



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF

[REDACTED]

Date of Birth: 08/25/2003

DATE of NEAR FATALITY: 12/12/12

Date of Oral Report: 12/13/2012

FAMILY KNOWN TO:

York County Children, Youth and Family Services

Report Finalized on:
10/15/13

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 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. York 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	08/25/2003
[REDACTED]	Guardian's child	[REDACTED] 2005
[REDACTED]	Half Sibling	[REDACTED] 2001
[REDACTED]	Guardian's child	[REDACTED] 2008
[REDACTED]	Mother-Non HHM	[REDACTED] 1983
[REDACTED]	Father-Non HHM	[REDACTED] 1983
[REDACTED]	HHM/Uncle	[REDACTED] 1972
[REDACTED]	Guardian	[REDACTED] 1989
[REDACTED]	Grandmother-Non HHM	[REDACTED] 1960

Notification of Child Near Fatality

On December 13, 2012, York County Children, Youth, and Family Services received a referral/notification of a child near fatality, alleging the identified child's condition was a result of suspected child abuse by his father.

The Legal guardian, who works the night shift, brought the child to the Memorial Hospital emergency room around 11:10 am on December 13, 2012 when she was able to secure a ride to the hospital. It is not known why she did not call an ambulance at the time. Injuries include [REDACTED]

[REDACTED]. Also [REDACTED] then contacted the police.

[REDACTED] certified that the child was in serious condition as a result of suspected child abuse. Child was then transferred to the Lehigh Valley Hospital [REDACTED]

Summary of DPW Child Near Fatality Review Activities:

For this review Central Region interviewed:

[REDACTED], CPS Supervisor at York County Children & Youth Services and [REDACTED], CPS caseworker at York County Children & Youth Services

Central Region also reviewed:

- Child Death Data Tool
- Police Report
- Case file
- Medical record

A near fatality review team meeting was held on January 4, 2013 in conjunction with the Act 33 requirements. The Central Region Program Representative assigned to York County Children, Youth and Family services attended the meeting.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

The family was referred to the agency earlier this past year on October 22, 2012 for [REDACTED] was listed as the alleged perpetrator (AP) with [REDACTED] missing 7 unlawful days of school. It was discovered later that the children were on home bound instruction during the dates that were reported to the agency. No services were offered to the family as [REDACTED] was not cooperative and refused the caseworker access to the children. The case was screened out on December 13, 2012 as decided by the Casework Supervisor and Manager.

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

At the time of the incident the children and the mother were living in the home of mother's ex-paramour, the legal guardian. Mother had recently moved out of the ex-paramour's home and into the home of a friend. The children remained with the ex-paramour, who the mother gave legal guardianship to.

On December 13, 2012 between 7-8pm the child's father [REDACTED] was visiting the legal guardian's home [REDACTED]. The father was called earlier by the mother about the child's behavior at school that day. He began punishing the child for his behavior at school. [REDACTED] beat the child and then put him in the bathtub with hot water and turned the hot water back on.

[REDACTED] came out of the bathroom and went downstairs telling the uncle/caretaker that he had just burnt his baby. When [REDACTED] encountered the child he put Vaseline on the [REDACTED] and indicated that the child had ceased crying and the child stated he was alright, so the uncle sent the child to bed. It is believed the child had stopped crying as a result of the [REDACTED], was caring for the other three children in the home, ages 4, 7 and 11 and did not know what else to do so he called the guardian and the child's biological mother. Allegedly the [REDACTED] had refused to take the child to the emergency room. The legal guardian, [REDACTED] had gone to work during the beating of the child and was not in the home during the burning. The legal guardian brought the child to the Memorial Hospital ER around 11:10 am on December 13, 2012 when she was able to secure a ride to the hospital. It is not known why she did not call an ambulance. [REDACTED] then contacted the police.

As a result of the incident, the child sustained injuries [REDACTED] burns to the [REDACTED] and to his [REDACTED]. Child also sustained burns to the [REDACTED].

There was a [REDACTED] from the hot water. It is estimated by the investigating officer that the water temperature had to be between 140-150 degrees as the child [REDACTED] certified that the child was in serious condition as a result of suspected child abuse. Child was then transferred to the Lehigh Valley Hospital [REDACTED].

Current/most recent status of case:

On 12/13/12 a safety plan was put into place stating that the identified child and sibling will have no contact with the child's identified father and the children will have supervised contact with the [REDACTED]. The plan was signed by the uncle and the legal guardian. Then on 12/14/12 a new safety plan was signed by the mother stating that she would ensure that there is no contact between the child and his father. Mother no longer needed to have supervised contact with the child. She was not involved in the abuse. On 12/20/12 an additional safety plan was developed with grandmother and the guardian to address the well being issues for the identified child, [REDACTED].

[REDACTED] was [REDACTED] on December 24, 2012 and remains in the legal guardian's home. Mother currently resides with a new paramour and visits the children regularly. [REDACTED] biological mother's brother, resides in the legal guardian's home. He is unemployed and is utilized as the children's caretaker while the legal guardian works at the nearby [REDACTED]. [REDACTED] has an outstanding bench warrant and is reluctant to turn herself into the police. [REDACTED], the children's maternal grandmother helps with the care of [REDACTED] and the children. She is [REDACTED] and resides with various friends. A [REDACTED] for [REDACTED] was scheduled for January 9, 2013 at the [REDACTED]. The child identified his father as the perpetrator of the abuse.

[REDACTED] is incarcerated in the [REDACTED] State Prison with no contact with any of the children. He was indicated by York County Children Youth and Family Services on 2/8/2013 as a perpetrator of physical abuse. The injuries caused the child severe pain and impairment of functioning as defined in the Child Protective Services Law. The father admitted to the abuse of the child.

Services provided to the family include:

- The family is [REDACTED] with York County Children Youth and Family Services and is receiving services from [REDACTED]. [REDACTED] has a [REDACTED].
- The victim child received [REDACTED] until January 2, 2013. He now receives services from the [REDACTED].
- York County Children Youth and Family services [REDACTED].
- The children receive [REDACTED] from the [REDACTED].
- The Guardian, [REDACTED] attends [REDACTED] for [REDACTED] and [REDACTED].
- Biological mother has accessed services from the [REDACTED], and

she receives [REDACTED]

County strengths and deficiencies as identified by the County's (near) fatality report:

County Strengths: County strengths include the agency's collaboration with the law enforcement officials, the safety planning completed by the agency and the agency's ability to find a kinship care provider for the child during and after the investigation.

County Weaknesses: No deficiencies were noted.

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

- 1) To reduce the likelihood of future fatalities/near fatalities, Children Youth and Family services will request that the investigating law enforcement check the temperature of the water in the home to ensure that this is not a risk factor for future injury to the subject child or any other child residing in that home.

Department of Public Welfare Findings:

County Strengths: The investigation completed by York County Children, Youth and Family Services was conducted in a timely fashion and in collaboration with the York City Police Department. The agency provided necessary services to all family members and was able to keep the child safe during the investigation.

Safety assessment and planning were completed thoroughly. The safety plans were timely, inclusive of family and care providers input and signatures. Referrals for services were completed and necessary services were coordinated.

County Weaknesses: No deficiencies were noted.

Statutory and Regulatory Compliance Issues:

York County Children, Youth and Family Services conducted a thorough and timely investigation in conjunction with the law enforcement officials. Safety assessments were completed and the victim child was able to be placed with kinship care providers during the investigation. Referrals for services were completed and necessary services were coordinated for the family. No compliance issues were noted.