



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF



BORN: 9/14/12

DATE OF INCIDENT: 10/13/12

FAMILY KNOWN TO:

Not known to any public or private child welfare agency

REPORT FINALIZED ON: May 23, 2013

DATE OF ORAL REPORT: 10/23/12 (Near Fatality)

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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. Chester County has convened a review team in accordance with Act 33 of 2008 related to this report on November 15, 2012.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	victim child	9/14/12
[REDACTED]	sibling	[REDACTED]/11
[REDACTED]	mother	[REDACTED]/93
[REDACTED]	father	[REDACTED]/92

NON HOUSEHOLD MEMBERS:

[REDACTED]	Maternal grandmother	[REDACTED]/60
[REDACTED]	Paternal grandmother	[REDACTED]/71

Notification of Child Near Fatality:

On 10/14/12, Chester County Department of Children, Youth and Families received a [REDACTED] report alleging that one month old [REDACTED] had burns [REDACTED]. The child was initially taken to Jennersville Regional Hospital by her parents. The [REDACTED] her to have second degree burns to her right arm, leg, and right side of her abdomen and buttocks. She was stabilized and transferred to Crozer-Chester Medical Center Burn Treatment Center. She was registered in critical condition. The child was in the care of her father at the time of the incident. He reports he was bathing her in the kitchen sink when her mother turned on the shower water upstairs causing the water in the sink to suddenly turn extremely hot. The hospital reports this explanation is inconsistent with the pattern of burns to the child's body.

Summary of DPW Child Near Fatality Review Activities:

For this review, the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation. SERO reviewed the county's investigation/assessment, structured case notes, safety assessments, safety plans and risk assessment. Interviews were completed with the investigative social worker

and supervisor, as well as the on-going social worker. SERO attended the Act 33 Review Team meeting on November 15, 2012.

Summary of Services to Family:

Children and Youth Involvement Prior to Incident:

The family has no prior history with the agency.

Circumstances of Child's Near Fatality and Related Case Activity:

Chester County Children, Youth and Families received the initial referral regarding [REDACTED] on 10/14/12. The County then notified the Chester County Detectives who coordinated with the county and the Oxford Police Department for the investigation. Law Enforcement arranged to interview the parents at the police department. The county caseworker saw the child in the hospital and obtained her medical status. Law enforcement reported the father admitted to burning the child and was charged with aggravated assault, simple assault, reckless endangerment of another person and child endangerment. He was remanded to the county prison.

A safety plan was developed by the County with the mother to ensure the safety of the child and her sibling: the father would have no unsupervised contact with either child, and when the mother was with [REDACTED] in the hospital, the other child would stay with her maternal grandmother. The grandmother was included and in agreement with the safety plan. The mother reported to the County that the child had been fussy and colicky in the days prior to the incident and that both she and her husband had been sleep deprived.

The hospital reported that the child had a full body scan and no other injuries or medical issues were noted. The other child had no signs of injury during her examination. [REDACTED] over the next few weeks, the child [REDACTED]. When seen by the county caseworker, [REDACTED] was alert, awake and responsive. She did not display any visible sign of pain. The mother appeared appropriate with the child and her needs.

On 10/23/12, Childline received supplemental information from [REDACTED] that the child was in critical condition when she arrived at their facility due to suspected child abuse. As a result, this was now deemed a near fatality.

On 11/2/12, the father's bail was reduced and posted on 11/5/12. He was released on electronic home monitoring (house arrest). He moved into his mother's home. As part of his bail condition, he will have supervised contact with his older child and no contact with [REDACTED]

On 11/30/12, the report was Indicated for physical abuse against the father based on his admission. The case has been opened for ongoing services to assist the family with [REDACTED], parenting skills, and ensuring the child's medical needs are met.

Current Case Status:

[REDACTED] from Crozer-Chester Medical Center on November 28, 2012. The victim child, her sibling and mother are residing in the home of the maternal grandmother. The father continues to reside with his mother on electronic monitoring. He continues to have no contact with [REDACTED] and supervised visits with the other child. He is providing financially for the family. His criminal trial has not begun. [REDACTED] are being provided to the family once a week. [REDACTED] receives [REDACTED] once a month for her injuries. Her medical prognosis is said to be fantastic and she will have minimal scarring from the incident.

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

- Strengths: The agency noted they followed established procedures as soon as the referral was made to them. Safety assessments and plans were made for both the children throughout the investigation. Ongoing In-Home services have been implemented to monitor the safety and care of the children. Appropriate referrals were made for the family.
- Deficiencies: None identified.
- ~~Recommendations for Change at the Local Level: None identified.~~
- Recommendations for Change at the State Level: The first recommendation centers around hospital policies and protocols for the reporting of injuries and near fatalities due to suspected child abuse, including education and instruction for physicians and hospital personnel. This would address making reports and the criteria for near fatalities.

Also recommended is the need to address the release of medical records when needed as part of a CPS investigation rather than the current practice of when a child is discharged from the hospital.

Finally, it is recommended that parents are educated and supported when dealing with a colicky baby. This involves parents who seek medical treatment from a health care provider and when a child is born, similar to the requirements of the mandatory shaken baby education program. Toll free support lines could be established to assist parents.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county and is in agreement with the county's findings.

Department of Public Welfare Findings:

- County Strengths: The County provided clear documentation in the case notes and investigation report. All relevant parties were interviewed. Children were seen in a timely manner. The county collaborated with the local police departments and hospitals. The family was referred for appropriate services.
- County Weaknesses: None identified.
- Statutory and Regulatory Areas of Non-Compliance: None identified.

Department of Public Welfare Recommendations:

Recommendations include the need for clear guidance for mandated physician reporters regarding near fatalities. Hospitals need to be engaged and have ongoing dialogue to clarify the definition of near fatality as per the Bulletin. The County and DPW are available for assistance to the medical community.
