pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Rion Matz

Date of Birth: 11/15/2017
Date of Death: 12/09/2017
Date of Report to ChildLine: 12/10/2017
CWIS Referral ID: [redacted]

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

Lehigh County Office of Children and Youth Services

REPORT FINALIZED ON:
June 1, 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 - 01/04/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Rion Matz	Victim Child	11/15/2017
[redacted]	[redacted]	[redacted]1991
[redacted]	[redacted]	[redacted]1985
[redacted]	[redacted]	[redacted]2014
[redacted]	[redacted]	[redacted]2014
[redacted]	[redacted]	[redacted]1955

Summary of OCYF Child (Near) Fatality Review Activities:

The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the [redacted] Investigation. NERO staff participated in the Act 33 meeting on 01/04/2018. The meeting included a review of the agency file, medical records and a discussion related to the incident.

Children and Youth Involvement prior to Incident:

Lehigh County Office of Children and Youth Services (LCOCYS) first became involved with the family in 10/2014. LCOCYS received [redacted] concerning lack of [redacted] and [redacted]. The condition of [redacted] was unknown at the time. LCOCYS could not locate the family initially but when located [redacted] was [redacted] due to drugs and drug paraphernalia being

found in the home. [redacted] did not have adequate food and a bottle of urine was found on a table in the home. LCOCYS was granted [redacted] upon [redacted] was arrested upon [redacted] and [redacted] was arrested [redacted] for bringing [redacted]. LCOCYS accepted the case for ongoing services and provided [redacted] services. The court [redacted] to [redacted] on 08/05/2016 and court supervision was terminated on 12/15/2016. LCOCYS continued to provide services through 06/01/2017 when the case was closed.

LCOCYS received [redacted] on 06/29/2017 alleging five adults were using [redacted] in a one bedroom home [redacted]. Although monthly home visits did occur during the [redacted] and other household members were never asked to [redacted]. There were no collateral contacts made with [redacted] doctor to confirm [redacted] compliance with [redacted] even though [redacted] had reported [redacted] lost [redacted] insurance and was not taking [redacted]. This case was closed in September, 2017 with no services being offered.

LCOCYS received [redacted] on 11/07/2017. This was a self-referral by [redacted] requesting financial assistance as [redacted] had missed [redacted] rent payments as well as electric utilities payments. [redacted] reported [redacted] lost [redacted] job due to health issues. [redacted] was [redacted] on 12/13/2017. The victim child was [redacted], born on 11/15/2017, [redacted] as a result of [redacted] was referred to in-home services. On 11/29/2017 LCOCYS requested [redacted] submit [redacted] however [redacted] failed to attend. On 12/05/2017 [redacted] admitted to LCOCYS that [redacted] and was [redacted]. On 11/29/2017 and 12/04/2017 the service providers had expressed concerns to LCOCYS of possible drug use by [redacted] as well as filthy home conditions. [redacted] services on 12/21/2017.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 12/10/2017, LCOCYS received a referral surrounding the death of the victim child. [redacted] reported [redacted] put the victim child down in his basinet around 9:00 pm, and left the victim child [redacted] alone in a room for approximately one hour while [redacted] folded laundry. [redacted] brought the victim child out of the room to [redacted]. [redacted] noticed the victim child's arm was limp and he was not breathing. [redacted] laid the victim child on a mattress and called 911. Emergency Medical Services responded, the victim child was not taken to the hospital as he had already been dead for some time[redacted] was working at the time of incident. [redacted] was home but was sleeping at the time of incident.

On 12/11/2017 law enforcement reported to [redacted] their evidence from the scene immediately following the incident. Law enforcement reported there was a blanket observed in the bassinet, however [redacted] had moved objects around so it was not clear as to what actually was in the basinet with the victim child. [redacted] were interviewed by law enforcement and it was reported [redacted] holding the victim child. Law enforcement did not report any visible signs of trauma to the victim child. The victim child was found to have nail polish on his arm and scratches to his chest. Law enforcement reported that a skeletal survey and eye exam were completed on the victim child and that toxicology testing was pending. Law enforcement speculated that if no asphyxiation was evidenced, the victim child's death would be ruled SUID, sudden unexpected infant death. An autopsy was performed on the victim child, the results have not yet been received.

