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REPORT ON THE NEAR FATALITY OF



BORN: February 13, 2009
DATE OF NEAR FATALITY: April 29, 2010

FAMILY KNOWN TO: Lehigh County Children and Youth Services

REPORT DATED September 27, 2010

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 Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 31, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected 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.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	02/13/2009
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father/[REDACTED]	[REDACTED]
[REDACTED]	Half- Sibling	[REDACTED]
[REDACTED]	Half-sibling	[REDACTED]
[REDACTED]	Father of [REDACTED] (non- household member)	[REDACTED]

Notification of Fatality / Near Fatality:

The [REDACTED] was dated April 29, 2010 and stated that the father was giving the child a bath at 8:00 pm. The father had the child in the kitchen sink and went to get a towel. When the father came back, he saw steam and the child was screaming. The child had second degree burns to 20% of his body. The child was burned from the middle of his back to his butt, as well as burns to the right leg, ankle and groin area. The child was admitted to [REDACTED]. The child was in serious to critical condition and was expected to survive.

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the [REDACTED] case file as well as the agency's prior involvement with the family. The program representative met with the caseworker, supervisor, and administration to discuss the case. The program representative also attended the county's internal review meeting.

Case Chronology:

- 04/29/2010 Near fatality of the child. [REDACTED] notified.
- 04/30/2010 Preliminary Safety assessment with a determination of safe for the two girls. A determination of safe with a comprehensive plan was made for the victim child. The safety plan stated the [REDACTED]/father was to be supervised at all times by the mother. This safety plan was signed by the father.
- 04/30/2010 CY 104 (referral to law enforcement) was completed and sent to the District Attorney's office.
- 04/30/2010 Law enforcement commenced their investigation.

- 05/06/2010 Child [REDACTED].
- 05/07/2010 Safety plan was amended to add additional supervisors of the [REDACTED]/father's contact with the child. These included family members and family friends.
- 05/25/2010 Conclusion of investigation safety assessment completed with a determination that the children were safe and the safety plan was lifted.
- 05/26/2010 Internal Review held at Lehigh County Children and Youth Services.
- 06/17/2010 Risk assessment completed with an overall severity of low and an overall risk of low.
- 06/17/2010 [REDACTED].
- 06/17/2010 Case closed by the agency.

Previous Children and Youth Involvement:

Lehigh County Children and Youth Services received a [REDACTED] referral on 03/11/2010. The child had disclosed to her [REDACTED] that on 03/07/2010 that she had smoked marijuana with her maternal grandmother's ex-husband. (Step grandfather of the child who is divorced from the grandmother) The child also reported that when she was six years old he had asked her to hump his leg. Law enforcement had already been involved with the case. The children had no contact with the [REDACTED] as he was divorced from the grandmother. The county closed the case on March 25, 2010 and determined that the family did not need ongoing services as the child was already in [REDACTED] and there would be no further contact between the children and their ex-step grandfather. Law enforcement was continuing their investigation and the county also had no further information regarding the allegations of the child humping the grandfather's leg. It was learned months later that law enforcement did arrest the step grandfather.

There was also a referral received by the agency in 1995 from the biological father of the girls with concerns that his daughter had redness in her diaper area and the mother said that it was diaper rash. The couple was separated at the time and the father was concerned because the mother had a past history of being [REDACTED] by her brother 10 years ago. The case was screened out by the agency .

Circumstances of the Child's Near Fatality:

On April 29, 2010 the father reported that he had brought the children home from their Nana's house around 6:45 PM as he had been at work and his wife worked nights. He stated that he fed the children and the two girls went upstairs. He said that he took his son outside to play with a bubble maker and the child was playing in the dirt. He said that his brother-in-law was outside putting in a sidewalk for the family and was using the garden hose. The father reported that he and his son were outside for approximately 30 minutes. He said that when he realized how dirty the child was from playing outside, he decided to give him a bath. The father reported that they had just remodeled their kitchen and the sink had a faucet with a button that when pushed created a shower like effect. The water had been running for 30-40 seconds. The father reported that he had forgotten a towel and ran upstairs to get one while the child was in the sink. He said that he was only gone 15-20 seconds. While upstairs, the father heard the child crying and just thought that the child was upset but then when he came downstairs, he saw the steam. The child was standing in the sink. The father grabbed the child and put him in a towel. When he unwrapped the towel, he saw that the child's ankle was peeling. The child did not have a diaper on in the

sink and when the child was lifted, the father had noticed that his buttocks were peeling also. He said he called his father's fiancé and she took them to the hospital. [REDACTED]

