REPORT ON THE NEAR FATALITY OF:

Date of Birth: 08/24/2016
Date of Incident: 09/17/2016
Date of Report to ChildLine: 09/17/2016
CWIS Referral ID:

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

Dauphin County

REPORT FINALIZED ON:
03/01/2017

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))

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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.

Dauphin County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 09/23/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
	Victim Child	08/24/2016
	Mother	1976
	Sibling	2013
	Maternal Grandmother	1956
	Mat. Step-grandfather	1959
	Father	Unknown

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a meeting with the Multi-disciplinary Team (MDT)/Act 33 Review board on 09/23/2016 to review and discuss case information. Additional discussion concerning the case was conducted with the Dauphin County Social Services for Children and Youth (DCSSCY) Director of Social Services on 10/19/2016.

Children and Youth Involvement prior to Incident:

No prior involvement.

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

On 09/17/2016, a referral was received stating that the mother had been bathing the victim child in the kitchen sink. The water was getting cold and the mother stated she turned the water back on to warm it up, left to get a towel, and when she return he child was burned. The victim child has scalding and partial thickness burns

The child's skin was completely sloughed off. The story was not consistent with the injuries due to length of time the child would have been unattended and the severity of the burns. The child was certified to be in serious or critical condition based on the suspected abuse/neglect but was not deemed to be a near fatality. The child was expected to survive.

The Agency contacted the hospital and was advised that the victim child was life flighted to Leigh Valley Hospital's earlier in the day. It was reported that the mother brought the child herself to the hospital. Lehigh County Children and Youth (LCCYS) was contacted and a caseworker responded to the hospital for a visual safety assessment of the child and her older sibling who was with the mother.

On 09/18/2016, the report was certified as a near fatality by physician at Lehigh Valley Hospital stated that the victim child was in critical condition She suffered 15 percent total body area burns and The child's mother reportedly left child in sink while she went to get a towel. certified the child to be in critical condition based on suspect abuse or neglect. The child is suspected to survive

The same day the mother was contacted by DCSSCYS via telephone. She reported that the hospital advised her daughter would be due to the extent of her injuries. The mother reported that on the day of incident, she was bathing the child in the bathroom sink and was not using a baby tub. She had been draining the water and noticed the baby "had pooped." She turned the water back on to rinse the child again. The mother kept a hand on the child in the sink as she turned to grab a towel. When she turned back around the child was noticeably pink. The mother acknowledged that the water heater was set at 155 degrees because of the length of time it was taking to heat up the shower water. The mother reported her son was staying with her aunt while the mother was at the hospital with the baby. The Agency completed a home visit on 09/18/2016 to the aunt's home to assure the safety of the 3-year-old sibling. No concerns were noted with the care of the sibling.

The Agency made frequent contacts with the hospital while the victim child was the mother was appropriate with the child, participated in her care, and continued to breast feed the infant while hospitalized. The Agency conducted a joint investigation with law enforcement and shared medical information and interview findings. Police Department interviewed the mother and maternal grandparents who resided in the same home where the incident occurred. The step-grandfather was home but was sleeping at the time of the incident. The grandmother returned home immediately afterwards, as the mother brought the child out of the bathroom crying that the infant was

burned. The mother's account of the incident was consistent with other retellings to the caseworker and the hospital. The police tested the water at the home and recorded a temperature of 152 degrees after running for 39 seconds. The water heater thermostat was set at 150-155 degrees.

This child [redacted] on 10/04/2016 and sent home to live with her mother in her grandparents' home. The mother was interviewed in person on 10/06/2016 at a home visit where both children were present. The mother again recounted an account consistent with her first interview over the telephone. The mother took the child immediately to the hospital after noting the redness on the baby. The mother no longer bathed the child in the sink and obtained a baby tub. The mother was aware of how to continue to care for the child's burns and had planned to attend scheduled follow up visits with medical providers.

The child had a follow up appointment with her pediatrician [redacted] on 10/18/2016 and a follow up appointment with the Lehigh Valley Hospital on 10/31/2016. [redacted]
The mother has extended family support and the family was referred for a Family Engagement meeting to help identify a long term plan. Safe sleep information was provided to the mother as well as information for [redacted]

The Agency determined there was no evidence the victim child was intentionally burned. [redacted] the mother responded immediately to the child's medical needs. The report was unfounded on 11/16/2016 and the case was not opened for services. Law Enforcement did not press any charges in relation to the incident.

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;
  - Upon receipt of this referral Dauphin County protocol was followed.
  - Immediate contact was made with the [redacted] Police and the Dauphin County District Attorney's office.
  - Lehigh County Children and Youth assisted and completed an immediate visit to the child's location at the Lehigh Valley Hospital.
  - Contact was made with the mother [redacted] by Lehigh Valley Children and Youth.
  - Dauphin County Children and Youth completed a seventy hour home visit with the child's sibling and the family member who was assisting in caring for the sibling.
  - Upon the child's [redacted] three follow up visits were made to the child's home, meeting state requirements.

- Throughout the completion of the investigation there was open communication between Dauphin County Children and Youth, ███ ███████ Police and The District Attorney's Office.
- CDRT Act 33 meeting took place and all of these Agencies were represented. Audio recorded interviews, police reports and medical records including photos were shared among team members. Dauphin County Children and Youth updated the team regarding the child's progress and service actions.

- <u>Deficiencies in compliance with statutes, regulations and services to children and families;</u>
  - Discrepancies in initial referral.
  - Per ███████, no one from Dauphin CYS contacted her regarding investigation.

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;</u>
  - None

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and</u>
  - None

- <u>Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.</u>
  - Police need to complete a doll reenactment as soon as possible.
  - Arrange meeting to discuss protocol with Lehigh Valley Hospital.
  - Make referrals for ██████████ and mother's ████████

Department Review of County Internal Report:

The Dauphin County Fatality/Near Fatality Review Team held an Act 33 meeting on 09/23/2016 where medical information and case history were presented. The County report was received by the Region on 12/06/2016. The CROCYF notified DCSSCY that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- <u>County Strengths:</u>
  - The Agency worked collaboratively with law enforcement and medical personnel through the county joint investigative team.
  - The Agency solicited cooperation from LCCYS when child was obtaining medical treatment in another county.

    - The county conducted a thorough investigation and obtained all applicable medical records.
    - The Agency provided Family Engagement Meeting to help family identify long term supports after agency involvement ended.

- County Weaknesses: and
    - None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - None noted

Department of Human Services Recommendations:

Dauphin County Social Services for Children and Youth should continue to conduct thorough and timely investigations in coordination with local law enforcement and other community partners.