



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



DATE OF BIRTH: 12/8/11

DATE OF NEAR-FATALITY: 4/13/12

DATE OF ORAL REPORT: 04/13/2012

FAMILY KNOWN TO:

Bucks County Children and Youth Services

REPORT FINALIZED ON:

September 24, 2013

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 meeting on May 7, 2012, in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	12/08/2011
[REDACTED]	Brother	[REDACTED]/2011
[REDACTED]	Sister	[REDACTED]2006
[REDACTED]	Mother	[REDACTED]/1977
[REDACTED]	Father	[REDACTED]/1970
[REDACTED]	Maternal Grandmother	unknown

Notification of Child Near Fatality:

On April 13, 2012, Bucks County Children & Youth Agency received a report [REDACTED] with the following information: The victim child was brought to the Emergency Room at Children's Hospital of Pennsylvania (CHOP) on April 11, 2012 due to lethargy and extreme irritability. The child was described to go "limp" at times. The child was medically seen and discharged only to return on April 13, 2012 due to vomiting and a poor appetite. The victim child was admitted on April 13, 2012, given a full skeletal scan and found to have injuries consistent with [REDACTED]. Due to the age of the victim, medical authorities suspected the child's condition to be as a result of non-accidental trauma. The child's mother, father and day care provider were considered to be "persons of interest" during the initial phases of the CPS and police investigation due, in part, to their substantial caretaking responsibilities.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the family case file which included the child's medical reports, police reports, safety assessments and plan, a family service plan, [REDACTED]. Follow-up interviews were conducted with the Bucks County CYS worker and Supervisor, who completed the [REDACTED] investigation and the worker who provided [REDACTED] services to the daycare provider's family. The regional office also participated in the County Internal Fatality Review Team Meeting which occurred on May 7, 2012.

Summary of Services to the Family:

- CPS Investigation
- Collaboration with Bensalem Township Police Department
- Ongoing collaboration with medical professionals at CHOP
- [REDACTED]
- [REDACTED] referral to the family of the victim child

Circumstances of Near Fatality and Related Case Activity:

On April 13, 2012, Bucks County Children & Youth Agency received a report from [REDACTED] with the following information: The victim child was brought to the Emergency Room at CHOP on April 11, 2012 due to lethargy and extreme irritability. On that date, the child had been dropped off at the day care provider's home. Mother reported that the child's behavior and physical condition were "normal" before being dropped off at the home. The daycare provider later called mom stating that the child had an apparent seizure and had passed out. The child was described to go "limp" at times. The provider chose not to call an ambulance at that time but instead waited for the parents to arrive and take the baby to the hospital. The child was medically seen at St Mary's Hospital and then transferred to CHOP. The child was initially diagnosed [REDACTED]. The child was [REDACTED] only to return to CHOP on April 13, 2012 due to vomiting and a poor appetite. The victim child was admitted on April 13, 2012 and given a [REDACTED] scan and found to have injuries consistent with [REDACTED]. The child was diagnosed with [REDACTED] and had [REDACTED]. The child also had a large [REDACTED]. The child also had an [REDACTED] injury which was consistent with [REDACTED]. Due to the age of the victim, medical authorities suspected the child's condition to be a result of non-accidental trauma.

The child's mother, father and day care provider were considered to be "persons of interest" during the initial phase of the investigation due in part to their substantial care giving responsibilities. The parents were given separate polygraphs by the Bensalem Twp. Police and questioned by Bucks County CYS. CHOP also gave an opinion about the parents. They were cleared of all allegations and therefore the safety plan related to their care and supervision of the children was lifted. The grandmother was also cleared, as she did not spend enough alone time with the grandchildren to be considered an alleged perpetrator (AP). The victim child's 6 year old sister has never been cared for by the babysitter as she is in school. She was questioned by the Children and Youth worker and expressed no concerns about her biological family. The victim child's twin brother was given a [REDACTED] scan and medical examination at CHOP and there were no issues.

The day care provider had been caring for the victim child and his twin brother for two weeks before the incident. The day care provider was also caring for other children and was determined to be operating an unlicensed day care. In addition, the day care provider has 3 young children of her own. On the day in question, the day care provider described the child's behavior as "fussy" and irritable requiring much of her attention. The day care provider stated that the child also "cried a lot, turned red, went rigid, and the child's eyes rolled in the back of his head." The day care provider chose not to call an ambulance at that time but instead waited for the parents to arrive and take the baby to the hospital. She has denied causing any injury to the child and does not know how the child's condition occurred. The day care provider participated in interviews with the police and the Children and Youth worker but refused a

polygraph. On June 11, 2012, the Bucks County Children and Youth agency determined the report to be indicated regarding the day care provider, based on the child's unexplained injuries and the perpetrator likely being the day care provider at the time the injuries occurred.

