



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE Near Fatality OF:**

██████████

**BORN: ██████ 2012**

**Date of Near Fatality Incident: 10/16/2012**

**FAMILY KNOWN TO:**

*Bucks County Children and Youth Social Services Agency (BCCYSSA)*

**REPORT FINALIZED ON: 3/12/2013**

**DATE OF ORAL REPORT: 10/18/2012**

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 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 convened a review team in accordance with Act 33 of 2008 related to this report on 11/15/2012.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim child	██████████/2012
██████████	Brother	██████████2010
██████████	Brother	██████████2011
██████████	Mother	██████████/1994
██████████	Father	██████████/1991

**Notification of Child Near Fatality:**

On 10/18/2012, ██████████ and his brother, ██████████, were being cared for by their father in their parents' bedroom. The mother was out for the evening; the nurse for their brother, ██████████, was in the living room with ██████████. The nurse heard the father get up twice during the night to get a bottle and diaper for ██████████. About 3:30 am, the nurse heard a loud cry then sudden silence. The father came out of the bedroom, and stated that ██████████ had become limp in his arms and was barely breathing. The nurse began ██████████ and instructed the father to call 911. ██████████ was taken to St. Mary's Hospital and transferred to Children's Hospital of Philadelphia (CHOP).

**Summary of DPW Child Near Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to this family. Interviews were conducted with the caseworker, supervisor and manager at BCCYSSA. The regional office also participated in the County Internal Fatality Review Team meeting on November 15, 2012.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

4/5/2010                      GPS report                      FILED AS INQUIRY

Allegations were that the parents had recently moved and had left the residence in filthy conditions, such as dirty diapers, used feminine hygiene products, and old food lying around. The reporting source indicated that the parents had access to the home computer and that the reporting source found numerous "drug references" on the computer. The parents were reported to have lengthy drug and alcohol histories. Unannounced visits were conducted to the parents' new address. A safety assessment was completed and the child was determined to be safe. The home was observed to be neat and clean. The parents were residing with the mother's father. He was interviewed and had no concerns about the parents' care of their child or any substance abuse by the parents.

**5/19/2010 GPS Investigation FILED AS INQUIRY**

Allegations were that the mother was very young and needed additional support. A home visit was conducted by the county agency worker on this date. At that time, the father was working full time as a flagger on construction/road work. The parents could afford to move out on their own, and were planning to do so. They had applied for [REDACTED] for their son and received [REDACTED]. Information about [REDACTED] was provided to the parents so that the mother could return to high school. The parents presented as calm and caring parents. [REDACTED] was described as a happy baby. A safety assessment was completed and the child was determined to be safe.

**3/24/2011 GPS Investigation Accepted for services**

The referral source had concerns about the parents' newborn son, [REDACTED]. [REDACTED] had a feeding tube and was recently hospitalized at CHOP. The reporting source was concerned that the parents were very young and immature and that the father reportedly had a temper. An unannounced home visit was completed on the day of this call. The county agency case notes indicate that the father was home with the older child, [REDACTED] while the mother was at CHOP with [REDACTED]. The father was cooperative throughout the interview and exhibited appropriate care for his son.

**3/28/2011 CPS Investigation [REDACTED]**

While evaluating [REDACTED] for breathing and feeding issues, a [REDACTED] and other testing was done. The results of these tests revealed that [REDACTED] had bleeding in different parts of his brain, some old and some new. He also had a fracture to his wrist. The doctors suspected intentional injury, as there was no medical or developmental explanation for these injuries. The father disclosed that he had dropped [REDACTED] while trying to manage his older son. The investigation [REDACTED] as this was determined to be accidental, based on the father's report.

This case was [REDACTED] on 5/19/2011 and assigned for [REDACTED] services. Tabor Services Family Preservation began on 5/19/2012 and they were to meet with the family three times per week. [REDACTED] had been discharged from CHOP with overnight nursing services to assist with the care of [REDACTED]. [REDACTED] services were started for both children. The county agency worker was in frequent communication with the family, as well as the different service providers. There were ongoing issues with the [REDACTED] which required frequent contacts between the county worker, the nursing service, and the [REDACTED].