[redacted] that [redacted] thought the victim child died of "SIDS", sudden infant death, and that [redacted] would not have hurt him. [redacted] stated [redacted] painted the victim child's finger nails but did not do anything else to him. LCOCYS did not interview [redacted].

On 12/11/2017 LCOCYS put [redacted] whereby [redacted] contact [redacted] would be supervised. [redacted] agreeable to the [redacted] and were willing to participate in recommended services. A [redacted] were identified to supervise contact. LCOCYS advised [redacted] would be approved to supervise when [redacted] stated [redacted] would have [redacted] home that night and [redacted].

On 12/11/2017 [redacted]. [redacted] on 12/14/2017 and [redacted]. [redacted] n 12/13/2017 and was [redacted] The [redacted] service reported [redacted] use of Flonase could result in a [redacted]. On the date of incident t[redacted] had been [redacted] by law enforcement. The [redacted] were [redacted]. LCOCYS also requested [redacted] on 12/18/2017 and 12/28/2017, and [redacted] failed to comply.

On 12/29/2017 [redacted] was found to be alone with [redacted], having been left with them by [redacted], in violation of [redacted]. LCOCYS [redacted] and [redacted]. On 12/28/2017 [redacted] report [redacted] to sleep, and on 12/29/2017 [redacted] admits [redacted] is taking [redacted]

On 01/19/2018 [redacted] interviewed [redacted] regarding the victim child's death. [redacted] provided identical history as to what [redacted] had provided on 12/10/2018.

Due to a lack of substantial evidence of an egregious failure to supervise, resulting in the victim child's death, the [redacted].

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;

  [redacted] workers supported one another during the early days of the investigation to manage the death of this child as well as the family's grief.

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

  The agency had a "missed opportunity' during its summertime referral (2017) to provide services due to [redacted], concern about [redacted], family stressors, and need for support.

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

  Agency should consider the [redacted] for future cases as [redacted] now accepts [redacted].

- 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:

LCOCYS submitted the County Review Team Report to NERO on 04/30/2018. NERO determined that the county internal report accurately reflected background case history and [redacted].

Department of Human Services Findings:

- County Strengths:

- LCOCYS conducted a timely [redacted]. [redacted] worked together and supported one another during the initial investigation. LCOCYS followed all established protocols for referral to law enforcement.

- County Weaknesses: and

- NERO acknowledges the importance of keeping children in their home environment whenever possible. LCOCYS utilized [redacted] to supervise [redacted] contact with [redacted]. LCOCYS did not conduct a thorough interview with [redacted] to determine whether or not [redacted] was aligned with [redacted], or that [redacted] had the protective capacity to ensure the safety of [redacted] LCOCYS had an extensive history with [redacted] surrounding use of illegal substances. At the time of the victim child's death [redacted] had relapsed. A thorough interview with [redacted] to determine how [redacted] was functioning at the time was not conducted. [redacted] had lost [redacted] job, the family was being evicted, and there were reported [redacted] problems. All of these factors should have been taken into consideration prior to utilizing [redacted] as a responsible party to supervise [redacted]. LCOCYS lack of thorough assessments has been addressed with our annual licensing inspection.

- LCOCYS made the decision to [redacted] as opposed to [redacted]. The coroner's report has not yet been received to determine how the child died and the decision [redacted] was based solely on [redacted] self-report of how long [redacted] left [redacted] unsupervised.

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

None

Department of Human Services Recommendations:

The Department recommends education for medical providers on the importance of [redacted], and community education to increase awareness of Safe Haven.