Current Case Status:

The family's case was closed shortly after the parents were cleared of the allegations concerning [REDACTED] of their son, [REDACTED] and [REDACTED] that was made on June 11, 2012. There were no further concerns about the ongoing care and supervision of their children.

[REDACTED] has been doing well but has not fully recovered from his injuries. The child had [REDACTED] in early September, 2012. The child is recovering nicely and is being followed on an outpatient basis at CHOP. [REDACTED] has had [REDACTED] screenings that suggest the [REDACTED] which are being addressed.

The day care provider was arrested on August 21, 2012 and charged with aggravated assault, simple assault and endangering the welfare of children. She was arraigned on August 27, 2012 and released on \$75,000 unsecured bail. She is currently awaiting trial and is under court order not to care for or be in proximity with any other children other than her own children and that of a relative (specifically nephews).

Currently, the day care provider's family is receiving [REDACTED] services from the Agency. The current safety plan is that there are to be 2 identified care givers with their own children at all times. There have been no ongoing areas of concern regarding the care and supervision of the day care provider's children during the length of time that the case has been opened. The day care provider continues to deny causing the injuries to the victim child.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's 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 (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. This meeting took place on May 7, 2012 at the Bucks County Children and Youth Agency's office in Doylestown, Pa.

Strengths:

The County reports that the family was not opened to the Bucks County Children and Youth Agency at the time when the near fatality referral was received, nor did either family have any previous CYS intervention. The Agency felt that the CPS investigation was completed in a timely fashion. The requirements of providing written and oral notifications were met. The CY-48 was filed within 60 days. Safety and risk assessments were completed and a safety plan was executed to ensure the safety of the child and other siblings.

Deficiencies:

Neither the victim child's family nor the day care provider's family was ever known to the Bucks County CYC prior to the near fatality report, therefore, there were no deficiencies related to compliance with applicable statutes and or regulations.

Recommendations for Change at the Local Level:

Bucks County did not note any needed change at the local level as the day care that was being operated by the perpetrator was unlicensed. The county's licensing authorities were notified and the day care was immediately investigated by Bucks County Labor and Industry and shut down. OCDEL was notified of the incident; however, since the home was unlicensed and unknown to them, they declined involvement and did not issue any citations.

Recommendations for Change at the State Level:

Bucks County Children and Youth did not note any needed changes at the state level.

Department Review of County Internal Report:

The Department received and reviewed the county report dated May 17, 2012 and is in agreement with the County's findings. As stated earlier, the case was not open with the Agency at the time of the incident. The Department noted that the County Agency conducted and completed an appropriate [REDACTED] investigation that was well supported by extensive medical documentation from CHOP as well as a police investigation that culminated with the arrest of the perpetrator.

Department of Public Welfare Findings:

Strengths:

The current CPS investigation involving the child was completed within 60 days fulfilling all regulatory requirements of the CPSL and Chapter 3490. The child remains in the home and is being cared for appropriately by his parents. The child continues to receive medical care for his condition. A safety plan was made for the safety of the victim child, siblings as well as the children of the perpetrator.

Deficiencies:

Discussion at the MDT identified unlicensed day care providers as an issue and focused on areas of concern with respect to (1) what constitutes and defines an unlicensed site (2) notifying the public of the dangers of unlicensed providers (3) early detection of unlicensed day care sites (4) appropriate penalties to be levied when an unlicensed site is discovered as well as (5) incentives that can be offered to make being "legal" more attractive.

Department of Public Welfare Findings:

The County conducted an investigation in conjunction with Bensalem Twp. Police and the Children's Hospital of Philadelphia (CHOP). The perpetrator was the only adult identified as the care taker for the child at the time of the

incident. The medical findings were consistent with non-accidental trauma and the police investigation culminated in the arrest of the perpetrator on numerous child abuse and endangerment charges. The outcome of the CPS investigation that the County conducted was indicated.

Department of Public Welfare Recommendations:

The Department is in agreement with the recommendations of the County that have been presented at the Act 33 review. The Department has no further recommendations at this time.