pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/16/2011
Date of Incident: 9/3/2013
Date of Oral Report: 9/4/2013

FAMILY NOT KNOWN TO:
Mifflin County Children and Youth Services

REPORT FINALIZED ON:
01/06/2015

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, 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. Although not required, Mifflin County has convened a review team related to this report on December 17, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	11/16/2011
[redacted]	Sibling	[redacted]2003
[redacted]	Mother	[redacted]1982
[redacted]	Father	[redacted]1983

Notification of Child Near Fatality:
The 22 month old victim child was taken to the Mount Nittany Medical Center on September 4, 2013 at approximately 6:00 PM by his biological parents. The father stated that he was cleaning a muzzle loader the previous night with boiling water and that he had spilled the hot liquid on the floor. He reported that the child slipped and fell in the hot water. The parents reported that the burns did not look that severe and did not see the need to have the child transported to a medical center. The child was given Tylenol. It was indicated that the child received burns from his right hip to the right knee. The skin was characterized as blacken and "coming off". The child's injuries also include large two (2) to three (3) inch blisters on the left, that the blister was also located between the toes of both feet. It was noted that the child's upper thigh is red and that the child had an oozing sore located near the front of the waist.

The child did not have injuries between the knees and the ankles and how he was burned in such a pattern is questioned. The possibility that the child was burned to chemical exposure (poured onto his lap) is being investigated. The decision was made to transport the child to the [redacted] Lehigh Valley Hospital-[redacted] Allentown. The burns were rated as [redacted]. There is a concern that the parents' account of the incident does not match the resulting child's injuries and that there is a concern of why the parents wait a day to take the child to a medical center. The child was in serious condition according to [redacted] of Mt. Nittany Medical Center and registered as a near fatality.

Summary of DPW Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families obtained and reviewed all current and case records pertaining to the [redacted] family. Follow up interviews were conducted with the Caseworker [redacted], the Supervisor [redacted] and the Agency Director [redacted] on September 4, 2013 and on September 9, 2013. The regional office also participated in the County Internal Fatality Review Team meetings on December 17, 2013 which included a review of child's medical records from [redacted].

Children and Youth Involvement Prior to Incident:
None

Circumstances of Child Near Fatality and Related Case Activity:
The child was brought into the Mt. Nittany Medical Center around 6 pm on September 3, 2013 with complaints of a worsening right leg burn that occurred last night. Mifflin County Children and Youth services received a child protective services report during on-call on September 4, 2013. The CPS case was registered as a Near Fatality because the family first took the child to [redacted] where the doctor believed the child was in serious condition due to injuries resulting from suspected abuse.

The father stated that he was cleaning his muzzle loader last night with boiling water and the water spilled on the floor and the child slipped and fell in the hot water causing 2nd and 3rd degree burns. The child is [redacted] The child has a [redacted] at the waist in the front. The child was transferred to [redacted]. The child was in serious condition according to [redacted] and registered as a near fatality.

Current Case Status:
The child was transferred to the [redacted] on September 5, 2013 and [redacted] on September 8, 2013. Lehigh County Children and Youth Services did a 24 hour contact as requested by Mifflin County Children and Youth Services. The Lehigh County caseworker took pictures and discussed the concerns with the parents. Both the Lehigh County [redacted] and the [redacted] personnel believed the parent's explanation for the injuries and did not feel this was due to abuse. [redacted] stated that at no time should this have been classified as a near fatality. He believed that the burns were consistent with the parent's explanation.

No safety plan was needed. Sibling [redacted] was staying with his grandfather while his parents were in the [redacted] with [redacted]. The parents remained in the [redacted] until the child [redacted] on September 8, 2013. CPS investigation was unfounded by Mifflin County Children and Youth services on October 3, 2013. The child's injuries were not a result of child abuse or neglect.

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

Strengths:

This was Mifflin County's first Child Death Review Team Meeting. The report initiated the group convening.

Deficiencies:

None Noted

Recommendations for Change at the Local Level:

None Noted

Recommendations for Change at the State Level:

None Noted

Department Review of County Internal Report:

County report was received on January 13, 2014. There were no discussions about particular recommendations to avoid this circumstance in the future.

Department of Public Welfare Findings:

County Strengths:

- Mifflin County worked in tandem with Leigh County Children and Youth Services on this case. Interviews were conducted by both caseworkers from Mifflin and Leigh counties.
- Mifflin County had two differing opinions from two different doctors as to the substantiation of this case as a near fatality which caused some confusion; however the county responded appropriately.
- The investigation completed by Mifflin County Children, Youth and Families was conducted in a timely fashion and in collaboration with the Lewistown Branch of the Pennsylvania State Police Department. The level of cooperation between the counties and the police department was commendable.

County Weaknesses:

None

Statutory and Regulatory Areas of Non-Compliance:

None

Department of Public Welfare Recommendations:

None