pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/15/12
Date of Incident: 5/1/13
Date of Oral Report: 5/1/13

FAMILY WAS NOT KNOWN TO:

Lancaster County Children and Youth Services

REPORT FINALIZED ON:
1/9/14

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, 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. Lancaster County Children and Youth Services 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	11/15/12
	biological mother	[redacted]/91
	victim child's sibling	[redacted]/08
	biological father	[redacted]/91
	paternal grandmother	[redacted]/62
	paternal grandfather	[redacted]/67

* The biological father and paternal grandparents do not live in the same residence where the incident occurred.

Notification of Child (Near) Fatality:

On May 1, 2013 the victim child's mother brought the child to Lancaster General Hospital. The child had received [redacted] burns on his left hand, cheek, chin and knee. Due to the severity of the burns and overall condition of the child, the child was transferred on the same day via ambulance to the [redacted] at Crozer Chester Medical Center. The medical staff at Crozer Chester Medical Center registered the child to be in serious condition as a result of suspected parental neglect. The Lancaster County Children and Youth Agency received a Child Protective Services (CPS) report regarding concern of physical mistreatment of the victim child on the same date as referenced above. The report to the county referenced that the child was currently at the hospital receiving treatment and expected to survive the incident. The report referenced the child was sleeping on a bed and rolled off onto a heater.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records pertaining to the [redacted] Family. Follow up interviews were conducted with the county agency caseworker [redacted], supervisor [redacted], intake director, [redacted] and agency administrator [redacted] on May 2, 8, 15, and 17 and June 27, 2013.

The Regional Office participated in the County Internal Fatality Review Team meeting on May 8, 2013.

Children and Youth Involvement prior to Incident:

N/A, the family had no prior involvement with the county children and youth agency.

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

On May 1, 2013 the mother brought the child to Lancaster General Hospital. The child had received [redacted] burns on his left hand, cheek, chin, and knee. The mother reported that the child was sleeping on his sibling's bed which was in close proximity to the bedroom's baseboard heater. The mother laid the child down towards the center of the bed. The child's mother stated she was not aware of the child's ability to roll off the bed. The mother went to her room to get ready for work. Approximately fifteen minutes later she heard the baby crying on the baby monitor. She ran into the room and found the child lying on the baseboard heater. The mother picked up the child and took the child to the hospital. The child was transported the same day to Crozer Chester Medical Center for further treatment for the burns the child received. During the child's stay in the hospital he received [redacted] The child has since recovered from the injuries. The child was [redacted] the hospital on May 26, 2013. [redacted] the child went to stay with his paternal grandparents along with his sibling. The mother was in agreement with the established plan of safety for the children. The mother was allowed contact monitored by the grandparents until the agency completed the investigation. The county agency conducted background check on the grandparents and they were determined to be an appropriate resource for the children. The county agency submitted a report to law enforcement. It should be referenced that the victim child's sibling was at school at the time of the incident. During the county's investigation the children were assessed at various intervals in accordance to the safety assessment and management process reference manual dated November 2012.

[redacted] Police conducted an investigation regarding circumstances pertaining to the child's injuries. The victim child's mother was interviewed by law enforcement on May 3, 2013 at the hospital and then conducted a full interview with the mother regarding the incident on May 10, 2013. The county children and youth worker was able to participate in the interview process. The mother's account of circumstances appeared plausible and the incident was determined to be accidental. [redacted] Police completed their investigation and no charges were filed against the victim child's mother. The Lancaster County Children and Youth Agency completed the child abuse investigation on June 27, 2013. The report was unfounded. The county agency determined the children (victim child and sibling) to be safe in the care of their mother. The victim child's sibling returned to the mother's care on 5/26/13 and the victim child returned to the mother's care on 6/5/13.

[redacted] mended [redacted] the case for services to provide mother with [redacted] through a contracted provider. There was also a [redacted] r the victim child. The child may need [redacted]

[redacted] however that may not occur until the child is older. The victim child's mother followed through with post hospital medical appointments and [redacted] associated with the injuries which had received.

Current Case Status:

The county agency has an open case for the family. The case was opened for services on June 26, 2013. The county has monitored the case and the mother is following through with provisions outlined in the family service plan. The county agency has not had any reported issues with the mother providing for the care of her children.

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

Strengths:
The county agency's report did not reference any specific identified strength.

Deficiencies:
The county agency did reference a concern in which the child was first seen at Lancaster General Hospital. However, the hospital did not make a report to the county agency or Childline for concern regarding the child's condition or injuries. It was the second medical provider, Crozer Chester Medical Center, who called to register the report.

Recommendations for Change at the Local Level:
The county team referenced a recommendation to educate parents on sleep space and child development. The information could be provided to new mothers and also be provided during scheduled visits with the child's pediatrician.

Recommendations for Change at the State Level:
The county agency's report did not reference any specific changes for recommendation at the state level.

Department Review of County Internal Report:
The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case. Due to the circumstances of this particular case there are no areas to dispute or concur with identified in the report.

Department of Public Welfare Findings:

County Strengths:
Upon review of the documents associated with this particular case it would appear there is a positive working collaboration between law enforcement and the county agency. In addition the county was able to keep the two children in care with a relative during the investigation rather than have the children enter placement.

County Weaknesses:
The circumstances of this incident and upon review of the county's case did not identify any systemic weakness.

Statutory and Regulatory Areas of Non-Compliance:
The review of the county case file notes and medical records did not find any areas of non compliance.

Department of Public Welfare Recommendations:
None