pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]
Date of Birth: 11/02/2015
Date of Incident: 02/14/2016
Date of Report to ChildLine: 02/14/2016
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 Office of Children and Youth Services

REPORT FINALIZED ON:
August 22, 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.

Lehigh County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on March 17, 2016.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	mother	[redacted]1992
[redacted]	father	[redacted]1991
[redacted]	sibling	[redacted]2014
[redacted]	paternal great grandfather	unknown
[redacted]	paternal great grandmother	unknown
[redacted]	Victim child	11/02/2015

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective Services (CPS) investigation. NERO staff participated in Act 33 Near Fatality meeting on March 17, 2016. Law Enforcement Officer (LEO) was also present at this meeting and provided information regarding their investigation.

Children and Youth Involvement Prior to Incident:

There is no prior agency involvement.

Circumstances of Child Near Fatality and Related Case Activity:
On 02/14/2016, the victim child was taken by his mother to St. Luke's Emergency Department because his head appeared abnormally shaped and he would scream and become inconsolable when his head was touched. The victim child had a skeletal survey completed and was then transferred to Lehigh Valley Health Network. The victim child was admitted [redacted]

During a second physical examination of the victim child on this same date, it revealed tenderness and swelling to both the right and left scalps, and minor facial abrasions. the victim child's symptoms would have occurred immediately and would have likely included crying, irritability, and change in mental status.

On 02/14/2016, the Lehigh County Office of Children and Youth Services (LCOCYS) caseworker visited the mother at the hospital and at the family home. During those visits, the mother reported that she fed the victim child and put him to bed prior to her departure for work. She left the child in the care of his paternal great grandparents. Mother arrived home from work around 7:40am and reported that the father was asleep with the victim child on the couch. The mother reported that she woke up her other child, and got him dressed. She then woke up the victim child around 9:00am and noticed his head looked abnormally shaped. When she touched his head, the victim child screamed and became inconsolable. The mother reported that she contacted the paternal great grandparents and they reported no issues with the victim child. The mother stated that the paternal great grandparents told her that the victim child woke up twice during the night and was fed both times. The paternal great grandparents left the family home at 6:55am, leaving the victim child alone with the father until the mother arrived home from work. The mother reported that when she contacted the father about the victim child's head he initially stated nothing had happened to the victim child while he was in his care, but later called the mother and stated he might have bumped child's head against an end table. The victim child's sibling was assessed to be safe by the LCOCYS worker on 02/14/2016. The caseworker also spoke with the paternal great grandparents briefly but did not interview them thoroughly.

On 02/14/2016, the father reported to the LCOCYS caseworker that the victim child was in his lap the entire time that he was in the home caring for him that morning. The father believed that when he got up to get a bottle for the victim child, he hit his head on the end table causing the victim child to cry. The father said the child stopped crying after he was given the bottle. The father also reported to the caseworker that he used heroin two or three days ago. The father agreed to submit a urine sample to test for drugs and alcohol. The results from this drug screen were positive for cocaine, heroin metabolite, and THC (marijuana). Law enforcement was contacted by LCOCYS, There was some communication between law enforcement

and LCOCYS regarding the father's drug use. [redacted] wanted the father to have a polygraph because the father changed his story of how the victim child was injured. The father attended a polygraph test on 02/22/2016 but was under the influence of substances which resulted in the test being unable to be completed.

On 02/16/2016 the mother entered into a Safety Plan with the agency agreeing that the victim child would have no contact with his father while the CPS investigation was being conducted. The victim child [redacted] to the mother [redacted] on 02/18/2016. Based on the mother following through with assuring the safety of the child, her relocating to a residence away from the father and her ongoing follow through with services, this Safety Plan was lifted [redacted] on 03/08/2016.

The mother and the father were provided in-home services through [redacted] The mother has been cooperative with the in-home services and has assured the necessary follow-up medical care for the child.

The father has been non-compliant with services and has not been receptive to agency outreach by the caseworker.

This case was reviewed by the Child Advocacy Center of Lehigh County's Multi-Disciplinary Team on 02/24/2016, followed by a Near Fatality Review Team Meeting on 03/17/2016.

Both review team meetings included a review of agency files, a review of medical files and a discussion related to the incident including medical overview and reports from law enforcement related to the status of the case. The Child Advocacy Center Multi-disciplinary Team recommendation that the agency ensures that the victim child's sibling is seen for a medical examination and that the victim child attends his follow-up [redacted] appointment and skeletal survey.

The investigation outcome was submitted on 04/14/2016. The investigation yielded an "Indicated" status concluding that the father caused bodily injury to a child through recent acts/failure to act. The victim child sustained [redacted] while in the sole care of the father. The father's initial history does not match the severity of the victim child's injuries [redacted] and the father continues to change the history of how the victim child was injured. [redacted] subsequent histories provided by the father were not consistent with the injuries the victim child sustained.

The Law Enforcement investigation is pending.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:</u>

- The mother in this case evidenced protective capacities immediately and assured the safety of the child. She has responded appropriately throughout the investigation and continues to maintain a safe environment for the child.

- The agency should investigate whether there is any criminal history for the paternal great grandparents.

- The agency should ensure that child and his brother receive [redacted] screenings for any possible developmental delay.

- The Agency should remain involved to support mother's protectiveness of her children and provide her with [redacted] support should that become necessary.

Department Review of County Internal Report:

- The NERO received the Lehigh County Child Near Fatality Team Report on 06/17/16. The report content and findings are representative of what was discussed during the meeting on 3/17/16. NERO notified the LCOCYS director on 07/19/16 of receipt and acceptance of the county report.

- The NERO requested clarification of several issues which the county replied to by email on 06/21/2016. Those issues included:
  - The report did not contain information regarding whether the recommendation regarding the skeletal exam was completed
  - The report included a statement that said, "the perpetrator continues to change the history of how the victim child was injured" however only one account was initially listed in the report.

Department of Human Services Findings:

- County Strengths:

  - The agency showed diligence in identifying the mother's strengths and protective capacities; ensured that she was apprised of her options as far as making a decision to protect both of her children.

  - The agency built trust by offering the mother in-home services and encouragement to follow through with safety plan.

- County Weaknesses:

  - The safety plan was promissory in nature; if the mother had the protective capacities to ensure the safety of the victim child, a safety plan was not necessary as there was no threat.

  - The agency could have gathered more information on the paternal great grandparents' backgrounds.

  - The agency could have interviewed paternal great grandparents separately regarding their roles and relationships with the child, the child's sibling and the mother, as well as with their son, the victim child's father.

- The agency did not follow through with Act 33 Review Team recommendations to have a skeletal survey performed on the child.

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

None noted.

Department of Human Services Recommendations:

- The agency safety lead should review the practice regarding safety assessments to ensure the safety assessment process is being implemented according to the state approved process.

- The agency should identify why the Act 33 review team recommendations were not followed.