pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/15/2015
Date of Incident: 12/17/2016
Date of Report to ChildLine: 12/18/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:

Beaver County Children and Youth Services

REPORT FINALIZED ON:
May 30, 2017

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 ChildLine 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 ChildLine.

Beaver County Children and Youth Services (BCCYS) convened a review team in accordance with the Child Protective Services Law related to this report on 01/12/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1994
	Father	[redacted]1994
	Victim child	08/15/2015
	Maternal half –sibling	[redacted]2014
	Mother's paramour	[redacted]1994

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) attended the Act 33 meeting on 01/12/2017. WRO reviewed documents provided by BCCYS pertaining to the family's previous history, and the current Child Protective Services (CPS) investigation that relates to the near fatality. WRO was notified of the near fatality on 12/18/2016.

Children and Youth Involvement prior to Incident:

At the time of the Near Fatality, the family was open for services with BCCYS [redacted] The mother had given the victim child to a friend in Ohio. When the friend could not provide documentation regarding custody or guardianship when she attempted to obtain medical treatment for the victim child, the child was detained by [redacted] County Children and Youth Services in Ohio. At that time, the mother [redacted] requested both children be placed with relatives. Both children were placed with the maternal grandmother on 09/25/2015. At that time neither of the children's fathers had involvement with the

children or BCCYS. On 10/26/2015, the maternal grandmother could no longer take care of the two children, and they were placed into foster care.

In March of 2016, the victim child and his sibling were placed with the mother's cousin. On 07/25/2016, the victim child and his sibling were returned to their mother [redacted] The mother was participating in parenting [redacted] The family was involved with [redacted] and both children were involved in [redacted] services. BCCYS was meeting with the family weekly to assess the children's safety.

BCCYS received a Child Protective Services (CPS) referral on 06/29/2016, while residing in the maternal cousin's residence, with allegations of a bruise on the victim child's backside from being "whooped". There were also allegations of poor home conditions, and people smoking marijuana in front of the children. The case was unfounded on 07/07/2016. However, the family was already open for services from General Protective Services (GPS) referral in 2015.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/18/2016, BCCYS received a CPS report on the victim child alleging that the child had second and third degree burns from hot bath water. The burns were described as more of a scatter pattern to the buttocks area. The report was certified as a near fatality by the University Of Pittsburgh Medical Center (UPMC)-Mercy Hospital [redacted] physician and [redacted] physician. The mother described drawing the bath water, and leaving the victim child in the bathroom alone so she could get the victim child's diaper and pajamas. When she returned, the victim child had turned on the hot water adding to the water already in the tub. The mother called for her paramour who was downstairs attending to the victim child's sibling.

The victim child was removed from the tub, wrapped in a blanket, and paramedics were called. The victim child was taken to UPMC - Mercy Hospital in Pittsburgh via ambulance where the child remained [redacted] 01/05/2017.

On 12/18/2016, the BCCYS caseworker conducted a hospital visit to see the victim child, his sibling and the mother. The mother agreed to and signed a safety plan. The mother agreed to have the victim child's sibling stay with his former foster parents that the children had lived with [redacted] in October 2015 – March 2016. [redacted] It was agreed upon by the mother, that when the victim child was [redacted] the hospital, as part of the safety plan/agreement, he [redacted] to the previous foster parents with his sibling. When the BCCYS caseworker first arrived at the hospital, the previous foster mother was already at the hospital sitting with the victim child, while the mother went home to shower.

On 12/19/2017, detectives from the [redacted] Police Department interviewed the mother and her paramour. The next day, on 12/20/2017, the mother and her paramour were interviewed by BCCYS. The mother stated that the past weekend, the previous foster parents were caring for the victim child and his sibling. The foster mother met the mother at the [redacted] Medical Center due to the victim child being sick. The victim child had diarrhea and was throwing up. The hospital [redacted] to the victim child, and provided the mother with [redacted] if he was still not feeling well after leaving the hospital. The mother went back to her home, and the foster mother took the victim child and his sibling back to her home. On 12/17/2016, the foster parents brought both children back to the mother's home. On the way there, the victim child had thrown up in the car. Later that evening, the mother bathed the victim child while her paramour cooked dinner with the victim child's sibling downstairs in the kitchen. The victim child had pooped again, so she gave him a warm bath. The mother filled up the bathtub with about an inch of water. She reported when she left the bathroom, the victim child was at the end of the tub opposite of the faucet. The mother went into her room to get a diaper, sleeper, and wipes. When she returned to the bathroom, the victim child was under the faucet with the water turned on. By this time, the water was up to his knees and his inner thighs and private area were burned. The victim child was screaming. The mother got him out of the tub, and called the paramedics. She put a diaper on him, and wrapped him in a towel and blanket. The victim child was pulling on loose skin on his leg. When the paramedics arrived, [redacted] The paramedics wanted to life flight the child, but due to the weather, the ambulance took the child to UPMC- Mercy Hospital in Pittsburgh.

