



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 01/28/2013
Date of Incident: 04/22/2015
Date of Oral Report: 04/23/2015

FAMILY NOT KNOWN TO:

Cumberland County Children & Youth Services

REPORT FINALIZED ON:
09/01/2015

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(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, DHS 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 Child Line 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 Child Line. Cumberland County convened a review team in accordance with Act 33 of 2008 related to this report on May 20, 2015.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	01/28/2013
[REDACTED]	Sibling	[REDACTED] 2015
[REDACTED]	Mother	[REDACTED] 1978
[REDACTED]	Father	[REDACTED] 1976
[REDACTED]	*Babysitter	[REDACTED] 1986
[REDACTED]	Paternal Grandfather	Unknown

*Non HHM

Notification of Child Near Fatality:

The initial incident occurred on 04/22/15 with initial report dated 04/23/15. Child was [REDACTED] to parents on 04/27/15. The case was upgraded to near fatality on 4/28/15.

The incident happened on 04/23/15. Child was being babysat by the alleged perpetrator who lives across the street from the family. The mother allegedly heard the child screaming from across the street. Mother went over and child's hands were burned. The babysitter said that hot water accidentally spilled on child. The babysitter had changed child's clothing and put a long sleeved shirt on the child by the time mother got there. Mother and Father took child to Harrisburg Hospital and then he was transferred to Lehigh Valley Cedar Crest [REDACTED].

The child had significant [REDACTED] on the [REDACTED] [REDACTED] (a total of 4% of child's skin was [REDACTED]). By the time child arrived at Lehigh Valley, multiple bruises and [REDACTED] were observed on the child's upper body as well. Reporting source stated that there is a concern for high velocity slaps or strangulation based on the pattern of the [REDACTED] bruising. [REDACTED]

[REDACTED]

Summary of DHS Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, and the Supervisor on April 29th, May 10th and May 20, 2015. The Regional office also participated in the County Internal Fatality Review Team meetings on May 20, 2015.

Children and Youth Involvement prior to Incident:

The family was not known to Cumberland County Children & Youth Services prior to the incident on April 22, 2015.

Circumstances of Child Near Fatality and Related Case Activity:

The initial incident occurred on 04/22/15 with initial report dated 04/23/15. Child was [REDACTED] to parents on 04/27/15. Case was upgraded to Near Fatality on 04/28/15.

The incident happened on 04/23/15. Child was being babysat by the alleged perpetrator, who lives across the street from the family. The mother allegedly heard the child screaming from across the street. Mother went over and child's hands were burned. The babysitter said that hot water accidentally spilled on child. Mother and Father took child to Harrisburg Hospital and then he was transferred to Lehigh Valley Cedar Crest [REDACTED]

The child has burns on both hands - the parents said that the "child spilled water on himself at the babysitter's house." This would have happened on 04/22/15. The child also has bruises on right outer thigh, one on right outer arm, two on left outer arm, left front shoulder and thin red line across anterior neck. The parents had no explanation - just that they noticed the bruising after the child was at the babysitter's home. There were partial [REDACTED] and [REDACTED]. The babysitter was interviewed by both CYS and the police. She reported that the child pulled hot water down on himself; however, she was not consistent with her story. The babysitter was indicated for abuse.

Cumberland County CYS closed the case with the parents because the parents were meeting the children's needs. The abuse was indicated against the babysitter on June 19, 2015. The perpetrator's family was opened for services. [REDACTED] of the [REDACTED] Police is involved in the investigation. No criminal charges have been filed as of yet.

Current Case Status:

The child had to have [REDACTED] between 04/24/15-04/26/15. The child was [REDACTED] in the parent's care on 04/27/15. The child will have follow-up appointments for the [REDACTED] and reporting source believes child will need separate follow-up appointments to assess the impact of the [REDACTED].

As of July 14, 2015, the child is doing well. Cumberland County CYS closed the case with the parents because the parents were meeting the children's needs. The child is getting no additional services at this time. It is expected that his injuries will heal in a year. The child expresses some anxiety with getting into baths. Children and Youth made a referral to [REDACTED] for the child.

The abuse was indicated against the babysitter on June 19, 2015. The perpetrator's family was opened for services. [REDACTED] of the [REDACTED] Police is involved in the investigation. No criminal charges have been filed as of yet.

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

- Strengths: None were identified
- Deficiencies: None were Identified

Recommendations for Change at the Local Level:

There were no recommendations for change at the local level identified by the Near Fatality report

Recommendations for Change at the State Level:

There were no recommendations for change at the state level identified by the Near Fatality report.

Department Review of County Internal Report:

County report was received and accepted on June 11, 2015. Verbal feedback was provided to the county on June 11, 2015 regarding their report and the regional office explained to the county that the report was fine. Safety plans were developed for the victim child's family as well as for the babysitter and her family. The report did not contain any county recommendations.

Department of Human Services Findings:

County Strengths:

The investigation completed by Cumberland County Children, Youth and Families was conducted in a timely fashion and in collaboration with the [REDACTED] Police Department. The agency provided necessary services to all family members and was able to keep both children safe during the investigation.

Safety assessment and planning was 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: None identified at this time
- Statutory and Regulatory Areas of Non-Compliance: None identified

Department of Human Services Recommendations:

Cumberland County Children, Youth and Family Services conducted a timely investigation in conjunction with the law enforcement officials. The agency provided necessary services to all family members and was able to keep both children safe during the investigation. These practices should continue within the County. It is also recommended that the County determine their strengths and deficiencies during the Act 33 Meeting and include it in their county report to the regional office.