



REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 03/17/2014
Date of Incident: 07/26/2015
Date of Report to ChildLine: 07/26/2015
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Bucks County Children and Youth Services

REPORT FINALIZED ON:

04/19/2016

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Bucks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 0-8/25/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	03/17/2014
[REDACTED]	Maternal Grandmother	[REDACTED] 1962
[REDACTED]	Maternal Grandfather	[REDACTED] 1962
[REDACTED]	Maternal Uncle	[REDACTED] 1994
[REDACTED]*	Biological Mother	[REDACTED] 1994
[REDACTED]*	Biological Father	[REDACTED] 1995

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near-Fatality Review Activities:

Southeast Regional Office of Children, Youth and Families (SERO) attended the Act 33 review on 08/25/2015. SERO also reviewed all records, including the medical records, the current investigation, and the earlier investigation in March 2015. SERO spoke with the county worker and supervisor on 01/07/2016.

Children and Youth Involvement prior to Incident:

On 07/26/2015, a report was made to Bucks County Children and Youth Services, stating that [REDACTED] age 12 months, had a change in mental status. He was brought to Doylestown Hospital because he was lethargic. [REDACTED] and it was found that he had [REDACTED] in his bloodstream. Reportedly, there were controlled substances in the home, including the [REDACTED] and [REDACTED]. It was thought that her son, who was allegedly abusing drugs, had dropped a pill that he had stolen from the grandmother. The grandmother was given a locked box for her medications, and she was told that she should not allow her son to come to the house. The grandmother was also advised

to file a police report if she believed that her son stole her medications in the future. This report of maltreatment was not substantiated and it was determined that no further services from the agency were warranted.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/26/2015, maternal grandmother had difficulty waking up the child in the morning. He was lethargic and had difficulty breathing. She took him to Doylestown Hospital. The attending physician believed that the child had [REDACTED]. On questioning, maternal grandmother at first did not mention her medications. On further questioning, she reported that she is taking [REDACTED] and other medications. The child was [REDACTED] and within seconds the child woke up and was alert. A urine toxicity screen was given [REDACTED]. The child was found positive for [REDACTED] and he had a Tylenol level of 10.4, with an unknown time of ingestion. The child was transported to Children's Hospital of Philadelphia (CHOP). At CHOP, a visitation restriction was implemented, restricting maternal grandmother's visits with the child. The child was admitted to the [REDACTED].

[REDACTED] CHOP was asked to maintain the visiting restriction, and family was explored for placement. The mother and her paramour were interviewed by phone to determine if they could take the child. It was noted that they both sounded impaired, and the mother said she did not know how she would provide for his needs. A maternal great-aunt was located to take the child. Clearances were run on that family. The family picked up the child from the hospital, and the caseworker met the family and the child in their home when they arrived home.

On 08/31/2015, the report was indicated for the maternal grandparents for "Causing Serious Physical Neglect of a Child, Repeated, Prolonged, or Egregious Failure to Supervise," according to the Indicated report submitted in the Child Welfare Information System (CWIS). The maternal grandparents failed to implement recommended procedures to secure [REDACTED] medications.

Law enforcement officials have declined to press charges in this case, as the cause of the ingestion of the medications is not known.

The child has reportedly made a full recovery, and he is achieving all developmental milestones. The child is placed with his maternal great-aunt and great-uncle, who are not able to be long-term resources for the child. The paternal grandparents expressed interest in becoming kinship resources for the child. The paternal grandparents have overnight visits with the child. [REDACTED]

Both parents have separate 2-hour weekly visits supervised by the county. The county is exploring implementing supervised visits through [REDACTED] to give the parents more support to improve their parenting skills. The mother has some

additional visits supervised by the maternal great-aunt in the maternal great-aunt's home. The maternal grandparents are able to visit in the maternal great-aunt's home, supervised by the great-aunt.

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

- Strengths in compliance with statutes, regulations and services to children and families;
The Review Team summarized strengths including: immediate response regarding [REDACTED] and the [REDACTED] family, appropriate questioning and follow-up, collaboration with law enforcement and the District Attorney's office, and a "healthy suspicion" regarding this repeated incident and the need for the child's removal from the home.
- Deficiencies in compliance with statutes, regulations and services to children and families; None identified
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
In near-fatality or fatality incidents where substance abuse/misuse is involved, a representative from the Bucks County Drug & Alcohol Commission should be included to educate families regarding drug and alcohol/services.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and None identified
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
The Child Advocacy Center (CAC) and/or Agency should follow-up, particularly with the Children's Hospital of Philadelphia, around protocols in toxicology reporting, specifically when and what is the protocol for performing toxicology testing, especially for children presenting with illegal drugs in their system. Children & Youth agencies need specific information regarding types and levels of medications in a child's system to more fully investigate and to determine the nature and origin of ingested substances.

Hospital staff should be educated on the signs of possible child abuse, and assisted in the development of an objective understanding of the potentiality of child abuse.

Department Review of County Internal Report:

The Department concurs with the county internal report.

Department of Human Services Findings:

- County Strengths: County staff conducted a thorough investigation, and collaborated well with stakeholders.

County staff identified concerns regarding the ability of the hospital to test children for specific substances, and medical staff's view that a report did not need to be called in to ChildLine regarding the child's ingestion of [REDACTED]. County staff committed to addressing these concerns with Children's Hospital.

- County Weaknesses: None identified
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None identified

Department of Human Services Recommendations:

During the Act 33 meeting, some team members discussed concerns with the grandmother's [REDACTED] doctor, who was prescribing [REDACTED] medication without additional monitoring of the grandmother, or guidance regarding the storage and use of the medications in her home. It is recommended that local law enforcement or medical authorities closely monitor physicians who specialize in [REDACTED].

