



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**BORN: January 9, 2011**  
**DATE OF NEAR FATALITY: October 21, 2011**

**FAMILY NOT KNOWN TO:**  
***McKean County Children and Youth Services***

**Report Finalized On: February 20, 2013**

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 No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.<sup>1</sup>

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. McKean County has not convened a review team in accordance with Act 33 of 2008 related to this report because the report was unfounded within 30 days of the agency receiving the oral report. The injury was determined to be accidental.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	01/09/2011
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Father	[REDACTED] 1986

**Notification of Near Fatality:**

On October 21, 2011 the child was taken to Kane Community Hospital with burns

[REDACTED] The burns were [REDACTED]. The

father stated that the child was in the kitchen by himself. There are no countertops in the kitchen and the child bumped into the "Baker's Rack" and a pot of coffee fell on the child. The father was in the living room playing a video game and the mother was in the nursery. The child was transferred to [REDACTED] where he was found to be in serious condition as a result of physical neglect because of a lack of supervision. The child's burns were consistent with the story. The child was expected to survive but may need surgery. The father was angry when he was told that a referral was made to McKean County Children and Youth Services (MCCYS). The father had been involved with Children and Youth Services as a child. He said that he would not allow them on his property.

**Summary of DPW Child Near Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed all current records pertaining to the family. The Department obtained the child's medical records from the agency and reviewed them.

<sup>1</sup> 23 Pa, C,S, § 6343(c)1,2.

### Summary of Services to Family:

#### Children and Youth Involvement prior to Incident:

McKean County Children and Youth Services did not have prior involvement with the family. According to the father he had involvement with Children and Youth Services. This involvement was in Elk County. According to [REDACTED] records there is an [REDACTED] report on the father. When the father was seventeen years old he was babysitting an eleven year old boy. He was accused of fondling the child's penis. The report was [REDACTED] by Elk County.

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

On Friday, October 21, 2011 McKean County Children and Youth Services received a [REDACTED] report on the child. The child was in UPMC Mercy Hospital with burns [REDACTED] burns were [REDACTED]. The father stated that the child was in the kitchen by himself. There are no countertops in the kitchen and the child bumped into the "Baker's Rack" and a pot of coffee fell on the child. The father was in the living room playing a video game and the mother was in the nursery. [REDACTED] found the child to be in serious condition as a result of [REDACTED] because of lack of supervision. The child's burns were consistent with the story. The child had been transferred from [REDACTED]. The parents were with the child at [REDACTED] in Pittsburgh.

The report from [REDACTED] included the information that there was a prior [REDACTED] report on the father as a [REDACTED] of [REDACTED] in 2004. He reportedly fondled a child's penis two times when he was babysitting the child. The father was seventeen at the time. The incidents occurred in Elk County. The criminal record check on the evening of the report showed that the father had a misdemeanor for corruption of a minor and possession of a controlled substance on his record.

The agency on-call worker called [REDACTED] and was told that the mother reported to them that she was putting clothes in a closet. The child was in a walker and got around her. When she returned to the kitchen the child had the coffee pot in his hand and was pouring coffee on himself. She put the child in the shower and called 911. [REDACTED] stated that the injuries were consistent with the mother's story. They believed that the injuries were accidental and not caused by lack of supervision.

The caseworker then spoke to the police officer from Kane Police Department who responded to the call. The police officer stated that the child had [REDACTED]. The injuries were not intentional. There are no other children in the home. The house was clean and well kept. The coffee pot was not broken.

The caseworker spoke to the [REDACTED] who reported that the Doctor was speaking to the father. The [REDACTED] reported that the child was in critical condition by age with [REDACTED]. The child's prognosis is good. [REDACTED]

[REDACTED] The mother was angry that MCCYS was called. The parents were observed arguing. The earliest that the child would be [REDACTED] would be mid-week.

Later that night the caseworker spoke to a [REDACTED]. The [REDACTED] reported to the caseworker that the father had gone home. The mother was still at the hospital. It was the [REDACTED] impression that the father came first in the mother's life and the child came second. The [REDACTED] was concerned about the mother's interaction with the child. The mother was observing the child from outside of the room. The mother had turned down the [REDACTED] offer for a chair so that she could sleep in the room with the child. She told the [REDACTED] that she was scared of the child's blisters and refused to change his diaper. The child was whining as he fell asleep. His current medications were Tylenol and Morphine. The hospital staff would continue to observe the mother's interaction with the child and report back to the agency any of their concerns.