The parents' relationship was very conflictual. The mother was described as treating the father in a demeaning manner. The father worked during the day while the mother stayed home with the boys. It was reported that the mother left the home in the evenings to spend time with friends, and would often return home about 3 or 4 am. The county and provider worker were encouraging the mother to return to high school with the support of [REDACTED]

[REDACTED] was born 7/27/2012. None of the service providers (Family Preservation provider, nurses, [REDACTED]) or the county worker was aware that the mother was pregnant. The mother initially reported being 5 months pregnant, but [REDACTED] weighed over 8 lbs at birth. After delivery, the mother experienced [REDACTED]. She was diagnosed with [REDACTED]. She also was experiencing high blood pressure.

**Circumstances of Child Near Fatality and Related Case Activity:**

On the evening of 10/17/2012, the mother had left the home to visit friends. The nurse was in the living room providing care to [REDACTED]. The father was sleeping in the bedroom with [REDACTED]. The nurse heard the father get up twice during the night to get a bottle and diaper for [REDACTED]. About 3:30 am on October 18<sup>th</sup>, the nurse heard the victim child cry loudly, and then suddenly stop. The father came out of the bedroom and said that [REDACTED] had become limp in his arms and was barely breathing. The nurse began CPR and instructed the father to call 911. Paramedics arrived and took the child to St. Mary's Hospital. [REDACTED] worker and police conducted a joint investigation. Multiple interviews were done with family members and medical personnel. The safety assessment and plan were completed. The safety plan was that the county would [REDACTED]

**Current Case Status:**

This investigated was [REDACTED] both parents as the child had old and new brain bleeds, and both parents had access to the child. Neither parent has provided a credible explanation for the child's injuries. The victim child is progressing well. He will be monitored for developmental milestones by his pediatrician. The police investigation is still ongoing. The DA's office and police are waiting for a final written report from the physicians at CHOP before filing charges. [REDACTED]

[REDACTED] Visits have had to be separate for each parent as the parents were getting into arguments during the visits. Paternity testing was completed [REDACTED] [REDACTED] is not his biological father. The mother has identified another man as the father and the county is completing paternity testing on him.

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

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. The county agency convened a review team in accordance with Act 33 of 2008 related to this report on 11/15/2012.

**Strengths:**

- Quality and quantity of ongoing services provided to the family: medical, nursing and family preservation services.
- The engagement of the parents.
- Nurse being in the home at the time [REDACTED] was injured.
- Hospital staff being diligent in their assessment of [REDACTED] abuse.
- Agency staff had several conferences with the agency solicitor about the possibility of pursuing legal custody of these children. The service providers reported that the parents were doing well meeting the children's needs.
- When [REDACTED] initially broke his wrist, [REDACTED].

**Deficiencies:**

- None identified

**Recommendations for Change at the Local Level:**

- Obtain medical review of [REDACTED] previous injuries (broken wrist and [REDACTED]) to re-assess that perhaps this was not accidental, as had been previously determined.
- Request in the county agency's Needs Based Plan and Budget for inclusion of respite care and homemaker services to support families in their homes.
- Continued collaboration between the county agency and Falls Township Police Department about the county agency's request for a polygraph of [REDACTED].

**Recommendations for Change at the State Level:**

- None identified

**Department Review of County Internal Report:**

The Department received the county's review on 1/11/2013. This report represents a thorough description of the circumstances of the investigation and of the meeting. This family represents a large percentage of child welfare cases: young parents with limited education and resources. The county implemented and coordinated with many service providers and consulted with their solicitor and the courts. Despite the implementation of services, there is still the dilemma of how to predict which parents could have the potential to injure their children.

**Department of Public Welfare Findings:****County Strengths:**

- Quick response time to [REDACTED] report.
- Good collaboration with the police and DA's office.
- Services were offered to the family after several [REDACTED] reports which identified concerns about young parents coping with very young children.
- Continuous communication with service providers involved with this family.
- Agency advocacy with other public agencies to ensure continuity of medical care, i.e. maintaining medical [REDACTED] coverage.

**County Weaknesses:**

- None identified

**Statutory and Regulatory Areas of Non-Compliance:**

- None identified

**Department of Public Welfare Recommendations:**

The Commonwealth needs to explore options to assist young parents, not just with parenting, but with basic life skills. These efforts would include education through the public schools, hospitals, doctors' offices, and other assistance offices.