



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Elaine Bobick
Director
Western Region

11 Stanwix Street, Suite 260
Pittsburgh, PA 15222

(412) 565-2339
Fax: (412) 565-7808

REPORT ON THE NEAR FATALITY OF



BORN: May 3, 2010
Date of Near Death Incident: July 4, 2010

**The family was not known to Children and Youth Services.
The family was not known to other public/private social service
agencies**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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 No. 1147, now known as Act 33 was signed by [REDACTED] 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 near child fatalities that were suspected to have occurred due to 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.

Circumstances of Child's Near Fatality:

On July 5, 2010, Erie County Office of Children and Youth (OCY) was informed that a two month old, [REDACTED] was seriously injured as a result of being burned in an accident at her grandparents' home on July 4, 2010. The child was brought to the Millcreek Community Hospital, in Erie, Pa, by the paternal grandmother. The child's parents were not present when the accident occurred. At the time of the accident, the child's parents were at an outside activity without the child. They were advised of the accident to their daughter by PGM. Upon notification of the accident, they proceeded to the hospital to be with the child. The child had sustained [REDACTED], and a [REDACTED] [REDACTED], as a result of being burned by a sparkler. The sparkler had gone through the child's diaper. According to the emergency room physician the injuries met the criteria of a near death. Following treatment in the emergency room at Millcreek the child was transported to the West Penn Hospital Burn Unit in Pittsburgh, via ambulance, for specialized treatment the same day. It is believed the child received specific care for her burns which would have included cleansing of the wound and subsequent bandaging.

According to the paternal grand mother, the child accidentally sustained her injuries when she, her husband, and two other children, (siblings of victim child) went outside the home to light some sparklers on the Fourth of July. Paternal grandmother stated that she took the child with them, and had her strapped in an infant seat, placed about eight feet away. Paternal grandfather lit a "morning glory" sparkler; there was a pop and hot white ash shot out, landing in the baby carrier under the victim child. Please note, the morning glory sparkler reportedly burns with a more vigorous effect than common sparklers and is more likely to drop small glowing particles. Paternal grandmother stated that she removed the child from the infant seat and PGF immediately ripped the diaper off of the child. She then took the child inside the house and wiped off the burns on the child's legs and buttocks with a warm wash cloth, then applied a generic form of Neosporin to the affected areas. The family then transported the child to Millcreek Hospital.

According to information subsequently obtained by Erie County OCY, the time frame and sequence from when the child was burned and her arrival at Millcreek hospital was approximately 2 hours. Millcreek hospital would have been the closest hospital to where the PGPs resided. It is unknown whether a call to 911 would have made any significant difference as to whether the child would have been seen at the hospital any earlier. The Erie County [REDACTED] investigation did not reveal discrepancies between the nature of the child's injuries and the grandmother's explanation of how they occurred.

Summary of Review

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
██████████	Mother	██████/89
██████████	Father	██████/84
██████████	Paternal grand mother	██████/65
██████████	Paternal grand father	██████/65
██████████	Victim child	05/3/10
██████████	Sibling	██████/05
██████████	Sibling	██████/06

Documents Reviewed and Individuals Interviewed:

The Western Region Office of Children, Youth and Families Program Representative reviewed the intake and █████ case documents provided by Erie County OCY. The file included: █████ service referral forms, Child Fatality/Near Fatality Data Collection Form, █████, and █████ report documentation form. The Erie County OCY staff involved in the investigation were interviewed regarding information obtained related to the incident and assessment of the family.

Case Chronology

Prior to the report of the child's near death on July 4, 2010, the family was not known to Erie County OCY.

Erie County OCY commenced an investigation upon receipt of the near death report. Arrangements were made for a █████ worker from Allegheny County to interview family members when the child was transferred to West Penn Hospital in Pittsburgh on July 4th. Based on the completed safety assessment, as well as confirmation from the West Penn physician and the Pennsylvania State police, that the child's injuries were consistent with the explanation provided by the paternal grandmother, the child was discharged from the West Penn hospital in Pittsburgh on 7/9/2010 to the care of the mother and father.

Following the child's discharge from the hospital, the assigned Erie County caseworker visited the parents at the home of the maternal grandmother, where mother, father, and victim child reside. The worker also interviewed the paternal grandparents in their home, where the victim child and her two older half siblings frequently visit. The two older children are the father's children, but not the biological children of victim child's mother. They reside with their biological mother in a separate residence. The county agency did not assess that home because there were no identified safety threats to those children. Based on the two separate visits to MGP and PGP homes no significant safety concerns were identified.

Collateral contact with West Penn Hospital confirmed that parents had brought the child in for a scheduled follow up appointment on July 13 and that child's burns were healing properly.

Erie County OCY completed its child line investigation with a status of unfounded within 30 days of the receipt of the near death report. This decision was based on information obtained from the treating physician at West Penn Hospital, who concluded that the nature of the subject child's injuries was consistent with the explanation that the injury was the result of an accident; as well as the investigation conducted by Pennsylvania State Police which also determined the injuries to be accidental. The agency subsequently closed the case on August 6, 2010 as there was no evidence to suggest family was in need of agency services.

Findings and Recommendations

The near death report pertaining to the subject child was based on preliminary assumptions about the nature of the child's injuries; those assumptions were subsequently determined to be erroneous. Prior to the report the family was not known to the child welfare agency, nor were they known to other public/private social service agencies. Erie County OCY conducted a timely and thorough investigation of the near death report. The agency worked collaboratively with the Pennsylvania State Police in pursuing a determination of how the subject child sustained injury. The agency appropriately sought assistance of a sister agency, Allegheny County CYF, in interviewing and assessing child's safety, as she was in that agency's jurisdiction while receiving medical treatment. Collateral contacts with the treating physician at West Penn confirmed that the parents were following through with recommended medical treatment and the child's injuries were healing properly.

The Western Region Office of Children, Youth and Families recommends that Erie County OCY utilize the county Multi Disciplinary Team to provide medical professionals with information about changes to the CPSL related to child death and near death reports and the criteria to be considered when making a near death report.