pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Quinn Wolfe

Date of Birth: 08.20.13
Date of Death: 11.18.13
Date of Oral Report: 11.12.13

FAMILY NOT KNOWN TO:

LEHIGH COUNTY CHILDREN AND YOUTH SERVICES

REPORT FINALIZED ON:
5/19/2014

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 has convened a review team in accordance with Act 33 of 2008 related to this report. The county agency conducted the Act 33 Death review on December 19, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
Quinn Wolfe	Child/Victim	08.20.13
[redacted]	Biological Mother of Child/Victim	[redacted].83
	Biological Father of Child/Victim	[redacted].84
[redacted]	Maternal Grandmother	
	Maternal Grandfather	
	Maternal Aunt	

* reside in a separate household/provided child care for Child/Victim intermittently prior to incident

Notification of Child Fatality:

The [redacted] contacted Lehigh County Children and Youth on November 11, 2013 with a [redacted] injury relating to a female infant transported to the [redacted] Saint Luke's Hospital by her biological father. According to the biological father of Child/Victim, the VC became lethargic and vomited while he was caring for her. Upon admission to the [redacted] the vc presented with [redacted] and [redacted] Following physical examination, it was determined that vc had evidenced of several [redacted] Vc was subsequently transferred to Saint Christopher's Hospital in Philadelphia where the [redacted]

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families commenced review of the fatality of Quinn Wolfe on November 14, 2013 by means of a collateral contact with Lehigh County Children and Youth [redacted] 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 December 6, 2013 regarding case progression and forwarded various case materials and evaluations.

OCYF/NERO representatives, [redacted], participated in the Act 33 Fatality review at Lehigh County Children and Youth on December 19, 2013.

OCYF/NERO conducted site interviews with assigned caseworker and supervisory staff at Lehigh County Children and Youth on January 7, 2014. Case status and case file was reviewed.

On February 20, 2104 OCYF/NERO conducted a case file review at Lehigh County Children and Youth Services. Assigned caseworker and supervisor were interviewed during site visit. Completed [redacted] 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 vc by any public child welfare agency since the birth of Child/Victim in August, 2013.

Lehigh County Children and Youth did have a brief history of involvement with the biological mother as an adolescent. Agency records indicate that the family was assessed when biological mother was fifteen years of age for acting out within the home. The case was not opened for services. The family was referred [redacted] from a [redacted] service provider.

Circumstances of Child Fatality and Related Case Activity:

On November 12, 2013 this case was referred to Lehigh County Children and Youth as Near Fatality due to medical professionals at Saint Luke's/Bethlehem [redacted] evaluating a three month old presenting as lethargic and with flaccid muscle movements. Information secured from biological father was determined to be inconsistent [redacted] in that vc was diagnosed with evidence of multiple bruises, [redacted].

Vc was transported to Saint Christopher's Hospital in Philadelphia on November 12, 2013. Child/Victim (vc) [redacted] until November 18, 2013. The vc died on November 18, 2013 as a result of [redacted]. This case was subsequently determined to be a fatality [redacted] and treated as such.

Lehigh County Children and Youth completed the [redacted]

Current Case Status:

Lehigh County Children and Youth Services completed the [redacted] on January 10, 2014 [redacted] that there was sufficient medical evidence to conclude that Child/Victim did die [redacted] As the Child/Victim [redacted]

Lehigh County Children and Youth were precluded from extensive [redacted]

The case has been determined to be a homicide by the Coroner's Office. However, as of this writing no criminal charges have been filed. The District Attorney's Office of Lehigh County continues to investigate this case.

As there are no other children within this household and the [redacted] are not cooperating with the investigative process, there is no information available relating to ancillary agency involvement with either party.

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

Lehigh County Children and Youth conducted a Fatality Review on December 19, 2013. The case was reviewed extensively with active participation by a broad range of social service, law enforcement and medical professionals. The discussion of case history and subsequent analysis of the case specifics was in depth and analytical in nature. The Act 33 Team concurred with the findings of the county children and youth agency as to the case assessment and analysis of the case circumstances.

[redacted] that suggested that the [redacted] to treat the [redacted] follow up by [redacted] or a [redacted] A recommendation was made to evaluate the current local practice relating to the identification, treatment and follow up [redacted]

Department Review of County Internal Report:

NERO/ OCYF received the county agency's full Act 33 Fatality Internal Review on March 22, 2014. Following a review by OCYF/NERO, follow up with Lehigh County Children and Youth was conducted on April 3, 2014.

The recommendations and analysis compiled by Lehigh County Children and Youth were determined to be comprehensive in nature and accepted in their totality by the OCYF/NERO. Lehigh County Children and Youth Services developed a series of recommendations for practice improvement as a result of the critical review of the circumstances leading up to the initial Near Fatality Report as it relates to pediatric well baby checkups. To wit, the following recommendations [redacted] by Lehigh County:

1. Develop an educational component for grandparents and alternate caregivers around bruising on an infant and the implications of same.
2. Child welfare/medical community should dialogue about what services can be offered to mothers [redacted].
3. Communicate with physicians and develop a protocol for consistent standards regarding reporting presenting bruising in infants.
4. Ideally, have a visiting nurse home visit for every baby after discharge.
5. Request the mother's [redacted] for the purpose of determining what else could have been done to help her, and why the [redacted].

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 case. The investigation drew upon multi-disciplinary information and was well coordinated with the law enforcement agencies involved. Case file was well documented and [redacted] were afforded all parties.

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

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. Additionally, the county agency is encouraged to utilize the existing structure and multi-disciplinary construct of the Act 33 Review Team.

OCYF/NERO notes the quality and procedural mechanisms currently in place in Lehigh County as they relate to the assessment and investigation of [redacted] cases and recommends their continuation.