On 10/22/11 the caseworker again called [REDACTED]. She was told that the child had been moved to the [REDACTED]. The hospital had assigned a "sitter" to the mother and the child. The mother was mostly watching what was going on. The hospital considered the mother's behavior bizarre but did not say why they considered her behavior bizarre.

On Monday 10/24/2011 the agency assigned the [REDACTED] for investigation by an intake caseworker. The father called the caseworker that morning upset that a referral had been made to MCCYS. The father stated that he had come back to their home from the hospital to make sure that the apartment would pass a home safety check by the agency. The father was anxious to return to the hospital to be with the mother and the child.

Later the caseworker spoke to the [REDACTED] on the [REDACTED]. This [REDACTED] observation of the mother and child interaction was different than what the [REDACTED] had reported to the agency over the weekend. He reported that the mother had a bond with the child and was interacting with the child. The mother was sleeping in the room with the child. The [REDACTED] stated that he thought that the mother's behavior over the weekend was the result of her being young and trying to cope with the accident. He told the caseworker that he would have to make his own determination of the mother and child bond.

McKean County CYC requested that Allegheny County Children, Youth and Families (ACCYF) do a safety check on the child at [REDACTED]. An Allegheny County CYF caseworker met with the mother and child at Mercy Hospital. The mother's statement to the caseworker was consistent with her prior statements that the child was in a walker and that he ran the walker into the baker's rack causing the coffee pot to spill on him. The child was bandaged and alert. The caseworker took pictures of the child's injuries and told the mother that McKean County CYC would be in contact with her. Allegheny County sent the information to McKean County CYC.

On 10/25/2011 the caseworker made a home visit to the family home. He met with the father and the maternal grandmother. The caseworker noted that the apartment was open and the parents would be able to see the child from their reported locations in the apartment. It was the caseworker's opinion that the coffee pot on the baker's rack was poorly situated. It was fairly easy for coffee to spill from the coffee pot when the child's walker bumped into the baker's rack. The father told the caseworker that he was in [REDACTED] and was not currently working because of spine problems.

The caseworker then drove to Pittsburgh and met with the mother and child at [REDACTED]. The mother stated that on the day of the incident that she was playing with the child and putting laundry away. She was trying to keep him occupied because he was teething. The coffee spilled on the child and he screamed. She was right around the corner putting clothes away. She ran to him and they took his clothes off and the father was holding him in a cold shower while she called 911. The mother stated that when she makes coffee that she puts the coffee maker on the washer so that the child can not get to it.

The mother then described for the caseworker how upsetting the incident was to her. She said that the child was crying and that she knew he was in pain. The hospital couldn't find his veins and attempted to use an instrument on him that looked painful. She said that she lost it. The child was heavily medicated and they used a helicopter to transport him to [REDACTED]. Once at [REDACTED] the mother does not believe that the [REDACTED] were telling her what was going on. The mother stated that she was watching what was going on and now felt comfortable with the child. The mother told the caseworker that it was okay to hold the child when he had his bandages on. The caseworker gave the hospital permission to suspend the sitter. The caseworker completed an In-Home Safety Assessment checklist that determined that the child was safe.

On 10/28/2011 the caseworker spoke to a [REDACTED] who reported that the child was doing well and that his [REDACTED] were in good shape. The child would need to heal some more before he could be stepped down to a [REDACTED]. The hospital would continue to monitor the parent's ability to care for the child. The mother had overcome her nervousness of caring for the child and was comfortable and

able to care for the child. The father was hesitant about caring for the child but he had just returned to the hospital from their home.

On 10/29/2011 [REDACTED] informed the agency that the previous evening when the mother was taking the child out of the high chair he bumped his knees and his wound started to bleed. The bleeding did stop. The mother called the [REDACTED] right away. The hospital again put a sitter in the room at all times.

On 11/1/2011 the caseworker spoke to the father who expressed his frustration with dealing with the [REDACTED] staff. It was his perception that the hospital staffs were not being open and honest with them. They were told that the sitter was in the child's room because the child had such a high level of need. The sitter was watching them and was not assisting in the care of the child. It was never arranged by the hospital staff for the mother to receive a tray at meal times. The [REDACTED] told the father that he would not assist them with the request from the caseworker to sign release of information forms and fax them back to the caseworker. The caseworker told the father not worry about the release of information forms.

