multiple referral sources starting as early as when sibling of C/V was an infant. The agency has provided intermittent short term voluntary services to this family for over a decade with little evidence of success. There is clear and reasonable case history related to this family that suggests more concerted and mandated services were warranted much earlier than the most recent attention brought on by the Near Fatality.

Department of Human Services Findings:

- County Strengths:

  This case evidences a comprehensive and thorough CPS assessment of the incident that brought the case to the agency's attention. It also demonstrates the viability of collaborative efforts between the medical CAC model and the county agency in those case circumstances where there are multiple siblings and reason to suspect that there is a history of prior abuse/neglect. The extensive collaboration between medical/CAC personnel, CPS intake case worker and the assigned ongoing caseworker in this case is certainly worthy of emulation and should be supported by the county agency. The diligence and accuracy of the CPS assessment of this case manifestly contrasts with the rudimentary attention paid to this family in prior agency assessments.

- County Weaknesses:

  While there is case evidence and information secured from the CPS caseworker that supports the agency's collaborative efforts with the local law enforcement community, they have not been consistently an active participant in the Act 33 process.

  The county agency did not assess the mother's buy-in for services and follow through did not occur.

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

  There are no statutory or regulatory areas of non-compliance by the county agency relating to the investigation and assessment of the Near Fatality. The case was investigated in a timely and thorough manner. In fact the thoroughness and accuracy of the current assessment of this family system highlights the superficiality and inadequacy of prior assessments.

  The issues that continue to be of great concern to OCYF/NERO at this juncture relate to review of prior agency case practice and assessment of this family which fall outside of the regulatory purview of this case.

Department of Human Services Recommendations:

It is recommended that county contracts for prevention/diversionary services should include language that addresses referrals back to children and youth services when a case is closed for non-compliance with the program so that the county agency can review and determine further involvement by their agency. In addition, counties must assess prior history and participation in prevention/diversionary services to determine the appropriateness of subsequent referrals for a family who has had repeated involvement.