COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF

[redacted]

BORN: 01/11/2011
DATE OF NEAR FATALITY: 04/11/2012

FAMILY NOT KNOWN TO:
Union County Children and Youth Services

Date of Oral Report: April 11, 2012
Date of Report: August 24, 2012

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. Union County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	01/01/2011
[redacted]	Mother	[redacted]1992
[redacted]	Mother's Paramour	[redacted]1988
[redacted]	Paramour's Child	[redacted]2007
[redacted]	Victim Child's Father	[redacted]1990

Notification of Near Fatality

On April 11, 2012, Union County Children and Youth Services (CYS) received a call from [redacted] regarding the 15-month-old Victim Child. According to the [redacted], the child had [redacted] on a large percentage of her body and was considered to be in serious condition as a result of alleged abuse or neglect. This report was relayed to [redacted] where it was [redacted] as a Near Fatality.

Summary of DPW Near Fatality Review Activities:

Complete Union County Children and Youth Services (UCCYS) case record of child abuse investigation.
Child medical records from Evangelical Community Hospital
Child medical records from Lehigh Valley Hospital
Union County Child Near Fatality/Act 33 Report
Interviews with Director, CPS Supervisor, and CPS Investigator

Summary of Services to the Family

Children and Youth Involvement Prior to Incident:
The family was not known to Union County Children and Youth Services.

Circumstances of child's near fatality and related case activity:
On April 11, 2012, Union County CYS received a call from [redacted] in Lewisburg regarding the Victim Child. According to the [redacted], the child had [redacted] on a large percentage of her body and was considered to be in serious condition.

The mother's paramour, the [redacted], was caring for the child while her mother was at work. At 2:00 pm the [redacted] intended to give the child a bath. He placed the child in the bathtub and

started to run the water. The [redacted] reports that the water temperature can vary due to the water heater being run by oil. (A police investigation later revealed that the water could reach the temperature of 130 degrees which could cause second degree burns.) He was not aware how hot the water was until the child started crying. He removed the child from the water and applied cool compresses and lotion to her back. The child cried for about an hour. The [redacted] texted the mother at work to "CALL ME" but she did not receive the message because she was not allowed to have her phone. The [redacted] did not have the mother's work number. The mother did not learn of the incident until she was on her way home from work. She reported that the child was sitting on the floor eating goldfish crackers when she got home and was not crying. At that point her skin looked red. The mother contacted the child's primary care physician who directed them to take the child to the emergency room. At 5:30pm, the child was taken to Evangelical Hospital, and was then [redacted] to the Lehigh Valley Hospital [redacted].

Union County CYS contacted Lehigh County Children and Youth Services (CYS) and requested that they see the child. On 04/12/12, the Lehigh County worker went to the hospital but was unable to see the child because she was in the [redacted]. The worker made contact with the child the next day and was able to take pictures. A safety plan was developed with the mother and the [redacted], that the [redacted] would have no unsupervised access to the child. All contact information was forwarded to Union County CYS.

The treating physician indicated that the child had [redacted]. The doctor stated that this could have been caused [redacted]. The doctor also stated that he did not think the delay in medical care caused any additional distress to the child, and that the actions taken by the [redacted] (lotion) probably helped to sooth the child's [redacted]. The [redacted] were not life threatening according to the physician. With proper care and dressing, the [redacted] would blister and heal.

The child was originally in the [redacted] but was then [redacted], and was [redacted] on 04/17/12 to her mother. The mother and child went to stay with the mother's father and half-brother in Danville, Montour County during the investigation. When the mother was interviewed by Buffalo Valley Regional Police and Union County CYS, [redacted] a prior incident between the victim child and the [redacted]. In February 2012, the [redacted] was in a caretaking role with the child and caused injuries to her by biting her foot. He reports that he did this when the victim child head-butted him while he was changing her diaper. [redacted] that the child did not seem to like the [redacted]. This incident was then called into [redacted] and was assigned [redacted] for investigation.

[redacted] remains with her Father and Brother in Danville, Montour County. A referral has been made to Montour County CYS to provide an assessment. [redacted] has indicated that she may return to live with [redacted] when the criminal investigation has been completed, as she is pregnant with his child. Union County CYS has indicated that [redacted] would be opened for In-Home supportive services should she return to Lewisburg.

