pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/13/2016
Date of Incident: 12/22/2016
Date of Report to ChildLine: 12/22/2016
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:
06/09/2017

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 01/13/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	12/13/2016
[redacted]	Mother	[redacted]1990
* [redacted]	[redacted] father	Unknown
* [redacted]	Maternal sibling	[redacted]2013
	Father of [redacted]	[redacted]1991

* 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 Region Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the [redacted] family. SERO staff reviewed various reports, assessments and case documentation provided by Bucks County.

Summary of Circumstances prior to Incident:

On 06/05/ 2015, Bucks County Children and Youth Services (CYS) received a referral regarding the family due to concerns of an empty syringe being found in the crib of the mother's 2-year-old son. At the time of this incident, the mother and the victim child were living in the child's maternal grandparent's home. The mother was asked to leave the home following this incident. [redacted]

The Bucks County CYS agency provided services and helped facilitate [redacted]

[redacted]

On 07/13/2015, the father of the 2-year-old son [redacted] He could not care for the child and the mother's whereabouts were unknown.

On 07/16/2015, the sibling [redacted] was placed with his maternal grandparents.

[redacted]

[redacted] The mother actively used heroin from 10/2015 through 04/2016 [redacted]

[redacted] She remained homeless from 10/31/2016 through 12/01/2016. She then obtained housing with the father of the victim child.

Circumstances of Child Near Fatality and Related Case Activity:
On 12/13/2016, the victim child was born at the Grandview Hospital in [redacted], Pennsylvania. [redacted] She was later transferred to the [redacted] for continued observation.

On 12/23/2016, Bucks County CYS received a report of suspected abuse regarding the 10-day-old victim child. The victim child had been hospitalized since her birth. It was reported that the mother reported that she accidentally dropped the child, the day before 12/22/2016. The alarm went off in the hospital room and a nurse came in to check. The mother did not tell the nurse she had dropped the victim child, but stated everything was fine. Later that day on 12/22/2016, a nurse came in to check on the victim child and noticed a bump on the baby's head. At this time, the mother informed the nurse that she had dropped the baby.

On 12/23/2016, the victim child was transferred to Children's Hospital of Philadelphia (CHOP) [redacted] was on the right side of her head. [redacted] Upon interviews, the mother reported that she did not tell nursing staff that she had dropped the baby for fear of getting into trouble. The mother reported that she checked the baby after she dropped the child and felt she was alright. At this time, a safety plan was put into place and the mother was not to hold the baby

pending the investigation. The agency social worker also informed [redacted] who was caring for the child of the verbal restriction that was being implemented. The mother informed the agency social worker that she had been sitting in a chair while feeding the child and fell asleep. The mother further reported that when she woke up to put the baby back in the crib, the chair foot rest was in an up position. The mother reported that she could not get the foot rest down and she attempted to step over the foot rest. The mother stated that she somehow ended up dropping the baby while in a standing position. The mother stated that the baby cried initially. The mother stated that that the baby was easily soothed and went back to sleep.

On 01/2/2017, Bucks County CYS received a report of the mother dropping the victim child a second time. It was reported that a second fall occurred in the overnight hours. This was a non-witnessed event. The mother reported she was again holding the baby while feeding her and fell asleep in the chair. The mother continued to report that she stood up to put the baby back in the crib and dropped the child. [redacted]

[redacted] The child was placed with her [redacted] father. [redacted] The mother did not provide any other family or friend resources for the child. A General Protective Service case remains open to monitor the victim child's care. [redacted]

On 01/06/2017, the mother was arrested and charged with aggravated assault, endangering the welfare of a child and simple assault. She remains in the [redacted] Correction Facility. If the mother is released on bail she is to have no contact with the victim child. The oldest child of the mother remains [redacted] foster placement with his maternal grandparent. [redacted]

The Bucks County CYS has [redacted] the child abuse determination due to the criminal proceedings. The trial is scheduled for 05/31/2017, for mother's charges of endangering the welfare of a child; all of the other charges were dropped.

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

Information in this section is copied directly from the county report.

- Strengths in compliance with statutes, regulations and services to children and families;
  Comprehensive services were accessed and provided to the mother including [redacted]
  Excellent collaboration existed amongst the Agency and all service providers Working with [redacted]

- Deficiencies in compliance with statutes, regulations and services to children and families;
  None reported

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  See below
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  Not applicable

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Subsequent to [redacted] hospitalization at Children's Hospital of Philadelphia, the Agency Social Worker advised and cautioned several hospital staff members—[redacted] to monitor [redacted] handling of the baby. Unfortunately, per information provided by [redacted] in the Near Fatality Review, it is not a valid communication to disseminate information to the hospital nursing staff. Additional considerations regarding communication in this near fatality instance could be inconsistent communication between changing shifts as well as the possible decreased staff due to the intervening Christmas holiday.

  During the Review, there was also mention of a cautionary note regarding [redacted] and her baby written on a "white board;" however, [redacted] was confused about why the notice was on the white board and the [redacted] erased the notice.

  Due to this communication issue, the Agency has contacted CHOP's Director of Safe Place: Center for Child Protection and Health/Program Director, Child Abuse Pediatrics to confirm all staff associated with the child abuse program

and to schedule a conference call to discuss communication procedures/protocols for future situations.

Department Review of County Internal Report:
The SERO reviewed the county internal report and finds it to be a comprehensive report and an accurate reflection of the history of the family prior to the near fatality and the circumstances of the near fatality.

Department of Human Services Findings:

- County Strengths:
  - The county followed up with the children's hospital regarding ensuring the safety of the child.
  - The county followed the mother closely regarding her 2-year-old child and her issues of addiction.
  - [redacted] the 2-year-old child [redacted] was placed with maternal grandparents.
  - The county informed the hospital of the mother's pending birth of the victim child.
  - The county provided several services to the mother in regard to her first child.

- County Weaknesses: and
  - None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None noted

Department of Human Services Recommendations:

- There is a need for greater communication and collaboration between the county children and youth agency and the Children's Hospital of Philadelphia regarding safety plans and ensuring the ongoing monitoring and ensuring the safety of children. Especially knowing that the child was hospitalized for non-accidental injuries.
- Safety plans should not be verbal they should be written and posted in the hospital room on the communication board. In addition the hospital administrative staff should be aware of all safety plans.

- Safety plans should be monitored by county children and youth as the hospital staff may not have the staffing to monitor the plan.