pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/24/2015
Date of Incident: 12-05-2017 through 12-11-2017
Date of Report to ChildLine: 12/11/2017
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:
05/16/2018

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))

Northeast Regional Office of Children, Youth, and Families, Regional Office
100 Lackawanna Avenue, Scranton, PA 18503 | Phone: 570-963-4376 | Fax: 570-963-3453 |
www.dhs.state.pa.us

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. A meeting was required as the report was not unfounded within 30 days.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	unknown
	Victim Child	10/24/2015

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) communicated with the agency early in the case to determine the status of the Lehigh County Children and Youth Services (LCCYS) investigation. LCCYS initially reported the case would be unfounded and completed within 30 days. However, once the case went beyond 30 days the agency was reminded of the need to convene a county Act 33 meeting. LCCYS decided not to convene the required meeting.

The NERO reviewed the Child Protective Services (CPS) referral file upon completion of the county's investigation.

Children and Youth Involvement prior to Incident:

There was no county children and youth involvement prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/11/2017 LCCYS received a Child Protective Services report for allegations of Serious Physical Neglect, specifically failing to provide medical care. The report alleges that the alleged perpetrator did not give the victim child his seizure medication over the past 5 days and the child had hypoxia resulting in cardiac arrest. The child was certified to be in critical condition and the report was registered as a near fatality.

The agency completed an interview with the mother on 12/12/2017. The mother reported that she recently moved and was working with the victim child's in-home nurse to transfer the medication to a local pharmacy. The medication needs to be compounded due to the victim child's [redacted] and his [redacted]. The victim child has numerous medical conditions and [redacted]. The victim child has [redacted], is [redacted] and [redacted]. Due to the medication needing to be compounded and approved from the insurance company, the mother had to wait 2 days for the prescription to be refilled. The victim child was given his last dose on 12/05/2017 and when the prescription was available on 12/07/17 the mother immediately administered the medication. The victim child is on [redacted] which he receives 2 times per day.

The mother did advise the agency that she receives 16 hours of nursing and [redacted] services in the home for the victim child. The [redacted] services include [redacted]. The agency completed several collateral contacts to the local pharmacies and were able to verify the mother's attempts to refill the prescription and the compounding process does take overnight.

The victim child received a consult from the [redacted] at [redacted] on 12/11/2017. The consult included medical, developmental and social history. The assessment determined that the victim child is a "2 year old male with [redacted], [redacted], [redacted] requiring [redacted] and [redacted], and [redacted] who has been hospitalized frequently and has had several admissions for [redacted]. It is unclear if his most recent [redacted] event was due to a [redacted] or [redacted]. Although mother had not been giving his [redacted] for 3 days, reportedly due to problems with the pharmacy, his admission [redacted] level was normal. A reasonable caregiver would ensure that her medically fragile child would receive his necessary [redacted] medications."

A physical exam was also performed as part of the [redacted] consult due to the observation of numerous hyper pigmented linear and curvilinear scars on his left thigh and left anterior chest which is concerning on a child who is non-mobile. A full skeletal bone survey was completed on 12/12/2017 and no concerns were noted as a result.

The agency unfounded the report on 01/25/2017.

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

The county did not conduct an Act 33 meeting therefore no information has been identified.

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

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

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

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

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

Department Review of County Internal Report:

N/A

Department of Human Services Findings:

- County Strengths: The county provided the records to the NERO in a timely manner.

- County Weaknesses: Although the report was unfounded and the medical evidence was unable to determine the direct cause of the child's critical condition, the county could have done more to assess overall safety and well-being of the victim child. There was no evidence that support was offered to the family to ensure that the medication can be filled timely, no follow up with the mother questioning bruising to the victim child and no contacts to the in-home nursing agency or [redacted] providers to assess the mother's compliance, cooperation and parenting skills.

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

  A Licensing Inspection Summary has been issues for the following non-compliance areas:
  - The report was unfounded in excess of 30 days and an Act 33 should have been conducted.
  - There were no efforts made requesting information of the child's biological father so that appropriate notifications can be made.
  - The preliminary safety assessment was not completed timely.
  - There were no collateral contacts made to community providers who worked with the family in the home or the child's primary care physician.

Department of Human Services Recommendations:

The Department recommends that there be coordination between the insurance provider and pharmacy to ensure timely dispensing of medication. The Department also recommends that when any service providers are working with a family who has a medically fragile child, that medication monitoring should be a routine part of their interactions with the family to help in identifying the need for refills or to offer assistance in navigating insurance processes.