



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 08/18/2007
Date of Incident: 01/20/2014
Date of Oral Report: 01/20/2014

FAMILY NOT KNOWN TO:

LEHIGH COUNTY CHILDREN AND YOUTH SERVICES

REPORT FINALIZED ON:
06/10/2015

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. 6349 (b))

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, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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 child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Lehigh County had no statutory requirement to convene a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	08/18/2007
[REDACTED]	Biological Mother	[REDACTED] 1972
[REDACTED]	Sibling	[REDACTED] 2000
[REDACTED]	Sibling	[REDACTED] 2003
[REDACTED]	Sibling of Child	[REDACTED] 2005
[REDACTED]	Maternal Grandparent	Unknown
* [REDACTED]	Biological Father	Unknown

* resides in a separate household out of state

Notification of Child Near Fatality:

[REDACTED] contacted Lehigh County Children and Youth on 01/20/2014 with a report alleging that Child/Victim [REDACTED] for severe respiratory distress at Lehigh Valley Hospital due to complications associated with [REDACTED] [REDACTED] personnel certified this case as a Near Fatality due to allegations that the biological mother impeded medical treatment in that she refused to give medical consent for various medical procedures and questioned the medical competence of treating staff.

[REDACTED] to the medical facility Child/Victim was subsequently [REDACTED]. Due to the biological mother's continued uncooperative relationship with medical personnel, it was determined that there was a need to involve [REDACTED]

Lehigh County Children and Youth commenced a CPS investigation on 01/20/2014. Data was secured from the medical facility and interviews were conducted by agency personnel with both the medical staff as well as the biological mother of Child/Victim.

A safety assessment of the all siblings of the Child/Victim and the maternal grandmother was also completed at this time. A determination was made that all three siblings of Child/Victim were safe in the care of the maternal grandmother while the county agency conducted the CPS investigation relating to the Child/Victim.

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families commenced review of the Near Fatality of [REDACTED] on 01/21/2014 by means of a collateral contact with Lehigh County Children and Youth Child Protective Services Intake Supervisor. Background data and case specific information was secured at this time, and the Preliminary Report was prepared and submitted.

Lehigh County Children and Youth supervisor had collateral contact with OCYF/NERO on 01/30/2014 regarding case progression. Lehigh County Children and Youth forwarded various case files and medical records at this time.

OCYF/NERO conducted site interviews with assigned caseworker and supervisory staff at Lehigh County Children and Youth on 02/06/2014. Case status and pending case file material was reviewed at this juncture.

On 02/11/2014 OCYF/NERO conducted a case file review at Lehigh County Children and Youth. Assigned caseworker and supervisor were interviewed during site visit. Completed CPS case file was reviewed for compliance with Department of Public Welfare Regulation and CPSL.

Children and Youth Involvement prior to Incident:

There is no record of service activity to either parent or Child/Victim by any public child welfare agency prior to this contact.

Lehigh County Children and Youth has ascertained that the family has had prior service activity [REDACTED]. When the Child/Victim and siblings of Child/Victim were of pre-school age, [REDACTED]

Circumstances of Child Near Fatality and Related Case Activity:

On 01/20/2014 this case was referred to Lehigh County Children and Youth as a Near Fatality due to medical professionals alleging that Child/Victim's biological mother was impeding the provision of life essential treatment for her son who presented in acute respiratory distress due to [REDACTED].

Due to the severity of the circumstances, [REDACTED]

[REDACTED] Child/Victim remained in [REDACTED] until 01/28/2014.

Parallel to the formal investigation of the biological mother [REDACTED] naming the mother as AP by omission, a safety assessment was also completed on the three siblings of the Child/Victim who remained in the care/supervision of the AP. A safety plan was developed that included the involvement of the maternal grandparent to ensure safety of all siblings pending completion of the CPS investigation.

On 01/28/2014 Lehigh County Children and Youth finalized the assessment of all children and family members. It was determined that Child/Victim could [REDACTED] to biological mother as she fully cooperated with all facets of the agency investigation.

Lehigh County Children and Youth completed the CPS investigation on 02/13/2014 assigning an Unfounded Status to the case. It was determined that the biological mother was experiencing a great deal of anxiety relating to the medical condition of her son upon entry into [REDACTED] and did not willfully hinder recommended medical treatment. The county agency did not find any abuse or neglect issues related to the care of either Child/Victim or the siblings.

Current Case Status:

Lehigh County Children and Youth completed the Child Protective Services investigation on 02/13/2014. Following short term services by the county agency, [REDACTED] and the case was closed. [REDACTED] the medical facility, Child/Victim was returned to the care/supervision of the biological mother as she fully cooperated with the county agency.

Lehigh County Children and Youth has closed its case on this family.

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

Lehigh County Children and Youth did not conduct a Near Fatality Review on this case as it was Unfounded within 30 days of assignment.

Department Review of County Internal Report: N/A

Department of Public Welfare Findings:

The Northeast Regional Office of Children, Youth and Families determined that the county agency conducted a thorough and comprehensive investigation of the instant case. Case file was well documented and [REDACTED].

NERO/OCYF determined that the county agency was in full compliance with all applicable Department of Public Welfare regulations.

The OCYF/NERO also commends the county child welfare agency in its collaborative relationship with this office in compiling case specific data and evaluating the overall process of Near Fatalities/ Fatalities in an effort to promote consistent, quality services to the children, youth and families involved in this aspect of public child welfare service delivery.

Department of Public Welfare Recommendations:

The county agency is encouraged to continue to investigate child abuse cases in a manner that is consistent with the case documentation and investigative efforts reflected in this case. There is a timely and thorough nature to the process that Lehigh County Children and Youth administrative staff should continue to promote. The county agency routinely elicits the medical expertise of a local pediatrician who participates in both the Act 33 review process as well as clinical case review/MDT process.

OCYF/NERO recognizes the quality and procedural mechanisms currently in place within Lehigh County as they relate to the assessment and investigation of CPS cases and recommends their continuation.