pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:
Kailah Johns

Date of Birth: 12/06/14
Date of Death: 5/30/15
Date of Report to ChildLine: 5/30/15
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

LEHIGH COUNTY CHILDREN and YOUTH SERVICES

REPORT FINALIZED ON:
11/5/15

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))

Office of Children, Youth, and Families, Northeast Region
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Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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 Act 33 of 2008 related to this report. The county review team was convened on June 18, 2015 and reconvened on August 20, 2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Biological Mother	[redacted]/87
[redacted]	Biological Father	[redacted]/71
Kailah Johns	Victim Child	12/06/14
[redacted]	Sibling	[redacted]/06
*[redacted]	Maternal Aunt	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 Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) commenced review of agency fatality investigation on 06/01/15 by means of a collateral case review with the [redacted] intake supervisor. Safety plan for the child's sibling was discussed. Current status of [redacted] investigation and preliminary data secured from county agency at this time.

On 06/18/15 NERO conducted a site record review at Lehigh County Children and Youth Services. Investigation status update received at this time. Case file review and collateral interviews with assigned [redacted] intake supervisor and [redacted] investigator completed.

NERO personnel participated in the Child Fatality Review on June 18, 2015 and the follow-up Fatality Review on August 20, 2015.

Consultation with Lehigh County Children and Youth administrative staff conducted on September 22, 2015 following reception of agency Act 33 Review document.

Children and Youth Involvement prior to Incident:

There is no record of service activity to this family by Lehigh County Children and Youth Services within the past 16 months.

Agency case file history indicates multiple incidents of brief service activity to this family by Lehigh County Children and Youth in 2009 and 2011. Primary involvement related to allegations of drug and alcohol usage by the biological mother. Lehigh County Children and Youth Services investigated four separate allegations during this time period which were all closed without ongoing intervention. The family was not referred for any outside services

Circumstances of Child Fatality and Related Case Activity:

Lehigh County Children and Youth Services received a referral from [redacted] on May 30, 2015. According to the referral source, the biological parents of victim child contacted 911 and an emergency medical response was dispatched to the family residence. The biological parents presented information to EMT personnel that their infant child was not breathing when they attempted to wake her up. The victim child was placed on life support and subsequently transported to a local medical facility.

The referral source alleged that the biological mother of victim child appeared intoxicated at the time of her arrival at the medical facility. The child was pronounced dead upon arrival at the emergency room on May 30, 2015.

[redacted] Preliminary cause of death was attributed to co-sleeping.

This case was assigned a child abuse registry number [redacted] resulting in the death of a child. [redacted] and [redacted] were both named as the alleged perpetrators. Lehigh County Children and Youth Services commenced a [redacted] investigation at this time. Investigative efforts were coordinated with the District Attorney's Office of Lehigh County and the [redacted] Police Department.

Agency personnel interviewed both biological parents on May 30, 2015. A safety assessment was also conducted at this time. The child's sibling was assessed as a precaution at the onset of the [redacted] investigation due to the fact that the agency did not have any significant involvement with the family. A safety plan was set in place whereby she would temporarily reside in the care of her maternal aunt. The safety plan was lifted within forty eight hours as there was a determination that no safety

threats existed. The child's sibling was returned to the care of both parents at that time.

Interviews were conducted by both the law enforcement agency and county children and youth agency. [redacted] did not feel that the mother was intoxicated as initially alleged. Subsequent interviews were conducted with the father to ascertain the specifics of the alcohol usage by both parents on the date of the incident. Lehigh County Children and Youth [redacted] determined that the father attempted to provide a safe sleeping environment for the child by positioning himself in such a way that he would not roll towards the child while he was sleeping. It was further determined that the mother made no such provisions and admitted to consuming prescribed medications and alcohol prior to co-sleeping with the child. Due to the mother's admissions to these facts and the corroboration of events by the father, it was determined that culpability rested with the mother. The county children and youth agency completed its [redacted] investigation on July 29, 2015, [redacted] The case was submitted to ChildLine Registry according to prescribed format and within the prescribed timeframe.

Lehigh County Children and Youth Services [redacted] intake personnel referred the parents to [redacted] through a private social service provider.

As of this writing the Lehigh County Coroner's Office has not released the toxicology reports relating to Kailah John's death. However, the [redacted] Police Department has ruled the death as accidental. No criminal charges have been filed.

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

Strengths

- Lehigh County Children and Youth Services conducted a timely and thorough investigation of this case and followed all provisions of the Child Protective Services Law (CPSL). [redacted] There was also ample evidence of information sharing and utilizing medical personnel in arriving at a status determination decision.

Deficiencies

- N/A relating to this case

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

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

- None

Recommendation for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

As was outlined in the Lehigh County Children and Youth Act 33 Fatality Review report, there is a more comprehensive and consistent need for the education of parents of infants relating to "co-sleeping" and the potential dangers associated with the practice. The medical professionals who participated in the Act 33 Fatality review acknowledged that there are inconsistencies in the information that is shared by the various medical providers regarding this topic. The recommendation that the local medical community address this topic in a uniform manner is certainly an endeavor that could promote a safer environment for children and offer safe options for parents that continue to "co-sleep" with their children. It is, therefore, recommended that Lehigh County's intention to share the Act 33 recommendations with the current operating local medical task forces also be explored from a broader statewide perspective.

Department Review of County Internal Report:

NERO received Lehigh County Children and Youth Services' Fatality Report of Kailah Johns on September 16, 2015. NERO has accepted the report in its entirety as it is an accurate account of the information presented at the June 18, 2015 and August 20, 2015 Act 33 Fatality Reviews. The conclusions drawn and recommendations set forth reflect the recommendations made by NERO as well.

Department of Human Services Findings:

- County Strengths: The county agency conducted a timely and thorough assessment of the incident. The investigation was completed within the prescribed statutory and regulatory parameters of the CPSL and Department of Human Services regulations. There was also documentary evidence of collaboration with outside agencies and the medical providers involved in the case

- County Weaknesses: This case evidences full compliance with Department of Human Services regulations and case documentation protocols. However, there was an absence of law enforcement participation in the initial Act 33 Fatality Review panel. The county child welfare agency should attempt to engage the law enforcement agency in all Act 33 convocations so that continuity of case planning and investigation can be assured.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency: There were no areas of statutory or regulatory non-compliance.

Department of Human Services Recommendations:

There is a need for more consistent education of parents of infants regarding the deleterious effects and potential hazards of "co-sleeping". The recommendations included in Lehigh County Children and Youth's Act 33 Fatality Review suggesting collaboration and consistent discussions/recommendations by the medical community on the topic of "co-sleeping" are certainly worthwhile considerations. Introducing this as an area of broader policy and practice discussion to the statewide social service and public health community will undoubtedly be a welcome first step. Engendering these discussions on the statewide level can only help address an issue that does not receive the attention it deserves. It is recommended that Lehigh County reach out to the Department of Health which has an educational program in place regarding co-sleeping. The county may also wish to invite a representative to the county Act 33 meeting as adhoc members when appropriate.