pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON NEAR FATALITY OF:

[redacted]

Date of Birth: 1/19/2013
Date of Incident: 4/9/2013
Date of Oral Report: 4/9/2013

FAMILY KNOWN TO:

The Bucks County Children and Youth Social Services Agency

REPORT FINALIZED ON:
November 7, 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. Bucks 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	1/19/2013
* [redacted]	Biological Mother	[redacted]/1989
[redacted]	Biological Father	[redacted]/1986
[redacted]	Sibling	[redacted]/2009
* [redacted]	Mother's Paramour	[redacted]/1988
[redacted]	Maternal Grandfather	[redacted]/1958
[redacted]	Step-maternal Grandmother	[redacted]/1968

- These family members do not live in the home of the victim child:

Notification of Child Near Fatality:

On April 9, 2013, Bucks County Children and Youth Social Services Agency (BCCYSSA) received a call from [redacted] that [redacted] had been hospitalized at St. Mary's Medical Center for respiratory distress and a bump on her head. She was transferred via helicopter to St. Christopher's Hospital [redacted] Child was left in the home with mother and mother's paramour, [redacted]. Mother was receiving [redacted] and left the home to go to [redacted] When mother returned home, an hour later, she saw ambulances and police officers at the home. Child was transported to St. Mary's Medical Center via ambulance. Child was later transported via helicopter to St. Christopher's Hospital for Children. [redacted] was certified as a near fatality.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the Caseworker, [redacted], Caseworker, [redacted], and Administrator,

[redacted]. The Regional office also participated in the County Internal Fatality Review Team meeting on May 6, 2013.

Children and Youth Involvement prior to Incident:

At the time of this incident the [redacted] family was involved with BCCYSSA and had an open placement case with sibling, [redacted]. The case was opened for services on 10/20/11 and subsequently [redacted] was placed in foster care on 2/23/12. Prior to placement into foster care she was with a kinship foster parent; however, the kinship family was unable to continue caring for her. The placement was due to mother's daily heroin use, child being unsupervised outside of the home as well as numerous dogs living in the home. The maternal step grandmother and grandfather were interested in obtaining custody of [redacted] as mother was not providing care for the child. During the process, it was determined that the grandfather, [redacted], had an indicated CPS report for sexual abuse. As a result, [redacted] was placed in foster care.

Circumstances of Child Near Fatality and Related Case Activity:

On January 19, 2013, [redacted] was born with opiates in her [redacted] At the time of [redacted] birth, Mother had [redacted]

On January 22, 2013, upon [redacted] BCCYSSA implemented a safety plan that mother was to be supervised at all times in the home and in the community with [redacted]. Mother was to be supervised in the home by [redacted] (step maternal grandmother) [redacted] (maternal aunt) and [redacted] (sister in law).

On March 1, 2013, a safety plan was implemented that stated the previous safety plan dated 1/22/13 was still in effect. However, the following safety actions were added; maternal grandfather, [redacted], was not be allowed alone or unsupervised with the child and mother's paramour, [redacted], could not drive the child in a motor vehicle, as he had a suspended drivers license.

On April 9, 2013, the January 22, 2013 safety plan was violated by [redacted], step maternal grandmother. She left [redacted] alone with her mother, [redacted], and mother's paramour, [redacted] was in the home with biological mother and paramour [redacted] had to leave for work. The safety plan supervisor, [redacted], was on her way to the home; however, she was delayed and did not arrive until one-half hour after mother left the home. Mother, [redacted], left the home at 10:30 am [redacted] was left in the home alone with mother's paramour, [redacted]. There was no one else in the home at the time of the incident. When Mother returned to the home an hour later she saw ambulances and police officers at the home. [redacted] called 911 and at that time reported that [redacted] fell. He later reported that he dropped the child. [redacted] was transported to St. Mary's Medical Center. [redacted] arrived at St. Mary's via medical ambulance in respiratory distress. [redacted] was then transported via helicopter to St. Christopher's Hospital in respiratory

distress. Child presented at St. Christopher's with a bump on her forehead [redacted] was unable to breathe on her own [redacted]

[redacted] gave several explanations of [redacted] injuries. He reported that while he was holding [redacted] she head-butted his chin and he dropped her. He further reported that she fell off the Boppy pillow which was on the bed. The maternal grandmother was extremely remorseful for violating the safety plan. [redacted] did call 911, when the ambulance arrived he told the EMT that he did not know what happened and he disappeared into a bathroom in the basement. [redacted] and [redacted] was drug tested. [redacted] results were negative. [redacted] claimed that she went for testing, but the BCCYSSA never received the results.

