



## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 01/07/2015**  
**Date of Incident: 09/04/2015**  
**Date of Report to ChildLine: 09/04/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Bucks County Children & Youth Social Services Agency

**REPORT FINALIZED ON:**  
04/18/2016

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.

Philadelphia 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 10/01/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/07/2015
[REDACTED]	Biological Mother	[REDACTED] 1982
[REDACTED]	Biological Father	[REDACTED] 1971
[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Renter	[REDACTED] 1973
[REDACTED]	Paternal GF of [REDACTED]	Unknown
[REDACTED]	Paternal GM of [REDACTED]	Unknown
* [REDACTED]	Father of [REDACTED]	Deceased
* [REDACTED]	Father of [REDACTED]	Unknown

\* 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:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current records pertaining to the [REDACTED] family. Follow up interviews were conducted with [REDACTED] on 02/16/2016 and [REDACTED] [REDACTED] Child Protective Services Caseworker on 02/11/2016. The regional office also participated in the County Fatality Review Team meetings on 10/1/2015.

**Children and Youth Involvement Prior to Incident:**

This family was not known to Bucks County Children & Youth Social Services Agency.

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

On 09/04/2015 police responded to a 911 call made by [REDACTED] due to victim child drowning in the tub. The biological mother reported to the police that she went to grab a towel and when she returned the child was face down in the bathtub unconscious. The officer at the scene found the biological mother's story flawed because the towel closet was beside the bathroom and it would take her seconds to grab the towel and come back to the bathroom. Bucks County Children & Youth Social Services Agency was notified [REDACTED] that an 8 month old male infant nearly died due to being face down in a bathtub full of water. Bucks County Children & Youth Social Services Agency investigated the case and named the victim child's biological mother as the perpetrator. In light of the incident there were conflicting recollections of the events that occurred that day. The biological mother reported that victim child and sibling [REDACTED] were left in the bathroom with victim child in the bathtub with the stopper not in the tub and water running. The sibling was standing in the bathroom while the biological mother went to answer the phone believing the doctor was calling her back. The biological mother reported that she called the doctor's office earlier due to a bug bite on victim child's nose. However, biological mother reported that it was actually the other sibling's father calling and she reported that she was on the phone for approximately 2-3 minutes. When she returned to the bathroom she found the victim child face down in the bathtub with the stopper in the drain. The biological mother went downstairs to renter, [REDACTED], who performed CPR on victim child until police and EMT arrived. The victim child was transported to St. Mary's Hospital and once evaluated was transferred to St. Christopher Hospital. During interviews at the Child Advocacy Center (CAC), the siblings, ages 11 and 7, reported that [REDACTED] was not in the bathroom with victim child when incident occurred but was watching television in the living room and the biological mother was on the telephone with [REDACTED] biological father for approximately 10 minutes. This was confirmed by [REDACTED] (father) who had no knowledge that victim child was in the bathtub unattended. The safety plan put into place during the investigation was that the paternal grandparents [REDACTED] of [REDACTED] would supervise both biological father and mother of the children at all times. This report was indicated on the biological mother due to serious physical neglect of a child on 10/16/2015. The biological mother is receiving [REDACTED] parenting weekly through a program called [REDACTED] and the victim child is progressing well. The biological mother was arrested on 10/22/2015 and charged with recklessly endangering another person and endangering the welfare of a child. She was released on bail.

It was learned that prior to the incident, the biological mother and biological father of the victim child were involved in arguments, especially when alcohol was involved. The biological father was previously arrested due to assaulting the biological mother and placed on probation but complied with his probation requirements. It was reported that both would drink alcohol excessively; however,

biological father [REDACTED]  
[REDACTED]

**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 team noted strengths including: collaborative relationships among the police department, district attorney's office, CAC, St. Christopher's Hospital and Children and Youth; the Safety Plan which engaged relatives for supervision; and the children remaining in their home school district.
- Deficiencies in compliance with statutes, regulations and services to children and families;  
No recommendations
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;  
Continued community education on child development, child safety, and parenting.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and  
No recommendations
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.  
Discussion ensued regarding the variability of determinations made by medical professionals in suspected child abuse and/or near fatalities. Specifically, at St. Mary Hospital [REDACTED], there appeared to be some reluctance in certifying this incident as a near fatality. After [REDACTED] case was reviewed at St. Christopher's [REDACTED], an expert in child abuse, the incident was certified a near fatality due to the child's need for intervention (CPR) to survive. Therefore, depending on where and by whom a child is medically treated, a determination regarding child abuse/near fatality could vary greatly.

**Department Review of County Internal Report:**

Bucks County Children & Youth Social Services Agency submitted the county report on 11/12/2015 and discussion surrounding issues was also discussed during the Act 33 review meeting. OCYF concurs with the findings of this report.

**Department of Human Services Findings:**

- County Strengths: Good collaboration between county police department, District Attorney's office, CAC, St. Christopher's Hospital and Bucks County Children & Youth Social Services Agency.
- County Weaknesses:  
None
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.  
None

**Department of Human Services Recommendations:**

It is recommended that there be more clarification issued to hospitals statewide with regards to certifying child Near Fatalities/Fatalities.