



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 08/11/2014
Date of Incident: 11/5/2014
Date of Oral Report: 11/5/2014

FAMILY NOT KNOWN TO:

Dauphin County Children and Youth

REPORT FINALIZED ON:

March 9, 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. Dauphin County has convened 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]	Victim Child	08/11/2014
[REDACTED]	Mother	[REDACTED]/1988
[REDACTED]*	Father	[REDACTED]/1991
[REDACTED]	Paternal Grandmother	[REDACTED]1968
[REDACTED]	Paternal Grandfather	[REDACTED]1963
[REDACTED]	Paternal Uncle	Unknown

* [REDACTED] was incarcerated at the time of incident; however, he currently resides in the family home.

Notification of Child (Near) Fatality:

On November 5, 2014, the child was brought to Penn State Hershey Medical Center by her mother. The child had [REDACTED] burns on lower abdomen, legs and genital area. [REDACTED] made a report to Childline stating the child had burns to 15-16% of her body and injuries are suspicious. Dauphin County Children and Youth (DCCYS) received the report the same day. The child was determined to be in serious condition and sent to Lehigh Valley Hospital (LVH) [REDACTED] for continued care.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the Agency case record pertaining to the family, which included medical records, case dictation, photographs, and other investigation documents. Follow up interviews were conducted with the Caseworker [REDACTED] on November 10, 14, and 25, 2014. The CROCYF also participated in the County Internal Fatality/Near Fatality Review Team meeting on December 1, 2014 where medical reports were presented.

Children and Youth Involvement prior to Incident:

Dauphin County CYC had no involvement with the family prior to the near fatality on November 5, 2014.

Circumstances of Child (Near) Fatality and Related Case Activity:

DCCYS responded to the Lehigh Valley [REDACTED] on November 5, 2014 along with the Dauphin County District Attorney's Office. The mother was interviewed and reported her daughter's Pediatrician diagnosed child with [REDACTED] and advised bathing the infant in the sink. On the date of incident, the mother reports her child was lying on a pad in the sink that partially blocked the drain but water was running while child was being bathed. The mother was holding child with her right arm and used left hand to turn off the cold water. In the time that it took her to reach for the hot spigot, the child started screaming. The mother applied cold compresses and called the pediatrician. She was told to take child to [REDACTED] for assessment. No one else was home that she was aware of at the time of incident. The mother called the maternal grandparents (MGPs) to come and get her as she did not have her own transportation. The child was driven to Hershey Medical Center where she received initial treatment before being sent to Lehigh Valley [REDACTED] by ambulance.

[REDACTED] Police responded to the home where the incident occurred. The hot water heater was set to 150 degrees. The [REDACTED] at the [REDACTED] confirmed the infant could have been burned in only a few seconds with water at that temperature. [REDACTED] evaluated the photos of the injuries and reported the flow of the burns were consistent with the mother's story. The Child was [REDACTED] to the mother's care on November 10, 2014.

On November 12, 2014 the Agency received a report from [REDACTED] with additional concerns about the child. An anonymous source reported the child had a lump and bruise on the right side of her head. The reporter was concerned as the child does not roll or crawl and the child had previously sustained burns while in the care of the mother. The Agency went to the home the following morning to observe and assess the safety of the child. The mother reported that prior to the [REDACTED] from Lehigh Valley Hospital; she had fallen asleep with the child in her arms. The child then slipped from her arms and hit her head on the floor. The Agency was able to verify the incident with [REDACTED] staff at the [REDACTED] and the child was also medically examined after the fall. The November 12th report was unfounded on December 10, 2014.

The Agency conducted multiple follow-up visits to the family home. The mother demonstrated how the incident occurred. The mother was cooperative with follow-up medical care at the LVH [REDACTED] and the Agency was able to confirm the mother's contact with her pediatrician's office surrounding the incident. The Child was also up to date with interval well-child care for her age. The parents reported they have asked the landlord to lower the temperature of the hot water heater. The case was determined to be unfounded on December 30, 2014.

Current Case Status:

The Agency met with both the mother and the father in paternal grandparent's home, as the father was released from [REDACTED] work release program. The Agency discussed additional child safety concerns including safe sleeping and limiting bedding in the child's crib. The

family reported having adequate support and intended to move into their own apartment in the near future. The Agency provided information about [REDACTED] for the child should the parents have any concerns with the child's development. The mother and father both were employed and denied a need for any additional services. The family was closed with the Agency on January 2, 2015.

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

Dauphin County hosted an Act 33 Meeting on December 1, 2014. The team was comprised of local CYs professionals, medical professionals, law enforcements, and regional staff.

- Strengths: The team recognized family strengths including: their cooperation with the investigation; creating an appropriate home environment for the infant; and follow-up with medical appointments. The child appears to be healing well in response to her medical care. It was also noted as positive that the case was reported through [REDACTED].
- Deficiencies: No deficiencies were noted at the team meeting.
- Recommendations for Change at the Local Level: Additional recommendations for case follow-up included asking for a reenactment of the incident, obtain photographs of where the incident occurred, discussing [REDACTED] services with the parents. Instructed the family to lower the temperature of the hot water heater.
- Recommendations for Change at the State Level: No recommendations were noted.

Department Review of County Internal Report:

Dauphin County CYs provided CROCYF with a copy of the near fatality report on January 20, 2015. The report contained the required information and a summary of the findings of the Act 33 review team. Written approval of the report was sent to the Agency on February 17, 2015.

Department of Public Welfare Findings:

- County Strengths: County response to the information received was urgent. The investigation was completed in a timely manner. The investigation was completed in collaboration with law enforcement and medical professionals. The Agency solicited expert consultation from the [REDACTED] to further evaluate the child's injuries in addition to the hospital medical review.
- County Weaknesses: No areas of weakness were noted.
- Statutory and Regulatory Areas of Non-Compliance: Supervisory reviews did not occur every ten days. Sixteen days elapsed between documented supervisory reviews on December 15, 2014 and December 31, 2014.

A licensing inspection summary was issued on February 25, 2015 citing the areas of regulatory non-compliance listed above. The Department will follow up with the county to assure compliance with their plan of correction.

Department of Public Welfare Recommendations:

Dauphin County Children and Youth should continue to conduct thorough and timely investigations in coordination with local law enforcement. The Administrative review process for how case supervision is documented should be reviewed to assure timelines are met.