pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: 11/23/2009
Date of Near Death: 02/14/2013
Date of Oral Report: 02/14/2013

FAMILY KNOWN TO:

York County Children, Youth and Family Services

REPORT FINALIZED ON:

02/04/2014

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))

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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. York 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	11/23/2009
	Mother	[redacted]1992
	Father	[redacted]1993
	Mother's Paramour	[redacted]1992
	Half-Sibling	[redacted]2013

Notification of Child Near Fatality:

The Victim Child [redacted] was brought into the York Memorial Hospital on February 14, 2013 with an almost complete [redacted] to her right hand. The [redacted] contacted [redacted] and this injury was numbered for medical neglect because it is believed that the condition of the [redacted] became worse because the Mother [redacted] did not seek out immediate medical attention. The child was considered to be in serious condition by the treating physician due to the fact that it will take [redacted] to correct the injuries to the hand, so this was processed as a Near Fatality.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth, and Families obtained and reviewed all current and past case records pertaining to the Victim Child and her family. Medical records were also reviewed. Conversations and interviews were conducted with the Caseworker [redacted] Supervisor [redacted], and Quality Manager [redacted] throughout involvement but specifically on February 15, 2013 and when the [redacted] Decision was made on April 12, 2013. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on February 28, 2013.

Children and Youth Involvement prior to Incident:

The agency had one prior case contact with this family. On May 21, 2012, the agency received a CPS referral regarding the older Brother, [redacted], of the Victim Child. According to the report, the child had bruising under both eyes and to his neck and back. He also had [redacted] in his left eye, and a swollen, [redacted] on his finger. The Mother's Paramour [redacted] was listed as the alleged perpetrator. The agency completed an investigation and determined that the Mother's Paramour did injure the child. This case was INDICATED against the Mother's Paramour on July 17, 2012. The maternal grandmother of the child was very involved and the Mother signed over guardianship of the child to the grandmother, who then moved to Florida with the child.

It should be noted that the agency file does not reference the Victim Child in any way during this entire investigation. The investigating worker states that this child was never discussed, and she was not aware of the child.

Circumstances of Child Fatality and Related Case Activity:

The Victim Child was brought into the York Memorial Hospital on February 14, 2013 with an almost complete [redacted] to her right hand. The [redacted] was almost completely [redacted] as well. According to the hospital, these were [redacted]. The skin was completely gone from the [redacted] of the right hand and the hand was severely swollen. The hand was so swollen that [redacted]. The child was considered to be in serious condition by the treating physician due to the fact that it will take [redacted] to correct the injuries to the hand.

The Mother of the child explained to the hospital staff that on February 13, 2013, in the morning, she was preparing water for laundry. The Mother stated that the water in her home gets very hot and she does not know how to turn it down. She was running the water in the bathtub and the Victim Child stuck her right hand into the water resulting in the burns. The Mother spread butter on the child's hand and wrapped it. She did not seek medical attention until at least 24 hours later. A [redacted] at the hospital stated that the injuries appear to be consistent with this story and does not believe that the child's hand was intentionally dipped in the water. However, it may have been more than 24 hours since the [redacted] occurred. The hospital staff contacted [redacted] and this injury was numbered for medical neglect because it is believed that the condition of the [redacted] became worse because the Mother did not seek out immediate medical attention.

The child was transported to the Burn Center at the Lehigh Valley Hospital where she was [redacted]

When the agency met with the Mother on the night of February 14, 2013, she stated that the Victim Child had been watching TV in the bedroom and she had drawn a bath

for the child. The Mother then went downstairs and this is when the child went into the bathroom and burned her hand. This story is not the same story that she provided to the hospital.

While at the Lehigh Burn Center, doctors noted other injuries in various stages of healing. There were [redacted] There were also concerns with the child's size and weight. The doctor noted some bruising on the cheek as well. A full skeletal survey showed a healing [redacted], as well as a [redacted] which could be indicative of an older injury. These injuries were unexplained. A report was made to [redacted] on February 15, 2013 regarding these injuries and was numbered for investigation.

The Victim Child was [redacted] from the hospital to her father on February 22, 2013. The child was to have no contact with the Mother or her paramour.

The agency completed an investigation, filing the CY48 with Childline on 04/12/2013. The case was INDICATED for [redacted] as a Perpetrator by Medical Neglect due to the delay in obtaining medical care for the child's [redacted], which caused the injuries to be more severe. No charges were filed as a result of this investigation.

The agency concluded the second investigation, filing the CY48 with Childline on 4/12/13. The case was UNFOUNDED against [redacted] as she denied injuring the child, and the agency could not determine through the investigation how the child received the injuries.

[redacted] was opened for In-Home services by the agency in regards to her infant child in order to monitor her parenting of this child, and assuring that proper care is secured. The Victim Child remained with her father. Agency services were not warranted in regards to this child.

Current Case Status:

The Victim Child remains in the custody of her Father [redacted] The agency has engaged the Mother to receive parenting services and a Family Group Decision Making meeting to initiate visitation with her daughter, but she has not been cooperative or responded to any suggestion. The [redacted] have indicated that the Victim Child will have little to no disability with her hand, and should not need any [redacted] as previously thought.

Since the case was opened for In-Home services, the infant child [redacted] is now in the guardianship of a paternal great-grandmother. According to the agency, the Mother only visited with her sporadically, but has now stopped visiting with the child. After a time of non-response, the agency has closed the case as the grandmother is able to provide for the child. The current caretaker is aware that she is to contact the agency if the Mother should attempt to regain a care giving role for this child.

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on February 28, 2013 at the York Hospital. The team was comprised of local CYS professionals, medical professionals, and regional staff.

- Strengths:
  The team felt that the agency handled the current CPS investigation well and provided information to all parties involved. The agency maintained consistent communication with the hospitals and medical professionals throughout the case.

- Deficiencies:
  None were noted by the team in regards to the handling of the case by the agency.

- Recommendations for Change at the Local Level:
  No recommendations were made.

- Recommendations for Change at the State Level:
  None noted.

Department Review of County Internal Report:

York County CYF provided a report on the Near Fatality of the Victim Child to the Regional Office on March 11, 2013 at the completion after the Act 33 meeting was complete. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on September 30, 2013.

Department of Public Welfare Findings:

- County Strengths:
  - County response to information received was urgent and thorough during the CPS investigation.
  - The CPS Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
  - The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
  - The agency took a very active role in maintaining communication between all members of the team including law enforcement and medical professionals.

- County Weaknesses:
    - It is concerning that the Victim Child was not even mentioned in the previous abuse report. It is hard to determine if the agency had any knowledge of this child, or that the family chose to keep this child concealed. More diligence could have been made to determine total family composition.

- Statutory and Regulatory Areas of Non-Compliance:
  None Noted

Department of Public Welfare Recommendations:

The agency should strive to discover and interview all family members. There were plenty of individuals involved that should have disclosed knowledge of the Victim Child in the previous report. While it may not have prevented injuries to this child, more information could have been gathered.