



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: August 25, 2008
Date of Incident: March 22, 2013
Date of Oral Report: March 23, 2013

FAMILY KNOWN to:

Erie County Children and Youth Services

REPORT FINALIZED ON:

2/24/2014

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. Erie County Children and Youth Services (CYS) has not convened a review team in accordance with Act 33 of 2008 due to the report being unfounded within 30 days.

Family Constellation:Name:Relationship:Date of Birth:

██████████	Victim child	August 25, 2008
██████████	Mother	██████████, 1982
██████████	Sibling	██████████ 2005
██████████	Sibling	██████████ 2013
██████████	Father	██████████ 1974
* ██████████	Father	██████████ 1980
██████████	Household Member	██████████ 1981

*Notes that this individual resides in another residence

Notification of Child (Near) Fatality:

On March 23, 2013, Erie County Children and Youth received a ██████████ report stating that on March 22, 2013, the child's mother was cooking soup at approximately 9:00 pm. A pot of water was boiling on the stove and the child pulled the water off of the stove and onto herself resulting in 40% of her body being burned.

It was reported that the mother told the University of Pittsburgh Medical Center Hamot Hospital ██████████ that she was doing other things around the house when the incident occurred. The child was transferred to the Mercy Hospital's ██████████ in Pittsburgh, Pennsylvania. It was also reported that the child's parents have a history of drug use. The report was registered for lack of supervision, listing the child's mother as the alleged perpetrator. The report

initially named the child's biological father as a perpetrator by omission. It was discovered that the child's biological father was residing in Florida when the incident occurred.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families received the initial notification of the near fatality on March 26, 2013. The Program Representative made a visit to the Erie County CYS office on April 11, 2013 and spoke with supervisor [REDACTED] regarding the incident, and reviewed the case file pertaining to both this incident and the ongoing case record. There was no Multi-Disciplinary Team review of this incident as the ChildLine report was unfounded within 30 days of the incident.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

On August 19, 2010, Erie County CYS had received a referral alleging that both parents were using drugs. The parents submitted to random drug testing and the case was closed on January 7, 2011.

On April 12, 2011, Erie County CYS received another referral that the parents were using drugs in the presence of their children. In addition, one of the household members had attempted suicide in front of children. The case was opened for services on June 8, 2011. The parents were asked to obtain stable housing, remain drug and alcohol free and to [REDACTED]. The mother [REDACTED]. The case was still active at the time of the near fatality report. At the time of the incident, the family was not receiving any outside services other than CYS case management services. The mother was supposed to, but did not submit to random urine screens to ensure she was not using illegal drugs.

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

On March 22, 2013, around 9:00 pm the victim child was in the kitchen with her mother making chicken soup. A pot of boiling water was on the stove, when the mother added vegetables to the soup. The victim child stepped on top of a popcorn tin on the side of the stove, and attempted to stir the vegetables in the soup when the popcorn tin slipped causing her to fall. The victim child grabbed a hold of the pot of boiling soup resulting in the hot water pouring over her face,

arms, chest and upper abdomen. Both the victim child and the mother gave the same account of events.

The mother's friend, [REDACTED] and the victim child's sister were in the living room when the victim child fell. The mother immediately began to spray water on the victim child, as her skin began to turn red immediately and peel off.

The mother and her friend drove the victim child to UPMC Hamot Hospital Emergency Room. The emergency room physicians made the determination that the victim child needed to be life-flighted to Mercy Hospital's [REDACTED] in Pittsburgh, Pennsylvania for emergency treatment. The victim child [REDACTED]

The victim child [REDACTED] on March 27, 2013 and April 2, 2013. Her biological father resided in Florida at the time of the incident, but immediately flew to Pittsburgh to be by his daughter's bedside. The victim child remained at Mercy Hospital until April 23, 2013 when she [REDACTED] and placed in the care of her paternal aunt, [REDACTED] due to the child's mother giving birth to son on April 22, 2013, and due to the father's work schedule in Erie, Pennsylvania.

On April 8, 2013, Erie County CYS completed an unfounded CY-48 based on all of the information gathered during the investigation which stated that the injuries endured by the victim child even though serious in nature were the result of an accident.

Current Case Status:

The family remains open with Erie County CYS. The victim child has had follow up [REDACTED] appointments at [REDACTED] in Pittsburgh, Pennsylvania. Those appointments were held on April 23, 2013, April 30, 2013, May 24, 2013 and on June 24, 2013. The victim child is healing [REDACTED]

The mother has been on [REDACTED] through [REDACTED] with her children. There are no charges pending with this family as the incident was determined to be an accident.

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

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. Erie County CYs has not convened a review team in accordance with Act 33 of 2008 related to this report due to the report being unfounded within 30 days.

- Strengths:

A county report was not required due to the report being unfounded within 30 days of the report being received.

- Deficiencies:

A county report was not required due to the report being unfounded within 30 days of the report being received.

- Recommendations for Change at the Local Level:

A county report was not required due to the report being unfounded within 30 days of the report being received.

- Recommendations for Change at the State Level:

A county report was not required due to the report being unfounded within 30 days of the report being received.

Department Review of County Internal Report:

A county report was not required due to the report being unfounded within 30 days of the report being received.

Department of Public Welfare Findings:

- County Strengths:

The county promptly responded to the [REDACTED] report, and completed the investigation within 30 days of receiving the report.

- County Weaknesses:

County had an open case with the family since June 8, 2011, but up to this point had no real follow up with mother on her drug and alcohol issues.

- Statutory and Regulatory Areas of Non-Compliance:

None were noted.

Department of Public Welfare Recommendations:

The Department suggests that the county be more vigilant when providing ongoing services to a parent with drug and alcohol issues while that parent is responsible for caring for young children. The agency did not follow up in ensuring that the mother was [REDACTED] for her drug and alcohol issues. The family has been open since June 8, 2011, and the mother has not followed up on [REDACTED] recommendations. However, since this incident the agency and the mother have established clear and defined drug and alcohol goals for the mother to achieve on her Family Service Plan.