pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY

[redacted]

Date of Birth: 12/23/2013
Date of Incident: 08/18/2016
Date of Near Fatality: 09/15/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Dauphin County Children and Youth Services

REPORT FINALIZED ON: 01/23/2017

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
[redacted]	Biological Mother	[redacted]/1993
[redacted]*	Biological Father	[redacted]/1993
[redacted]	Victim child	12/23/2013
[redacted]*	Maternal Aunt	[redacted]/1987
[redacted]	Full sibling	[redacted]/2013
[redacted]	Full sibling	[redacted]/2014
[redacted]*	Maternal Aunt's Paramour	[redacted]/1985
[redacted]	Maternal Grandmother	[redacted]/1966

* 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 Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CRO) 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. Discussions occurred with the caseworker on 09/16/2016 and 11/09/2016. The CRO attended the Act 33 meeting on 09/23/2016.

Children and Youth Involvement prior to Incident:

Dauphin County Children and Youth Services (DCCYS) became involved with mom and her oldest child on 10/14/2013. The allegations were that mother and father got into an argument in the car that caused mother to swing at father. Mother hit her oldest child two times in the face. The child was sitting between the mother and father when this incident occurred. Mother lives with 15 other individuals in the

home and does not have the items that the baby needs. The referral did not identify all the individuals living in the home. The agency did respond immediately to the address provided. No one was home during the first attempt. DCCYS then went to the father's home to try and locate mom and child and to discuss the referral. DCCYS attempted several times at mom's address the same day. A neighbor came out and explained that there was two of the same address but this one is considered [redacted] and the other is considered [redacted]. The neighbor explained where that street is located and DCCYS went to that location and met with mom. The agency offered Family Group Conference to both parents who agreed. The agency also opened the family for on-going services. During the time opened for services; the agency received two additional referrals that were addressed under the open case. On 04/02/2014, the victim child and his older sibling were [redacted]. The victim child appears to be very [redacted] and the children do not have medical insurance. On 04/08/2015, it was reported that father allegedly smokes marijuana in front of the children. DCCYS provided in home services to this family from 10/25/2013 to 7/23/2015. During the family's involvement, referrals were made to [redacted] and [redacted]. A family group conference was held on 12/11/2013 and a visitation plan for the family was developed by the family. Mother agreed to services through [redacted] and both parents completed urine screens. Both parents cooperated with agency personnel during their involvement and it was noted that communication between both parents improved and a visitation plan was developed.

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

On 8/18/2016, the victim child and his sibling were in the care of the maternal aunt's paramour since 7:00 AM that day. The maternal aunt's paramour called her at her place of employment and told her the victim child had a "rash like" pattern on his legs. The maternal aunt's paramour reported that the aunt instructed him to put Vaseline on the rash. The maternal aunt's paramour called her several times to report that the rash appeared to be getting worse. At 2:00 PM, he advised the maternal aunt that the victim child was refusing to walk. The maternal aunt arrived home at approximately 3:30 PM. When she observed how bad the victim child's skin looked, she took him to the emergency room at Harrisburg Hospital around 4:00 PM. DCCYS was informed by the Harrisburg Hospital where the victim child was initially examined; he was being assessed for [redacted] and was treated with [redacted]. The victim child was then transferred by ambulance to Hershey Medical Center. While the victim child was seen at Hershey [redacted] the victim child was treated initially for [redacted] and that information was shared with both DCCYS and the parents of the victim child. He was then taken to Lehigh Burn Center for treatment and was seen by the Child Protection Team. On 8/25/2016, the Child Protection Team reported the victim child's injuries were related to being put into scalding hot water. The victim child was [redacted]. The burns were consistent with the victim child being submerged in scalding hot water according to the Child Protection Team at Lehigh Valley Burn Center. On

09/15/2016 the case was then upgraded to a near fatality by the Child Protection Team at Lehigh Valley Burn Center.

DCCYS responded immediately to the initial referral on 08/18/2016. DCCYS first went to the Harrisburg Hospital and learned that the victim child was already transferred to Hershey Medical Center. DCCYS was told at that time that the victim child was being treated for [redacted]. DCCYS then went to Hershey Medical Center and learned that the victim child was being admitted to [redacted]. DCCYS was told by the doctor that a burn was ruled out; it was felt that it was medical and that the parent's reaction was appropriate. The victim child was being treated for [redacted] and then transferred to the Lehigh Valley Hospital for treatment.