On April 11, 2013, [redacted] was discharged from the hospital. She initially was placed into foster care and then into kinship care with maternal grandparent. She is currently in the full legal custody of her step-maternal grandmother, [redacted].

On June 3, 2013, the CPS investigation was determined indicated for [redacted] due to [redacted] being positive for opiates while she was in his immediate care. It was not determined how [redacted] was exposed to the opiates. It was reported by [redacted] that [redacted] 20 year old sister had stayed in the home on April 4th and 5th. After she left, the family found dirty needles on the floors, shelves and in drawers. She reported that she cleaned up the dirty needles and she could have touched the baby. St. Christopher's Hospital stated that there would have had to be a significant amount of drugs on the baby's skin to cause this result. The physical abuse was unfounded due to the inability of determining whether [redacted] were accidental or intentional. St. Christopher's Hospital reported that [redacted] that was caused by trauma, but cannot identify if the cause was non-accidental. The hospital also reported that there was [redacted]

Current Case Status:

The BCCYSSA will be closing the case on November 7, 2013. The family is stable and there are no areas of concern or safety threats.

[redacted] and [redacted] are living in the legal custody of step maternal grandmother, [redacted]. [redacted] was extremely remorseful for violating the safety plan. She had no choice but to leave the child as she had to go to work. [redacted] is developing well with no signs of development delays as a result of the injury.

[redacted], maternal grandfather, had an indicated child sexual abuse report. He was cleared of all charges after a jury determined him not guilty of the abuse [redacted] reported that he did not realize he needed to appeal the ChildLine report since he was cleared criminally. The BCCYSSA confirmed that his name has been cleared from this report.

[redacted] is currently incarcerated in the [redacted] Prison for burglary charges and outstanding warrants. [redacted]

[redacted] whereabouts are unknown to the police and BCCYSSA. [redacted] is living in the home of the maternal grandparents and his children [redacted] and [redacted]

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

Strengths:

The strengths included collaboration with the police department and repeated unannounced visits on off hours to verify that the safety plan was being followed.

Deficiencies:

Although staff had a Safety Plan regarding supervision of mother with her child; it was agreed that adding more specific language relative to who can and cannot supervise the mother would have been beneficial.

Recommendations for Change at the Local Level:

Educate child welfare staff to increase specificity of Safety Plans regarding who can/cannot supervise parents with their children. In addition, staff should be educated on increasing their inquires into who else spends significant time in the family home.

Recommendations for Change at the State Level:

No recommendations

Department Review of County Internal Report:

The county report was received on July 8, 2013.

Department of Public Welfare Findings:

County Strengths:

The County provided quality services to the family. The county assisted the mother [redacted] In review of the county record regarding [redacted] it is apparent that the county worker provided detailed services to the family. The worker was aware of the family dynamics and the areas of concern with biological parents and extended family.

County Weaknesses:

The Safety Plan that was in effect should have stated under no circumstances should [redacted] be left alone with mother without the appropriate supervision. The safety plan was that mother, [redacted], is to be supervised at all times in the home and in the community with [redacted] The safety plan of 2/1/13 stated that mother's paramour [redacted] could not drive the child

in a motor vehicle (due to a suspended driver's license). The safety plan did not state that he was to be supervised at all times in the home and in the community with [redacted]

Statutory and Regulatory Areas of Non-Compliance:

There are no areas of non-compliance.

Department of Public Welfare Recommendations:

The Department recommends more collaboration between systems, [redacted] Necessary information regarding mother's [redacted] was not shared with the county prior to this near fatality incident. It was discovered after the near fatality incident that [redacted] at the time of the incident. This information was not known to the county children and youth agency.

The county should closely monitor safety plans to ensure that the safety plans are being appropriately implemented.