REPORT ON THE FATALITY OF:

McKenna Rose Felmly

Date of Birth: 12/15/2015
Date of Death: 04/01/2016
Date of Report to ChildLine: 04/01/2016
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:
11/16/2016

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))

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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.

Northampton 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 04/26/2016. While the family are Lehigh County residents, the Fatality occurred in a daycare facility in Northampton County necessitating the Review by Northampton County Children and Youth Services.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
McKenna Rose Felmly	Child/Victim	12/15/2015
[redacted]	Sibling of C/V	[redacted]2005
[redacted]	Biological Mother of C/V	[redacted]1986
[redacted]	Biological Father of C/V	[redacted]1987
[redacted]*	[redacted] Day Care Owner	[redacted]1956

* 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 Fatality Review Activities:

Department of Human Services/Office of Children, Youth and Families/ Northeast Regional Office (DHS/OCYF/NERO) received referral regarding fatality in Sharon's Daycare LLC on 04/01/2016 [redacted]

Due to a contractual relationship between Northampton County Children, Youth and Families Division and the daycare facility, the case was assigned to DHS/OCYF/NERO for [redacted] investigation.

DHS/OCYF/NERO commenced [redacted] investigation on 04/01/2016 by means of coordinating investigative responsibilities with the Northampton County District Attorney's Office and [redacted] Police Department.

Case background material was secured by DHS/OCYF/NERO from Lehigh County Children and Youth Services. Case data was also secured from the Northeast Regional Office of the Office of Child Development and Early Learning (OCDEL). Investigative roles were clarified

Multiple collateral contacts were made by assigned DHS/OCYF/NERO Human Services Program Representative with the assigned investigators from Northampton County District Attorney's Office and Police Department from 04/02/2016 through September, 2016.

DHS/OCYF/NERO interviewed all involved during incident as well as parents of C/V. Case summaries and all relevant incident documentation were secured and reviewed by OCYF/NERO as part of the investigation. Collateral interviews were also conducted with Lehigh County Children and Youth staff and the medical provider for Child/Victim.

OCYF/NERO supervisory and program staff participated in the Act 33 Review conducted at Northampton County Children, Youth and Families Division on 04/16/2016.

On 05/18/2016 a dispositional report was filed identifying that this investigation was as the criminal investigation was still open. Autopsy findings issued on 06/06/2016 listed the cause of death as "Sudden Unexplained Death in Infancy". The autopsy opinion also noted that "an atypical sleeping environment (prone position in crib) and an asphyxia death could not be excluded..." DHS/OCYF/NERO received a copy of the autopsy on 06/20/2016.

An interview of the Alleged Perpetrator was conducted on 08/25/2016 by DHS/OCYF/NERO Human Services Program Representative

As of 09/09/2016, the status is still pending. investigation regarding Child/Victim by OCYF/NERO remains status due to criminal investigation.

Children and Youth Involvement prior to Incident:

Lehigh County Children and Youth Services had brief involvement with the family in December of 2015. At the time of the agency's initial involvement a referral was received due to the mother's possible use of drugs and Child/Victim's

exposure to this at time of delivery. The case was assessed at the [redacted] [redacted] intake level. Following consultation with the family's medical provider and a home visit, the case was subsequently closed [redacted] [redacted]

As the family resided in Lehigh County, there is no record of service activity in any other county. Northampton County Children, Youth and Families Division is charged with convening the Fatality Review as the incident occurred in a daycare facility within Northampton County.

Circumstances of Child Fatality and Related Case Activity:

On 04/01/2016 the biological mother took the Child/Victim to Sharon's Daycare LLC as she was scheduled to return to her full employment.

Biological mother reported to daycare provider that child was still breast feeding and provided a supply of pumped breast milk to daycare provider prior to going to work.

During the morning of 04/01/2016 the Child/Victim had a difficult time adjusting to the daycare setting. Daycare providers reported that Child/Victim cried frequently and refused to take a bottle. Daycare staff report that Child/Victim only ingested "two ounces" the entire day.

Throughout the day Child/Victim was supervised by the owner of the daycare in an area adjacent to the actual licensed daycare facility. Child/Victim was placed in a crib in the bedroom area of the daycare owner's house where she was intermittently left alone while the daycare owner assisted daycare staff in the licensed portion of the daycare facility.