On 08/19/2016, DCCYS was informed by the social worker at Lehigh Valley Hospital that the victim child was diagnosed with [redacted]. It wasn't until 08/25/2016, that DCCYS was informed that the victim child was seen by the Child Protection Team and it now may be [redacted] as initially thought. On 09/15/2016, the case was then upgraded to a near fatality by the Child Protection Team at Lehigh Valley Burn Center, naming the maternal aunt's paramour as the perpetrator.

DCCYS did their initial Safety Assessment Worksheet on 08/18/2016 and saw all the children by the next day. DCCYS notified law enforcement on 08/22/2016 and waited for their response to schedule the interviews with the alleged perpetrators. DCCYS along with [redacted] Police conducted the interview with the AP on 08/31/2016. [redacted] Police contacted DCCYS later that evening to state that the AP finally "gave it up". At the Act 33 meeting, it was explained that the maternal aunt's paramour finally admitted that he gave the victim child a bath that morning of the incident because the victim child soiled himself. DCCYS still had the other children continue with their scheduled interview at the CRC.

The victim child was transferred to the [redacted] Rehab for two weeks before being discharged on 09/19/2016. The victim child was initially going to be discharged to his father with the paternal aunt babysitting him while dad worked. However, the parents agreed for the comfort of the victim child; to have the victim child discharged to mom who was residing with her mother.

DCCYS indicated the maternal aunt's paramour for physical abuse on 10/17/2016 and the District Attorney's office charged the maternal aunt's paramour with aggravated assault and endangering the welfare of a minor.

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;
    - DCCYS responded immediately to the referral.
    - Investigation Protocol Procedures were followed.

- Agency, Law Enforcement, and Hospital communicated with each other.

- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>;
  - There were several diagnoses from the hospital and information not relayed to DCCYS appropriately.
  - DCCYS was unaware of the Tele-burn camera app which Harrisburg Hospital has to communicate a [redacted] with Lehigh Valley Hospital. This app can be helpful if used initially to identify a correct [redacted].
  - Hospital initially told DCCYS the victim child was not a [redacted] but instead had [redacted].

- <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>;
  - DCCYS should contact a doctor at the hospital regarding possible abuse to have the doctor review the medical records/see the child and relay information back to DCCYS.
  - Appoint a point of contact person at Lehigh Valley Hospital for DCCYS.
  - Information gathered on Act 33 review should be sent to Harrisburg Hospital.
  - The Harrisburg Hospital Emergency Room should appoint a staff member to participate on the Child Death Review Team/Multi-Disciplinary Teams.
  - Trauma treatment should be set up for victim child.
  - Early Intervention set up for child.

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

- <u>Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.</u>
  - None noted.

<u>Department Review of County Internal Report:</u>

The Dauphin County Child Death Review Team held an Act 33 meeting on 09/23/2016 where medical information and case history were presented. The county report of the Act 33 meeting was received by the CRO on 11/14/2016. On 12/13/2016, the CRO sent correspondence to Dauphin County Children and Youth Services Director, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:
    - The agency responded to the referral immediately and went to both hospitals to see the child.
    - Agency personnel conducted joint interviews with Law Enforcement and communicated well with each other.
    - The agency's Act 33 meeting was well represented by county personnel, medical providers, and law enforcement. The meeting was very thorough and the county seemed receptive to suggestions made by others.
    - The agency obtained medical records from each of the hospitals that the child was being treated.

- County Weaknesses: and
    - The FSP and reviews were not signed by the supervisor of the case in 2013 and 2014 when the family was first accepted for services.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - During the review of the family record, the Agency was found to be out of compliance in regard to the supervisor failing to sign off the initial FSP and subsequent reviews. This issue was addressed in prior licensing inspection summary and has since been rectified by the Agency through their plan of correction and monitored by their CRO program representative.

Department of Human Services Recommendations:

The investigation was completed in a timely manner by Dauphin County Children and Youth Services. The agency worked in conjunction with their local law enforcement to do joint interviews for their investigation. Since the agency employs a registered nurse; it is the recommendation that the agency utilize their registered nurse to assist in any way with cases involving different hospitals. The registered nurse could be utilized to assist with communication with the different hospitals as a contact person for the agency.