The mother's paramour reported to the BCCYS caseworker that on the night of the incident he was downstairs with the victim child's sibling. He heard the water turn on. The victim child usually cries when he takes a bath, but when he heard the victim child screaming, he knew something was wrong. The mother's paramour ran upstairs, but by the time he made it to the bathroom, the mother had the victim child wrapped up. The mother's paramour stated that the children usually bathe together, and he was not sure why their mother decided to put the victim child in the tub. He had asked the mother to wait until he was done in the kitchen to do so. The mother's paramour thinks the victim child had soiled himself, so instead of changing his diaper, the mother bathed him. He also reported the diapers for both children are located right inside of the door for their bedroom, which is steps from the bathroom. He is not sure what took the mother so long. When the mother's paramour got to the bathroom, the victim child's skin was peeling off. He stated that he has seen the victim child go for the faucet before; however, since he would be under supervision, he had never been successful in turning the faucet on.

On 12/20/2016, the [redacted] Police conducted a home visit to the mother's home where the incident occurred. They checked the water temperature. Within one minute, the water reached 104 degrees. Once the water was turned all the way to "hot", within 30 seconds the temperature reached 150 degrees.

[redacted]. On 01/06/2017, the pediatrician sent a letter to the physician who certified the child's injuries as near fatal stating the child's injuries were most consistent with immersion into scalding water. However, while the burns were serious injuries that required skin grafting, those burns were not considered near-fatal injuries from a medical perspective. [redacted] physician also explained the ChildLine criteria to certify an injury as a near fatal incident. [redacted]

On 01/04/2017 and 01/05/2017, hospital staff and BCCYS had a difficult time reaching the mother [redacted]

On 01/12/2017, an Act 33 meeting was held as required [redacted] Police reported they interviewed the mother on one occasion and her "story" didn't make sense. The police believed the burns were a result of immersion. BCCYS reported the mother gave them the same story.

On 01/11/2017, BCCYS submitted the Child Protective Services Investigation Report with the status of "Indicated" on the mother. The mother has been charged with a Misdemeanor 2 count of Recklessly Endangering Another Person and a Misdemeanor 1 count of Endangering Welfare of Children-Parent/Guardian/Other Commits offense. On 05/19/2017, the mother pled guilty to Endangering the Welfare of Children and received 5 years of probation.

The victim child [redacted] on 01/13/2017 to the foster parent's home. [redacted]

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

Strengths:

- BCCYS collaborated with [redacted] Police Department detectives, Mercy Hospital and Children's Hospital of Pittsburgh CAC to conduct a thorough investigation. The agencies were all quick to respond.

Deficiencies:

- After further investigation by the pediatrician [redacted] she determined the case was not a near fatality. The pediatrician spoke to the certifying physician, and he also agreed that it was not a near fatality. There was a second certifying physician, but she has not responded to attempts.

Recommendations at the Local Level:

- To expedite medical personal to promptly notify law enforcement officers immediately to the suspected child abuse incident, so a criminal investigation can be pursued thoroughly. A delay in notification prevents law enforcement from properly collecting evidence, interviews and photographic documentation of the crime scene.

Recommendations at the State Level:

- None

Department Review of County Internal Report:

BCCYS submitted the county's internal near fatality report on 02/13/2017. The Department reviewed the County's near fatality report and agree with their findings

Department of Human Services Findings:

- County Strengths:

- BBCYS began the intake investigation immediately and within the required time frame.

- The BCCYS caseworker saw the victim child and family in a timely manner in order to make an informed decision regarding safety and well-being of the children.

- The initial safety assessment and new information safety assessment were completed in a timely manner.

- The BCCYS caseworker made collateral contacts with medical professionals throughout the investigation to collect valuable information.

- The Risk Assessment was completed as required in a timely manner.

- An indicated status determination was made within 30 days of the day of the oral report to ChildLine.

- <u>County Weaknesses:</u>

- The County Near Fatality report that was submitted to the Department has the child's first name as [redacted] The child's first name in the case file on other documents is listed as [redacted]

- BCCYS needs additional training in the requirements of the Fatality/ Near Fatality process.

- <u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>

- None

<u>Department of Human Services Recommendations:</u>

The Department recommends ongoing education for physicians as to what constitutes a near fatality.