pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/27/2017
Date of Incident: 08/05/2017
Date of Report to ChildLine: 08/06/2017
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

REPORT FINALIZED ON:
01/25/2018

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. The county agency completed the CPS investigation within 30 days and unfounded the report. As per Act 33 statute no review is required.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Child/Victim	06/27/2017
	Sibling of C/V	[redacted]2012
	Sibling of C/V	[redacted]2004
	Sibling of C/V	[redacted]2003
	Biological mother/AP	[redacted]1975

Summary of OCYF Child Near Fatality Review Activities:

OCYF/NERO reviewed case specific circumstances with assigned Lehigh County CPS intake caseworker on 08/06/2017. Safety plan reviewed at this time.

On 08/07/2017 Lehigh County Children and Youth administrative personnel had collateral contact with OCYF/NERO regarding veracity of the allegations and the assignment to the county agency as a near fatality. [redacted]

[redacted] Lehigh County followed up with referral source. Despite multiple efforts on the part of the county agency to have the referral source modify the allegations associated with the report the agency was unable to do so.

On 09/05/2017 Lehigh County Children and Youth submitted a completed CY 48 on the case and assigned an unfounded status determination to incident.

OCYF/NERO conducted case file review of completed case file. All due process procedures and regulatory mandates were followed by investigating caseworker. Case documentation reflects thorough review of allegations. Collateral medical professional consultation was utilized in completion of investigation.

Children and Youth Involvement prior to Incident:

At the time of the allegations the family was receiving ongoing protective services from Lehigh County Children and Youth Services. The family was also receiving in home supportive family services from [redacted] Primary focus centered on [redacted] to the biological mother, parenting instruction and assisting in household organization. At the time of the referral the family was cooperative with ongoing casework services.

Circumstances of Child Near Fatality and Related Case Activity:

Lehigh County Children and Youth Services received a report alleging that the biological mother of child/victim brought the child to the emergency room of a local medical facility for evaluation and treatment for a purported fall from a "bouncy seat."

The child was initially [redacted] and transferred to [redacted] unit of a local medical facility.

Following the initial call to Lehigh County Children and Youth an emergency safety assessment of the care/supervision of the child and siblings was completed. Information secured from biological mother was not consistent with alleged injuries. Subsequently, the agency completed a safety plan that removed the child and siblings from the biological mother's care. The fourteen year old sibling [redacted] foster care services. The other siblings of the were placed with a family friend pursuant to emergency clearances. [redacted]

Upon transfer of the child [redacted] it was determined that the [redacted] was not correct in that the child did not have any injuries. Lehigh County Children and Youth secured medical consultation from multiple specialists confirming that the child did not have the injuries as initially alleged in the report. [redacted]

Due to the disparity in the medical data surrounding the initial allegations Lehigh County Children and Youth endeavored to have the near fatality nomenclature deleted from the incident. Following multiple attempts by Lehigh County Children

and Youth administrative personnel to do so the agency was not able to abrogate the near fatality appellation. The referral source did not provide the required information to afford the decertification of the incident as a near fatality report.

Lehigh County Children and Youth Services subsequently conducted a full CPS investigation. This investigation included expert medical review of the data and was conducted in conjunction with the District Attorney's Office of Lehigh County. An unfounded status determination was assigned to the to the incident on 09/05/2017.

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

N/A

Case was completed within 30 days and assigned an Unfounded status.

Department Review of County Internal Report:

N/A

Department of Human Services Findings:

- County Strengths:

Lehigh County Children and Youth conducted a timely and thorough investigation of incident under CPSL. Investigation was conducted in conformance with established conjoint investigative procedures with the assigned law enforcement agency. Case file was well documented.

The incident under investigation also involved multiple medical consultations and expert review of medical reports.

- County Weaknesses:

  N/A

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

  N/A

Department of Human Services Recommendations:

OCYF/NERO recommends that the county agency continue to investigate CPS allegations in a manner consistent with this case. Lehigh County Children and Youth Services was timely and thorough in the investigation of this case. The investigation was collaborative in nature in that the law enforcement agency was consistently involved in assessing all aspects of the incident. What is of significant note is the

fact that the CPS investigation also included the caseworker's active use of multiple medical professionals in evaluating all the circumstances associated with the report.

OCYF/NERO's review of the case specific circumstances of this near fatality has determined that a review of the de-certification process by Lehigh County Children and Youth administrative personnel could serve the agency in the future. The process as established in the Bulletin should be reviewed with Lehigh County Children and Youth administrative personnel in an effort to enhance the county agency's ability to secure de-certification in cases similar to this one.