



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 04-19-2012
Date of Incident: 01-12-2015
Date of Oral Report: 01-12-2015

FAMILY NOT KNOWN TO:
Bucks County Children and Youth

REPORT FINALIZED ON:
August 27, 2015

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 did not convene a review team in accordance with Act 33 of 2008.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	04/19/2012
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Mother's Paramour	[REDACTED] /1986
[REDACTED]	Maternal Grandmother	Adult
[REDACTED]	Maternal Grandfather	Adult
[REDACTED]	Maternal Uncle	23 Years old
[REDACTED]	Maternal Aunt	21 Years old
[REDACTED]**	Father	[REDACTED] /1980

** Not in household

Notification of Child Near Fatality

On 01/12/2015, the reporting source stated that the child was found around 6:00 pm unresponsive and "blue". The mother's paramour and maternal grandmother were watching the child while the mother was at work. The maternal grandmother stated that she put the child down for a nap around 3:00 pm. The family reported that there were no empty medication bottles found in the home. EMS brought the child to the Lower Bucks Hospital due to cardiac arrest. The child was unresponsive and in cardiac arrest when she arrived at the hospital. [REDACTED] [REDACTED] The mother's paramour told EMS that there were narcotics in the home. Maternal grandmother has [REDACTED] and has numerous medications in the home [REDACTED] [REDACTED]. The maternal grandmother and mother's paramour had been watching the child at the time of the incident. The child was given [REDACTED] to reverse any [REDACTED] [REDACTED] and was certified by the doctors to be in critical condition upon her arrival at the hospital [REDACTED]. This was suspected to be neglect if the child was not being observed and had access to some of the medications. It is believed that the child's cardiac arrest was due to ingestion of some type of narcotic. The child was not able to communicate and could not explain how she got the medications.

Summary of DHS 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], the Supervisor, [REDACTED] and the Agency Director, [REDACTED], on April 13th and 23rd 2015.

Children and Youth Involvement prior to Incident:

The family had no prior involvement with Bucks County Children and Youth or any other social services agencies.

Circumstances of Child Near Fatality and Related Case Activity:

The reported allegations were investigated and all household members were interviewed. The mother's paramour was named as a perpetrator as he was acting in a care giver capacity when the incident occurred. He explained to the Bucks County worker that he took his fiancé to work at 8:30 am, ran some errands and later came home at 11:30am. He stated that the child was running around and everything was normal. At 5:15pm he left to go and pick up his fiancé, the mother of the victim child, from work. Her parents were watching the child while he was out. Upon their return, he stated that his fiancé went upstairs to check on the child. The maternal aunt stated to her sister that she thought the victim child was having a night mare because she was breathing rapidly. The mother picked up the child; she went limp and her lips were blue. The paramour contacted the Bucks County [REDACTED]. The cops arrived at the home with the EMT. The paramour was asked about the medications in the house and also advised the paramedics that the maternal grandmother [REDACTED] She keeps these medications in her bedroom in an unlocked box.

On 03/06/2015, the Child Protective Services Investigation was unfounded based on the investigation and medical evidence. It was determined that the incident was not caused intentionally, knowingly or recklessly.

Current Case Status:

The case has been closed with the county.
There was no criminal investigation.

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

County CPS investigator and supervisor were not aware that this was certified as a near fatality, so an Act33 review was not held.

Department Review of County Internal Report:

Bucks County received this report on 01/12/2015 through the Child Welfare Information Solution (CWIS). Due to the change in communication from ChildLine of the fatality/near fatality reports and the high volume of reports that were coming in through CWIS, the County was not aware that this was certified as a near fatality.

Department of Human Service Findings:

- **County Strengths:**
The County collaborated with the hospital in the investigative and treatment processes. The County has also provided lock boxes to all families that have individuals in their homes with similar conditions.
- **County Weaknesses:**
The County CPS investigator and supervisor were not aware that this was certified as a near fatality, so an Act33 review was not held. However, the county completed a thorough investigation and collaborated with police and medical professionals in making their determination.
- **Statutory and Regulatory Areas of Non-Compliance:**
The Agency will not be cited for this non-compliance. At the time of this near fatality report, many counties were experiencing overwhelming numbers of new reports and having difficulties with the implementation of CWIS. The County reported that they experienced a 92% increase in calls with the implementation of CWIS and the new CPSL.

Department of Human Service Recommendations:

After conversation with a Bucks County administrator, the agency will refine its protocol of reviewing and assigning cases as they come in through CWIS.

Other counties should replicate the County's practice of providing lock boxes to families with substance abuse issues.