A police investigation is ongoing for the physical incident which occurred in February 2012. This is the incident involving the [redacted] and the incident where he bit the Victim Child's foot. No charges have been filed.

UCCYS conducted a Child Protective Services (CPS) investigation with the [redacted] named as the [redacted]. The investigation was concluded on May 25, 2012 with a status of Unfounded for medical neglect (resulting in a physical condition) and physical abuse as defined by the Child Protective Services Law for the [redacted]. The Union County case was closed as the Mother and Child no longer resided in the County. Montour County Children and Youth Services was made aware of the situation at the Act 33 meeting and will follow up with referrals on the family as needed.

The District Attorney contacted Union County CYS after the agency had concluded their case to inform the agency that he believed that the [redacted] intentionally burnt the child, and they would be filing charges. Charges have not been filed as of August 24, 2012.

Current/most recent status of case:
The Mother and the Victim Child remain with her father in Montour County. The Mother is pregnant with the child of her Paramour and remains in contact with him. The Mother has contacted the Union County worker to check in. She has indicated that she will probably move back with her paramour when their child is born. There is a current court order due to a complaint filed by the Father of the Victim Child that prohibits the Child from living with the Paramour. This would need to be addressed prior to the Mother returning to Union County.

The second [redacted] investigation against [redacted] was Unfounded by the agency. Due to no physical evidence, and no way to assess the pain or impairment of the child, the agency could not determine that [redacted] abused the Victim Child. [redacted] did admit to biting the child's foot, and it is possible that criminal charges may still be filed. Union County is aware of the support that will be needed if the Mother would return to live with [redacted], and will be in the home to assure that all needs are addressed.

Services to children and family:
Evangelical Community Hospital – Medical Services
Lehigh Valley Hospital – Medical Services
Union County Children and Youth Services – Child Protective Services
[redacted] – Childcare Services

County strengths and deficiencies as identified by the County's fatality report:
A Fatality/Near Fatality Multidisciplinary Team Act 33 meeting was held on May 2, 2012 at Union County Children and Youth Services. The Team was comprised of CYS Workers, the CASSP Coordinator, a representative from the faith-based community, school personnel, and other child welfare stakeholders. The worker from Lehigh County and a physician from the Lehigh Valley Hospital participated by phone. The team felt that the agency's response to this case was appropriate and thorough. The physician did discuss that he was not in agreement with the child being classified as a Near-Fatality because she was not at risk of death. He maintained his stance after the Child Fatality Review procedures were explained. The physician provided valuable insight into the nature of the [redacted] and how, even though the Paramour did not seek immediate medical attention, his action of putting on lotion, did probably alleviate some of the pain of the [redacted].

County Strengths:
- The agency's response to the situation was quick, detailed, and sought to assure the safety of the child and help the family.
- There was good teaming with Lehigh County CYS to assure that the child was seen and safety was assured. The agency was able to establish concrete collaboration with the Lehigh CYS worker to assure that all information was received.

County Weaknesses:
- No weaknesses were noted

County recommendations for changes at the local (County or State) levels as identified in County's fatality report:
The Act 33 team discussed that, in this case, the Paramour did not seek out immediate medical attention since this was not his child and he could not contact the Mother to provide consent for

medical treatment. It was suggested that the community be notified, possibly through an article or PSA, about regulations for accessing medical care when a parent or legal guardian is not present.

Department of Public Welfare Findings:

County Strengths:

- County response to information received was urgent and thorough.
- The CPS Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
- MDT participants were supportive of the county's response, and praised the workers for their collaboration with all involved.

Recommendations:

- The physician from the Lehigh Valley Hospital raised a concern about the wording of "near fatality" in reference to this case. The concern was that if this case was to go to trial and someone said "near fatality" to a jury, it would elicit a very different response than a discussion of the actual injuries. Even when the fatality review process was explained to the physician, there was still not a complete understanding. Union County did an excellent job of explaining this to the physician, but this could be a concern in subsequent cases. In these kinds of cases, agencies should be educating medical professionals on the terminology and process of the fatality reviews.

Statutory and Regulatory Compliance Issues:

All regulations regarding CPS investigation and subsequent county services were followed.