Several calls were placed to the Child/Victim's biological mother throughout the day apprising her of the Child/Victim's refusal to take a bottle.

The daycare owner placed Child/Victim down for a nap at approximately 1:00 PM until 2:30 PM. At approximately 2:30 PM the Child/Victim was found to be unresponsive and EMT personnel were called to daycare site. Child/Victim was transported to [redacted] Hospital where she was pronounced dead.

Following a regulatory review of the daycare by the Northeast Regional Office of Child Development and Early Learning (OCDEL) on 04/02/2016, a decision was made to revoke the daycare license of Sharon's Daycare LLC. OCDEL's decision was predicated on the severity of the regulatory violations associated with the care/supervision of the Child/Victim and the fact that the Child/Victim was placed in an unlicensed portion of the daycare facility for the duration of the day.

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

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

This case was not active with any county child welfare agency at the time of the incident.

Agency case file history review reflects brief [redacted] intake activity within Lehigh County Children and Youth following the birth of Child/Victim. Referral was associated with weaning Child/Victim from [redacted] OCYF/NERO case file review evidenced timely assessment of referral. Case file was accurately completed by Lehigh County Children and Youth and contained documentation of family's compliance with all medical recommendations.

The primary reason for child welfare agency involvement in Northampton County was the assignment of fatality review responsibilities to Northampton County Children, Youth and Families Division as per the Act 33 Statute. Northampton County Children, Youth and Families Division convened a timely and thorough review panel to review the circumstances surrounding the fatality. Northampton County Children, Youth and Families Division prepared the County Review Team Report according to the prescribed Act 33 timeframe submission requirements.

Both Northampton County Children, Youth and Families Division and Lehigh County Children and Youth Services were very supportive to the DHS/OCYF/NERO throughout the [redacted] investigation. Both agencies provided information and assistance as requested.

Lehigh County Children and Youth Services coordinated data relating to the Fatality review with Northampton County Children and Youth and sent administrative and supervisory personnel to participate in the Act 33 Review in Northampton County.

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

N/A

This daycare was licensed by the Office of Child Development and Early Learning according to prescribed regulatory timeframes. All issues that were determined to be of concern relate to the daycare provider's violation of existing regulatory and safety requirements following the licensing and inspection cycle.

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

Daycare providers should be trained in CPR in addition to the required first aid training.

As space heaters were noted to be at the daycare, it was unclear if there was any prohibitions against their usage or storage at the facility.

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

N/A

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

There was discussion as to the necessity and/or ability of daycare providers to be apprised of the background medical history relating to drug usage/exposure

There were also questions relating to the ability of the daycare provider to adequately monitor the infant in a crib that was outside of the licensed daycare area. A recommendation was made to explore the viability of mandating infant monitors for all cribs in a daycare facility.

Department Review of County Internal Report:

DHS/OCYF/NERO received the completed County Review Team Report from Northampton County Children, Youth and Families Division on 07/07/2016. The report accurately reflects the discussions and findings set forth at the Act 33 held on 04/26/2016. DHS/OCYF/NERO accepts the report as written.

Department of Human Services Findings:

- County Strengths:

Lehigh County Children and Youth Services intake case documentation reflects an accurate and timely assessment of the family in December, 2015. There was case documentation that addressed all issues presented at the time of initial agency involvement. No safety issues were present and the family fully cooperated with all recommended services.

Northampton County Children, Youth and Families Division's convening of the Act 33 Review on the fatality in the daycare evidenced attendance from a wide range of the local community social service providers as well as participants from all investigating entities.

- County Weaknesses:

N/A

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

There were no Statutory or Regulatory areas of non-compliance associated with this case.

Department of Human Services Recommendations:

DHS/OCYF/NERO recommends that the positive collaborative relationship OCYF/NERO has with Northampton County Children, Youth and Families Division and Lehigh County Children and Youth be maintained.

The positive collaborative relationships that exist between the investigating law enforcement agencies, Office of Child Development and Early Learning and OCYF/NERO on this case are an exemplar model of multi-disciplinary coordination. It is recommended that this style of collaboration be promoted and is certainly worthy of emulation. These relationships have greatly assisted OCYF/NERO in investigating a very complex case.

OCYF/NERO recommends that future analysis of the viability of employing individual infant monitors for all cribs in a licensed daycare setting be explored.