



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: February 9, 2011
DATE of NEAR FATALITY: November 9, 2011

FAMILY KNOWN TO:

This family was not known to the county agency.

REPORT DATED:
April 2, 2012

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 reviews 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. Luzerne 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]	Child	2/09/2011
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1988
[REDACTED]	Paternal Grandmother	[REDACTED] 1974
[REDACTED]	Paternal Grandfather	[REDACTED] 1958

Notification of Fatality/Near Fatality

On November 9, 2011, Luzerne County Children and Youth received a call from [REDACTED] concerning the victim child. The information that the agency received reported that the 9-month-old child was brought to the [REDACTED] Hospital [REDACTED]. The child was certified to be in critical condition [REDACTED]. The child was life-flighted to [REDACTED] Hospital burn center.

Summary of DPW Child (Near) Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families obtained and reviewed the current case record pertaining to this incident. The family was not known to the county child welfare agency prior to this incident. Information was also obtained from the [REDACTED] Supervisor and the ongoing casework supervisor.

Summary of Services to the Family

Children and Youth involvement prior to Incident:

There was no prior involvement with this family.

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

The case was [REDACTED] as a near fatality on November 9, 2011 by a physician at [REDACTED] Hospital. The child was then life-flighted to the [REDACTED] Hospital burn center. Luzerne County CYS requested that Lehigh County CYS conduct a courtesy assessment of the child and family since the child was at [REDACTED] Hospital in [REDACTED]. Luzerne County CYS implemented a safety plan in cooperation with the parents and the paternal grandparents temporarily requiring the paternal grandparents to supervise all contact between the children and their parents. The victim child remained in the hospital and his sibling went to stay with the paternal grandparents. Lehigh County CYS saw the child at the hospital and took pictures. Luzerne County CYS went to the child's home and interviewed the parents.

The parents reported the following to the caseworker. The mother was at home with the children at the time of the incident. The father was at work. The mother reported that she picked the children up from the daycare after work and arrived home around 2:35AM. She gave the children a bath, fed them, watched T.V., played with them and fell asleep with them on a twin size bed. She left the room around 4AM. Mother then showered, went to her room, watched T.V. and then went back to the children's room and turned the heat to high. She then went back to her room and fell asleep sometime around 6AM. She slept until around 7AM when she heard the victim child crying. She found him stuck between the bed and the wall with the sibling child still sleeping. He was crying when she pulled him up.

When the father arrived home around 8AM, he heard the child crying. The mother was holding the child and the child was wrapped loosely in gauze and was wearing only a diaper. There was gauze on the child's leg, arm and back. Mother told father that she found the child stuck on top of the baseboard heater in between the bed and the wall. Father asked why an ambulance had not been called and mother responded that she made a mistake and children and youth would take the children away. The parents called family members to ask them what they should do. Mother put ointment on the child and changed his bandages. Father reported that he thought the burns looked better and the child was playing and laughing. Father was looking up burns on the internet and trying to figure out what to do, how to treat it and if they should take the child to the hospital. Father called the paternal grandfather and he came right over. Paternal grandfather took the bandages off and told the parents that the burns were too serious and that the child had to go the hospital regardless of the outcome because he needs medical attention. Paternal grandfather took the mother and child to the emergency room around 2:30PM.

The Detective tested the electric heater in the home which registered at 270 degrees. The detective stated that the mother's explanation for the injuries seemed plausible and consistent with the injuries. [REDACTED] Hospital concurred with the detective that the child's injuries were consistent with the mother's explanation [REDACTED].

On December 9, 2012, at the [REDACTED], the mother was [REDACTED] resulting in the child being severely burned. The [REDACTED] was based on the mother placing the 9 month old child unsupervised in an unsafe sleeping arrangement (twin bed) for an extended period of time causing the child to suffer severe burns.

Shortly after the [REDACTED], the parents were involved in a domestic dispute. As a result, the father was arrested and was incarcerated. The safety plan for the children remained the same with the children residing with the paternal grandparents and all contact between the children and their parents was to be supervised by the paternal grandparents. All parties were in agreement to this plan. The mother resided temporarily with the paternal grandparents; however, after a disagreement, mother left the home and went to reside with family members in New York. The father was residing with a cousin at this time. On January 10, 2012, the agency sought [REDACTED] of the children for continued placement in the paternal grandparent's home. A [REDACTED] was held on January 12, 2012. The parents agreed to the [REDACTED] and placement of the children with the paternal grandparents. They also agreed to the services to be provided by the county agency. [REDACTED] services included parenting education, [REDACTED], obtain and maintain safe and stable housing and allow the caseworker access to the home both announced and unannounced.

Current/most recent status of case:

The case has remained open for services since the incident. The children remain in the care of their paternal grandparents. The parents have obtained their own apartment, are both working full-time and are participating in reunification services including [REDACTED] and an in-home parenting reunification program. The visits are at the paternal grandparent's home and are supervised by the paternal grandparents.

The victim child was last seen at the burn center in April for a follow-up. He must still wear the special clothing for the next 10 months. His next follow-up appointment will occur in June.

The safety plan remains in effect that requires that the paternal grandparents supervise all contact between the parents and the children. The agency is intending to revise the safety plan soon to allow for some unsupervised contact.

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

County Strengths:

An Act 33 meeting was held by the county; however, the written report has not yet been provided to the regional office.

County Weaknesses:

An Act 33 meeting was held by the county, however, the written report has not yet been provided to the regional office.

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

An Act 33 meeting was held by the county; however, the written report has not yet been provided to the regional office.

Department of Public Welfare Findings:

County Strengths:

The paternal grandparents were identified as a relative resource and the children have remained with them since their initial placement. Visitation has been flexible and in a natural environment (the grandparent's home).

County Weaknesses:

Although the county agency has begun to review cases as required by Act 33, the meetings have not been held within the established time frames and written reports are not provided timely to the regional office.

Statutory and Regulatory Compliance Issues:

Although the county agency has begun to review cases as required by Act 33, the meetings have not been held within the established time frames and written reports are not provided timely to the regional office.