



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/02/2007
Date of Incident: 08/29/2015
Date of Report to ChildLine: 08/30/2015
CWIS Referral ID: [REDACTED]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Mifflin County Children & Youth Services

REPORT FINALIZED ON:
03/02/2016

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))

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 Child Line 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 Child Line.

Mifflin County did not convene a review team in accordance with the Child Protective Services Law related to this report. The team was not convened in 30 days even though the case decision had not been made yet. The county review team was convened on 10/05/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	victim child	07/02/07
[REDACTED]	adoptive mother	[REDACTED]/61
[REDACTED]	adoptive father	[REDACTED]/59
[REDACTED]	brother	[REDACTED]/03
[REDACTED]	adoptive niece	[REDACTED]/13
[REDACTED]	adoptive sister	[REDACTED]/85

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, and the Supervisor on September 10, 2015 and October 5, 2015. The regional office also participated in the County Internal Fatality Review Team meeting on October 5, 2015.

Children and Youth Involvement prior to Incident:

The family was not known to Mifflin County Children & Youth Services prior to the incident on August 29, 2015.

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

The report was made on August 30, 2015 and the incident occurred on August 29, 2015. [REDACTED] was outside playing with her siblings and the parents were inside the home. [REDACTED]. The grandparents heard [REDACTED] screaming and found her on fire. They put her in their swimming pool to put the fire out. 911 was called and the child was driven to the

emergency room at Geisinger/Lewistown Hospital where she was then transferred to Leigh Valley [REDACTED] suffered second and third-degree burns [REDACTED].

After this incident occurred a lighter was found in the back seat of the van and it is believed this may have contributed to the start of the fire. Child was wearing a swimsuit with a sundress overtop of it at time of incident.

During the investigation an agency caseworker met with all family members and the child and also spoke to several medical personnel. The police were notified of the event but no charges were filed and the incident was ruled accidental. Adoptive mother was at the hospital the entire time with the child and there were no suspicions of abuse.

With her health improving, [REDACTED] the hospital right before Thanksgiving. She is currently [REDACTED] the fire caused. She was having some [REDACTED] back in November but this condition has improved. Medical personnel [REDACTED] to see if there was damage to her throat due to inhaling the smoke.

She participated in homebound schooling for 3 months and now she is trying [REDACTED] Online but the school wants her to go 5 hours a week but [REDACTED] is only able to handle 1-2 hours. This is a struggle that [REDACTED], her grandmother is attempting to work out with the school. [REDACTED]

The police were notified of the event but no charges were filed and the incident was ruled accidental. The case was closed on October 5, 2015. The case was unfounded on October 8, 2015.

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

Strengths in compliance with statutes, regulations and services to children and families:

- The safety of the other children in the home was ensured immediately.

Deficiencies in compliance with statutes, regulations and services to children and families:

- The team was not convened in 30 days even though the case decision had not been made yet. The county review team was convened on October 5, 2015.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

- None

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

- None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- None

Department Review of County Internal Report:

Central Region received the Mifflin County Internal Fatality Review Team report on November 3, 2015. Verbal feedback was provided to the County on November 3, 2015. The wrong form was sent to the regional office. A revised report received on November 13, 2015. The team did not take any actions due to the accidental nature of the incident. The police were notified of the event but no charges were filed and the incident was ruled accidental.

The Department concurs with the county report's findings and recommendations.

Department of Human Services Findings:

County Strengths:

- Safety of the other children was ensured immediately.
- Mifflin County Children, Youth and Family Services conducted a timely investigation in conjunction with the law enforcement officials.
- The agency provided necessary services to all family members and was able to keep the children safe during the investigation.

County Weaknesses:

- The County was not familiar with the Fatality/Near Fatality Bulletin in order to be in compliance during the investigation.

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

- The team was not convened in 30 days even though the case decision had not been made yet. The Agency was cited for regulatory noncompliance.

Department of Human Services Recommendations:

The Department recommends that the County become familiar with the Fatality/Near Fatality Bulletin in order to be in compliance during any fatality/near fatality investigations in the future.