On 11/2/2012 the mother and the [REDACTED] from [REDACTED] left messages for the caseworker that the child was now at the [REDACTED]. On 11/3/2011 the caseworker spoke to the mother, she said that things were going well and the child may be [REDACTED] in a week.

On 11/4/2012 the agency determined that the report of suspected child abuse to be unfounded. The agency did not determine that the child was unsupervised. The injury was determined to be an accidental injury as defined in the Child Protective Service Law.

On 11/8/2011 the child was discharged from [REDACTED]. The discharge report included instructions on skin care of the burns. There were no prescription medications for the child at the time [REDACTED]. Referrals were made to [REDACTED]. The parents were instructed to call the [REDACTED] from [REDACTED] if they had any concerns or questions.

On 11/10/2011 the caseworker made a home visit to the family home. The mother, father and the child were present. The caseworker delivered a high chair to the family. The apartment was clean and well ordered. The child was clean and was happy and active. The parents told the caseworker that the child would be receiving [REDACTED]. The parents told the caseworker that their landlord was not working with them to child proof the apartment. The parents again expressed their frustration with their treatment at [REDACTED]. The father reported that when he initially arrived at the hospital that he was separated from the mother

and the child. Whenever he asked where they were he was told by the hospital staff that they did not know where they were. The hospital staff told the father that the child was going to be taken away from him. The mother reported that she spent the first night at the hospital in the child's room and she did hold him. The next day the hospital assigned the sitter to the room. The mother stated that she was told that the sitter was to take care of the child but the sitter just watched her. The caseworker completed the In-Home Safety Assessment work sheet and determined that the child was safe.

1/21/2011 the child had his [REDACTED] in the home. The mother and the child were present. The father was in and out of the apartment during the [REDACTED]. The mother was the primary caregiver to the child and was cooperative with the service. No one was home for the scheduled 11/28/2012 [REDACTED] appointment.

The mother and the child were available for the 12/5/2011 [REDACTED] appointment. During this appointment the mother disclosed that she had had an altercation with the father. She said that she was planning to move out of the apartment later that day and return to her mother's home in New York State. The father returned to the home and smelled of alcohol. He took one of his rifles and said that he was going hunting. The mother attempted to stop him from leaving but he left anyway. The father then returned a second time and took more guns and said that he was going camping. The mother attempted to stop him from leaving again but he left anyway.

While the [REDACTED] appointment was taking place the father called the agency and spoke to the caseworker. He told the caseworker that he was not taking his medication and was drinking. The father did tell the caseworker that he was going to stay with friend.

The caseworker, the police and the [REDACTED] worker went to the home. The maternal grandmother was at the home when they arrived to take the mother and the child back to New York State. The mother reported that the father had called and was threatening her. She disclosed that there was a history of domestic violence between them. The mother's plan was to take the child to her mother's home in New York State. The caseworker obtained the name, address and the phone number of the grandmother. The caseworker completed the In Home Safety Assessment worksheet and determined the child would be safe in his mother's care.

[REDACTED] contacted the child's service coordinator to make arrangements to transfer the provided services to New York State.

**Current Case Status:**

McKean County Children and Youth Services have closed their case. The case was not referred to New York State since there were no concerns of the mother's care of the child.

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

Act 33 of 2008 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. McKean County was not required to convene a review team in accordance with Act 33 of 2008 since the status determination of "Unfounded" was made on 11/4/2011 which was within 30 days of the oral report from ChildLine.

**Department of Public Welfare Findings:****County Strengths:**

- County Responded immediately to the report
- Agency maintained regular ongoing contact with [REDACTED] and other service providers once the child returned home.
- Agency staff worked with the parents especially the father to encourage them to form a working relationship with [REDACTED] to learn the care of the child.
- The agency files contained the records of the medical and service providers.
- The agency completed the In Home Safety Assessment, Risk Assessment, and other required documentation in a timely manner.
- The Agency completed the investigation of suspected abuse within thirty days of receiving the report.

**County Weaknesses:** None

**Statutory and Regulatory Compliance Issues:** None