pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/02/2012

Date of Incident: 02/28/2013

Date of Oral Report: 03/01/2013

FAMILY KNOWN TO:

Bucks County Children and Youth Social Services Agency
Delaware County Children and Youth Services

REPORT FINALIZED ON:
11/21/2013

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. Delaware 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	10/02/12
[redacted]	Mother	[redacted]/82
[redacted]	Father	[redacted]/87
[redacted]	Sister	[redacted]/10
* [redacted]	Half Sister	[redacted]/04
* [redacted]	Half Brother	[redacted]/06
[redacted]	Paternal Grandmother	Adult
[redacted]	Paternal Grandfather	Adult
[redacted]	Paternal Uncle	[redacted]/93

Non House Hold Member:

* [redacted]	Father	Adult

The father of the two half siblings to the VCH is currently residing in Texas and during the course of the investigation made contact with Delaware County and stated that he is currently unable to be a resource for his children.

Notification of Child Near Fatality:

On 2/28/2013, at 10:02 pm, the victim child was transported by emergency first responders to Crozer Chester Medical Center, because the victim child was vomiting and not breathing. The father stated that the victim child woke up crying. The father fed the victim child. The father reported that the victim child began projectile vomiting, screaming, crying and eventually stopped breathing, then went limp. The paternal grandmother told the father to call 911. On 02/28/2013 the agency [redacted] stating that the victim child, age 5 months, was admitted into the hospital [redacted]. The victim child was [redacted]. The early evaluation by the medical professionals indicated evidence of old injuries on the victim child. The father stated that the victim child fell off the bed two weeks ago and both he and mother took the victim child to the pediatrician who said there were no injuries.

The victim child was later transferred to AI Dupont for evaluation and treatment. The initial report did not mention the victim child being in critical condition. The [redacted] indicated that the victim child had an [redacted]. It was speculated by the medical staff that the victim child suffered significant impact. [redacted] at AI DuPont Hospital for Children determined the victim child's presentation of a [redacted] and numerous [redacted]. The parent's explanation and history of how the victim child was injury were not consistent with the magnitude and the extent of the child's injuries. [redacted] was the sole care taker at the time of the incident. [redacted] recommended that the [redacted] were very severe and not consistent with those seen in simple falls or non-abusive situations.

On 3/01/2014, Delaware County received a registered report [redacted], stating that a 5 month old, male, victim child was transferred to AI Dupont Hospital suffering from [redacted] as result of suspected child abuse. The report identified the perpetrator as an [redacted]

On 3/04/2014, Delaware County received supplemental report from [redacted] registering the victim child as a near fatality [redacted] The report identified the perpetrator as [redacted]

Summary of DPW Child Near Fatality Review Activities:

The South East Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family including: Records from Bucks and Delaware County C & Y, Safety Assessment from emergency call received from [redacted] CW Delaware County, MDT report (including Risk Assessment, FSP and Police Report). SERO participated in the Act 33 Review and collaborated with the County, Physicians and police.

Children and Youth Involvement prior to Incident:

The family was referred to Bucks County Children and Youth on October 4, 2012 after mother tested positive for marijuana at the birth of the VC. Bucks County provided [redacted] to the family. The mother was provided [redacted] and [redacted] for her extensive marijuana use.
On January 7, 2013, the family moved into the home of the paternal grandparents and the case was transferred to Delaware County Children and Youth.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/28/2013 the child was taken to Crozier Hospital by paramedics because he was projectile vomiting, crying and screaming. The father stated that the child had fallen off of the bed about two weeks prior to the appearance of the symptoms. From Crozier the child was transferred to AI

DuPont Hospital, where he was [redacted].

On 3/01/2013, Delaware County C&Y received a [redacted] report from [redacted] was the reporting source.

[redacted] Initial report did not identify an alleged perpetrator for [redacted] of the victim child. It was determined by the county's investigative team that the child victim and the older siblings were unsafe in the home and could not be left alone with the parents and the paternal grandparents because they all shared the care taker responsibilities for the children.

Initially, the mother and father stated that the child had fallen 2 weeks prior to the onset of the current symptoms. This was later determined, through the investigation to be an untrue statement.

