



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

BORN: 12/16/2011
Near Fatality: 08/25/2012

FAMILY NOT KNOWN TO:
Allegheny County Children, Youth and Families

REPORT FINALIZED ON:
May 23, 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 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

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. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	12/16/2011
[REDACTED]	Mother	[REDACTED] 1994
[REDACTED]	Father	[REDACTED] 1993

Notification of Child (Near) Fatality:

On August 25, 2012, the child received burns [REDACTED] due to mother leaving the child alone in the bath tub while the water was running. It was reported that [REDACTED]. The child experienced [REDACTED]. Some areas of his lower body had [REDACTED]. Mother said she had the child in a small tub inside a regular bathroom tub. Mother reported she has a gadget on the bathtub faucet that regulates the water temperature to ensure that the water does not become too hot. Mother says she left the child in the tub while the water was running into the little tub. The mother reported that she does this all the time. She claimed she kept checking the water and it was fine. Mother explained all of a sudden water came spurting out, and it was very hot.

She called the maternal grandmother who is a pediatric nurse and she told her to take child to the emergency room right away. The child and mother were transported to the hospital by the great grandfather. The attending physician, [REDACTED], noted based on the story and clinical exam she was suspicious of physical harm and non-accidental trauma. [REDACTED] noted that the child was in severe pain, he had blisters on his [REDACTED]. The physician also was concerned about neglect due to the length of time the child was left in the tub [REDACTED] certified child to be in serious condition, child was expected to survive, report numbered for physical abuse.

There were discrepancies in the mother's story, mom was grabbing at the child's [REDACTED] as she was trying to undress him. Mom claimed the child never cried until the hospital put [REDACTED] in him. Referral source stated the child was crying before [REDACTED] was done.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to this family. The regional office also participated in the County Internal Fatality Review Team meeting that occurred on 9/18/12.

Summary of Services to Family:

Crisis in-home services worked with father on [REDACTED]. These services continue to be available to the father even though the family's case is closed.

Mother had been working with Family Focus services through a local provider prior to the incident to assist in increasing her confidence as a parent.

The child was working with a [REDACTED] due to a previous diagnosis of [REDACTED]. The child had an [REDACTED] and has been gaining weight since services began. Child also has [REDACTED] in his body.

Children and Youth Involvement prior to Incident:

No previous CYF referrals had been received on this child. Mother had one referral as a child that was unfounded. Father had no previous CYF history.

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

Allegheny County DHS Office of Children, Youth and Families (CYF) received a [REDACTED] referral from [REDACTED] on August 25, 2012, regarding an eight-month-old male child who sustained first and second degree burns [REDACTED] while his mother was bathing him. The mother and father do not live together and had an informal visitation schedule for father, while child lived with mother, maternal grandparents (MGPs) and maternal aunt (MA) full-time. The mother had a temperature sensing device that she used when preparing the child's bath water. This device was later confiscated by the investigating police department. The Allegheny County CYF caseworker never saw this device. She reported checking this device to ensure the water was not too hot. Mother also reported that the child was in the water for approximately 15 – 25 seconds. The child was initially admitted to [REDACTED] then transferred to [REDACTED].

While the child was hospitalized, father [REDACTED] the child has been in the care of his father with support from the paternal grandparents (PGPs) since September 5, 2012. An arrangement was made that the mother and the maternal grandmother could have visitation with the child if the paternal grandfather supervised the visits.

Mother, age 17 at the time of the incident, was charged [REDACTED] with Aggravated Assault, Simple Assault, Endangering the Welfare of a Child and Recklessly Endangering Another Person. The court hearing is scheduled to be heard on January 17, 2013. Allegheny County CYF completed their investigation into the allegations of alleged abuse. The agency submitted a report to ChildLine stating that the status determination was [REDACTED].

Mother was working with Family Focus services through a local provider prior to the incident to work on communication with her Mother and to establish confidence in her role as a parent. The child was working with a [REDACTED] agency due to a previous diagnosis of [REDACTED]. The child had an [REDACTED] and has been gaining weight since services began. Child also has [REDACTED] in his body.

Following the incident, crisis in-home services worked with father on [REDACTED]. These services closed through CYF, but are still available to father. CYF closed this case on October 24, 2012.

Current Case Status:

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

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. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths: -The Act 33 Review Team identified no statutory or regulatory compliance issue.

Deficiencies: None

Recommendations for Change at the Local Level:

During the review of this case, the Team reviewed information related to scalding injuries for children and the need for public education regarding the appropriate temperatures for water heaters and bathing. This child was burned after a very short time immersed in water, and appropriate temperature controls could assist with preventing burns in infants and young children.

The Team discussed the interface between CYF and [REDACTED] and the need for compliance with shared case management processes. In this case review, there was a lack of communication between the two offices prior to CYF's case closure.

Mother and father have extensive [REDACTED] involvement. The Team recommended review of Mother's [REDACTED] needs by the DHS [REDACTED] [REDACTED] for quality improvement purposes, in order to support the enhancement of mother's outcomes, as mother has had minimal success through a variety of [REDACTED]

Recommendations for Change at the State Level: None

Department Review of County Internal Report:

The county submitted a draft final report; this report was reviewed and accepted.

Department of Public Welfare Findings:

County Strengths: The County responded timely and ensured safety of the child and worked with the family in order to gain safe closure of this case.

County Weaknesses: none

Statutory and Regulatory Areas of Non-Compliance:
None

Department of Public Welfare Recommendations:

There are no concerns with the County on their reporting process or the completion of this investigation.