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REPORT ON THE NEAR FATALITY OF



Born: 05.27.11

DATE of Near-Fatality: 09.21.12

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

This report is confidential under the provisions of the Child Protective Services Law and cannot be released. (23 PA. C.S. § 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.

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. Susquehanna County has convened a review team on 11/16/12 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]	Child/Victim	05.27.2011
[REDACTED]	Sibling of Child/Victim	[REDACTED] 2009
[REDACTED]	Biological mother of Child/Victim	[REDACTED] 1989
[REDACTED]	Biological Father of Child/Victim & Sibling	[REDACTED] 1987

Notification of Near Fatality

Susquehanna County Children and Youth Services received a [REDACTED] on 09.21.12 following the emergency medical treatment that the Child/Victim received for burns [REDACTED] to medical staff treating Child/Victim was not consistent with severity and nature of the injuries. As [REDACTED] was the primary caretaker at the time of the incident she [REDACTED]

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families completed a preliminary review of the incident involving Child Victim on 9/24/12 by means of consultation with the assigned case worker and supervisory personnel at Susquehanna County Children and Youth Services. Preliminary case file notes, progress reports and medical documentation secured from the county children and youth office on this date were reviewed.

A follow-up consultation by Northeast Regional Office staff was conducted on 9/28/12. All medical documentation and case file notes from the attending physician at the medical facility were reviewed. Susquehanna County Children and Youth Services collaborative involvement with the [REDACTED] was also reviewed. The current status of agency's safety assessment relating to Child Victim and [REDACTED] was reviewed. The county

agency is [REDACTED] to both children with a provision that the [REDACTED] have no access to either [REDACTED] sibling of Child Victim.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

Susquehanna County Children and Youth Services has no record of service activity to this family. The family resided in Colorado until recently when [REDACTED], Child/Victim and Sibling of Child/Victim relocated to the Susquehanna County area, while the biological father of Child/Victim and Sibling of Child/Victim maintained employment in the [REDACTED]. Biological father would return to the Susquehanna County area when employment commitments allowed. At the time of the incident the biological father was in Colorado.

Circumstances of child's near fatality and related case activity:

Susquehanna County Children and Youth Services commenced an investigation relating to the near fatality of the 15 month old Child Victim when child was treated at a [REDACTED]. The case was assigned a [REDACTED] on 9/21/12 due to the lack of plausibility of the information [REDACTED] relating to the etiology of the injuries. The Child Victim's medical condition required specialized treatment [REDACTED] which necessitated a transfer of the Child Victim from the medical facility in [REDACTED].

The Northeast Regional Office of Children, Youth and Families commenced a review of the circumstances of the near fatality on 9/24/12 and reviewed all case work documentation and all available medical data. By means of a follow up site record review on 9/28/12 and 10/17/12, there was documentary evidence contained in the case file that supported that the agency commenced the investigation as per the response time contained in the CPSL. The agency also followed established Department of Public Welfare protocols in the timely effectuating of all required safety assessments and risk assessment matrices. Case file notations included documentation of collaborative investigative efforts between Susquehanna County Children and Youth Services and the Pennsylvania State Police.

The family case file contained supporting documentation of consultation [REDACTED] with caring for the Child Victim. Copies of all relevant medical reports were also contained in the case file.

Case file documentation included consistent contact [REDACTED] of Child Victim and the [REDACTED] and custodian.

Susquehanna County Children and Youth Services completed all [REDACTED] notifications as prescribed by Section 6303 of the Child Protective Services Law. These notifications were completed in a timely fashion.

The county agency completed the formal child abuse investigation within the prescribed temporal parameters of the Child Protective Service Law, Safety Assessment Bulletin and the

“Best Practice” standards governing the public child welfare agency.

Current/most recent status of case:

Susquehanna County Children and Youth Services has completed its investigation of the incident involving Child Victim securing significant burns [REDACTED] and determined that the biological mother of Child Victim was negligent in caring for child. The county agency assigned an Indicated status [REDACTED] to this incident naming [REDACTED] as the perpetrator.

Subsequent to the commencement of the CPS investigation, the biological mother of the Child Victim absented herself from contact with both Child Victim and sibling of Child Victim. The biological mother relocated with a friend to an undisclosed location and only provided minimal information relating to her circumstances to both the investigating agency as well as the biological father of the Child Victim. As of this writing, the biological mother has not resurfaced or maintained any contact with family in Susquehanna County.

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

County Strengths:

The county child welfare agency completed an internal review of this case on 12/28/12. The agency panel included members of the law enforcement community, supervisory and administrative staff from the C & Y agency as well as participants from local social service providers. The agency's strength in this case centers on the comprehensive and timely attention to commencing the investigation of a serious allegation of physical abuse while at the same time completing a comprehensive strengths based assessment of the biological family and putting into place a safety plan that assures safety as well as continuity of contact between the non-offending parent, sibling of Child Victim and Child Victim.

County Weaknesses:

Susquehanna County Children and Youth Services completed a timely and comprehensive assessment of this case. The Northeast Regional Office of Children Youth and Families determined that the agency followed established “Best Practice” and sound investigative procedures. The agency complied with all DPW regulations. The only issue that could be enhanced in this case is that the agency did not credit a number of the internal agency case consultations through documentation within the actual case file. During the site record review conducted by the Northeast Regional Office staff on 9/28/12, it was evident that the information secured during interviews with case work and supervisory staff was comprehensive in nature. The agency was duly diligent in meeting the protocols established for CPS investigations. However, they did not include all of the information in a written format.

It is recommended that Susquehanna County Children and Youth Services develop a more formalized mechanism to review near fatality/fatalities within the county. While the agency has been fortunate in not having the need to conduct such reviews with any great frequency, it would

benefit Susquehanna County Children and Youth Services to "impanel" a group of professionals that could be available on an emergency basis.

County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:

There were no recommendations which emanated from the county near fatality report that would modify agency practice or protocol.

Susquehanna County Children and Youth Services should develop a more systematic approach to documenting the outcomes and analysis that are set forth in internal agency reviews. This is especially recommended when Act 33 Fatality Review Meetings are conducted.

Department of Public Welfare Findings:

County Strengths:

Susquehanna County Children and Youth Services conducted an investigation that was timely and comprehensive in nature. The agency conducted the child abuse investigation conjointly with the law enforcement agency. The level of collaboration was positive and reflected an attention to the statutory needs of both entities. The agency also secured all the necessary medical data surrounding the investigation of the incident from the medical facility and utilized the expertise of the medical practitioner in arriving at a decision relating to the status determination.

County Weaknesses:

The county agency completed the investigation and subsequent arranging of services to the family in a proficient manner. The only area that the agency could enhance in regards to this case relates to recommendations referred to in the county near death summary report. Susquehanna County Children and Youth Services completed the Act 33 Review on 11/16/12 as required. However, the written documentation that was developed following the formal review lacked a comprehensive rendering of the case scenario and formal review process.

Statutory and Regulatory Compliance Issues:

Susquehanna County Children and Youth Services evidenced full compliance with the Department of Public Welfare regulations associated with the initiation and timely completion of a child abuse investigation pursuant to Section 6303 of the Child Protective Services Law.

The Northeast Regional Office of Children, Youth and Families determined that there were no statutory or regulatory areas of non-compliance.