On the day of the incident the mother had left the home around noon to pick up two of the victim child's siblings from school and take them to the doctor's office and did not return to the home until a few minutes before the ambulance arrived for the victim child. While the incident was occurring another sibling was sleeping on the couch in the living room. [redacted], who moved into the home two weeks prior, stated that maybe the baby swing and the gravity was the reason for the child's injury. He denied caring for the victim child on the day of the incident. On the day of the incident the father brought the victim child into the paternal grandmother's bed room. The victim child's eyes were open but the victim child was un-responsive. The PGM advised the father to call 911 and started CPR until the ambulance arrived.

The attending physician stated the injuries were not consistent with those seen in simple falls or non-abusive situations.

The mother and the father have a [redacted]. Both parents openly admit to smoking marijuana. At the time of the near fatality incident, the mother was receiving [redacted] following the victim child's birth. [redacted] He has rage issues [redacted]

It was determined through the [redacted] investigation that [redacted] was the sole care taker at the time of the incident [redacted]

On 03/15/2013, a criminal complaint was filed against [redacted] charging him with Simple Assault, Aggravated Assault and Endangering the Welfare of a Child. [redacted] gave an interview that was taped by the police. On tape, [redacted] stated that on the day of the incident he was sitting on the couch feeding the child around 8:30 am. The victim child only took a few ounces and started crying and then began to projectile vomit. When the victim child vomited on him his natural reaction was to "toss the child aside". [redacted] stated that he threw the victim

child onto the couch next to where he was sitting. [redacted] stated that he took the child up stairs to get changed and he was frustrated at the time, so he sort of threw and dropped the victim child onto the changing table from a distance according to his estimation of about 8 inches to a foot. [redacted] stated that the child could have hit his head on the metal rail around the changing table.

On 4/1/13 the CPS investigation was indicated for physical abuse. The determination was made based on the [redacted] investigation and medical evidence. The medical documentation indicated that the child had a [redacted]. The Medical doctor, [redacted] believed that the child is a victim of physical abusive head trauma. The medical reports indicated more than one episode of head trauma and the [redacted] are very severe and inconsistent with those seen by simple falls or non-abusive situations head trauma.

Current Case Status:

- The [redacted] investigation determined that on February 28, 2013 the [redacted] Police Department received an emergency call from [redacted] for a child in respiratory distress. The ambulance arrived and [redacted] was transported to Crozier Chester Medical Center.
- Parents and paternal grandparents were interviewed.
- [redacted] On 4/1/13 the CY 48 was completed and the CPS investigation was determined indicated [redacted].
- [redacted] he was the primary caretaker for [redacted] at the time of the incident.
- The father was drug tested on 3/1/13; the results were positive for [redacted]
- [redacted] is incarcerated at [redacted] Correction Facility.
- A safety assessment was conducted and the siblings of [redacted] were placed in foster care because initially the family members were covering for [redacted] and did not believe the [redacted] caused the injuries to the child. The children remain in foster care with the goal of re-unification.
- All of the household members were interviewed regarding the incident. No one was able to explain the child's injuries and no one admitted to ever seeing [redacted] abusing any of the children.
- [redacted] On 3/6/13, [redacted] and placed in medical foster home through [redacted]

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

- Strengths:
  Staff followed established procedures regarding safety assessment and planning. The agencies communicated well and the case was transferred timely. A higher level of intervention or court involvement was not necessary prior to the near fatality incident as the agency engaged the family and the parents cooperated.

- Deficiencies: NONE

- Recommendations for Change at the Local Level:
  It was recommended that the manner in which information is shared between C&Y and [redacted] Providers be reexamined especially when the information may impact the safety of children.

- Recommendations for Change at the State Level:
  The MDT recommended that child welfare agencies and providers work together to better communicate and earlier identify risk factors for abuse and neglect.

Department Review of County Internal Report:

The Southeast Office of Children Youth and Families obtained the family's Delaware and Bucks County case records and the victim child's hospital medical records. A review of records and discussion of the same was held with the county's [redacted] caseworker, supervisor and the ongoing case worker of the victim child and the victim child's family. The Southeast Regional office and Bucks County's treatment team was an active participant in the Delaware County internal Act 33 near fatality review team. The Southeast Region is in receipt of the County's Act 33 review, and has reviewed it. The Department is in agreement with the findings.

Department of Public Welfare Findings:

- County Strengths:
  The county provided follow up with public and private stake holders from the onset of [redacted] report and investigation.

- County Weaknesses:
  None identified

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

Department of Public Welfare Recommendations:

Improved collaboration and communication between the various county agencies, specifically the county children and youth agencies and providers could benefit the families of children especially when [redacted] issues exist in the family.