[REDACTED]. The child was seen in the emergency room and was [REDACTED] and later transferred to the [REDACTED]. The child was taken to [REDACTED] on 04/30/2010 and underwent [REDACTED] to all involved areas. The child was [REDACTED] on 05/06/2010 and had follow-up appointments with the [REDACTED] and received [REDACTED] to [REDACTED]. Law enforcement investigated the incident jointly with the [REDACTED] Caseworker. The investigation included a reenactment of the incident and water temperature measurements. The sink was eight and one half inches deep. The child had been bathed on the right side of the sink as the garbage disposal was on the left side. The hot water heater was set at 130 degrees. At the time that the father said that he had the water on and went to get a towel, the temperature was estimated at 70.6 degrees and when he returned, State Police tested the temperature and it was 91.7 degrees. This was using the approximate time that the father anticipated that he had left the child in the sink.

Current / Most Recent Status of Case

The case was [REDACTED] by the Lehigh County [REDACTED] Unit. The [REDACTED] was completed on June 17, 2010. The investigation could not substantiate that the period of time that the AP left the victim child alone was prolonged and felt that the injuries were sustained accidentally. No criminal charges were filed as the Pennsylvania State Police have ruled the incident an accident. The case was closed by the agency as the assessment concluded that the family was not in need of additional services and the family was following up with the child's medical needs.

Statutory and Regulatory Compliance:

Lehigh County Children and Youth Services conducted and completed safety assessments at the appropriate intervals. The preliminary safety assessment dated 04/30/2010 determined that the two girls were safe as they were older and determined that the victim child was safe with a comprehensive plan. This plan stated that the father's contact with his son should be supervised at all times by the child's mother. Additional supervisors were approved by the county on May 7, 2010. Five family members/friends were approved to supervise contact between the father and the child. A referral to law enforcement (CY 104) was made on April 30, 2010. Interviews were appropriately conducted.

Lehigh County Internal Review Findings:

Lehigh County Children and Youth Services completed their internal review report which has improved in content. However, it still needs to encompass a critical approach regarding weaknesses in the handling of the case. When the case was called in and the report was given to the on-call worker, there were some practice issues that could have been handled differently. The on-call worker spoke to the parents via telephone contact and made a safety plan over the phone

and advised the father and mother that the father was not to have unsupervised contact with the children. The caseworker was told that the other two children would be staying with family members. The children were seen the next day by the assigned caseworker.

At the review meeting, it was discussed by law enforcement that there was a breakdown in communication as law enforcement was not notified until the next day and there is a protocol in place that the agency needs to contact law enforcement immediately when there is a near death/death. This was reviewed by the district attorney's office with all parties. The [REDACTED] [REDACTED] who is a review team member discussed immersion burns and how the father's story was consistent with the injuries of the child.

Lehigh County Children and Youth Services have a strong review team. The team was concerned as bathing in sinks appears to be a common theme and was unable to make any recommendations on how to increase community awareness on the dangers of this practice. The team discussed hospital maternity education for mothers regarding bathing of children, however, this pertains mainly to infants.

Department of Public Welfare Findings and Recommendations:

The Northeast Regional Office Program Representative has discussed with the [REDACTED] [REDACTED] Manager and Agency Director the concern that a verbal safety plan was formulated over the phone that was not clarified in person with the family or the hospital in regard as to who was supervising contact between the father and the child and how this plan would be monitored.

Although the agency has 24 hours to see the children and assess safety, it would have been more appropriate for the on call worker to have gone to the hospital in this case to assess the situation and formulate a clear safety plan in person with the family. In addition, the other children needed to be seen to assess their safety as well that evening. The Director states that quality assurance and the safety lead have been randomly pulling files and reviewing safety plans to clear up any confusion that staff may have. The county reports that they will continue to receive technical assistance from the Child Welfare Training Program and the Northeast Regional Office.

In this case there were two safety plans formulated. The second plan approved additional persons who were able to supervise the contact between the father and the child. It is recommended and was conveyed to the Director and [REDACTED] Program Manager that the safety plan needs to be concise and establish who is responsible for the plan and how it will be monitored. In this case, the safety plan was very confusing as there were multiple persons responsible but it wasn't clear if all were needed and what their roles were. In addition, only one person signed the plan along with the father and the mother. The first plan was only signed by the father and not the mother, while the mother was the responsible person to supervise contact.