pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/17/1999
Date of Incident: 04/07/2017
Date of Report to ChildLine: 04/09/2017
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 & Youth Services

REPORT FINALIZED ON:
08/24/2017

Unreacted 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.

On 05/04/2017 Bucks County Children and Youth Services (BCCYS) convened a review team in accordance with the Child Protective Services Law related to this report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/17/1999
* [redacted]	Biological Mother	[redacted] 1980
* [redacted]	Father of [redacted]	[redacted] 1971
[redacted]	Father of [redacted]	Unknown
[redacted]	Mother's Paramour	[redacted] 1972
[redacted]	Sibling	[redacted] 2000
[redacted]	Sibling	[redacted] 2008

*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 (SERO) obtained and reviewed all past and current case records pertaining to the family. The Regional Office participated in the County Fatality Review Team meeting on 05/04/2017.

Children and Youth Involvement prior to Incident:

The family was known to Bucks County Children and Youth Services (BCCYS) prior to the incident.

Bucks County Children and Youth Services had the following referrals prior to the 04/17/2017, incident:

On 05/04/2016, BCCYS received a General Protective Services (GPS) referral. The referral stated school had not received documentation that middle sibling [redacted] the children were staying in the

home/trailer with the mother's paramour who does not want the children in the home. When the biological mother and the paramour leave the home the children are left alone. The biological mother and her paramour could be heard having sex throughout the trailer. The agency caseworker discussed the referral with the biological mother and paramour, and confirmed that the family could remain in the home. The caseworker verified with the biological mother [redacted] The caseworker met individually with the victim child who reported having no concerns in the home. The referral was closed 06/02/2016.

On 10/07/2016, a GPS referral was received. The youngest sibling went to a neighbor's home at 5:00 AM, and stated he was locked out of his house. The allegations stated that the biological mother and her paramour would leave home for work at 5:00 AM, and the youngest sibling was left home alone, and would wander around the neighborhood in the mornings until he went to school. The biological mother and her paramour were reported to be using drugs, and the paramour would rage and break her things. The middle sibling said that he is afraid most of the time the paramour is in the home. The Agency determined that this incident appeared isolated, and the biological mother had obtained a caregiver in the morning for the youngest sibling. Concerns regarding parental substance abuse and domestic violence were unsubstantiated.

On 10/12/2016 another GPS referral was received. The referral source received an anonymous tip that drugs were being sold out of the home, a small male child (youngest sibling) was left unattended and could be seen walking the street all hours of the night, there were several handguns and high powered long guns that could be heard being shot at the home at least weekly, and the police had been to the home several times. The agency caseworker met with the biological mother and her paramour. The biological mother reported that she and her paramour leave for work around 7:00 AM, and the older boys are home for a time. The biological mother stated that the youngest sibling has been going to work with her and her paramour in [redacted], and then the mother drops child back off at bus station. The biological mother also reported that she has asked a neighbor to watch the child in the mornings. The biological mother denied drug use, but reported that she uses [redacted] The victim child was interviewed and did not report concerns. Prior to close of referral, the biological mother reported having difficulty following through with medical appointments for the children. [redacted] A letter was written to the children's pediatrician confirming follow-up [redacted] appointments and requesting that the pediatrician contact ChildLine if the biological mother does not follow through with medical or healthcare recommendations in a timely manner. Referral was closed on 11/30/2016.

The County received an inquiry on 12/07/2016. An inquiry was made regarding the middle sibling and concern for his overall well-being. [redacted] Referral source was advised that the agency was no longer involved with the family; the referral deemed invalid and filed as inquiry.

On 02/17/2017, the County received another GPS Referral. This report alleged domestic violence between the biological mother and paramour, substance abuse and unclean home conditions were reported in the home. The older sibling and the middle sibling were interviewed but denied domestic violence or drug abuse. The biological mother and her paramour were interviewed, admitted to "normal arguing," but denied any drug abuse. The worker returned to the home on 02/24/2017 to meet with the rest of the family. The biological mother and paramour denied domestic violence and drug use but admitted to drinking beer. During this assessment period, additional information was received which resulted in the following Child Protective Services (CPS) report.

On 03/08/2017, the County received a CPS Referral. The report alleged that the victim child had received a bruise from his mother who had smacked and screamed at him. The referent related that information from the victim child was that his mother was strung out on drugs and "paranoid on drugs." The victim child asked the referent to have someone come see him at school. The intake worker attempted to meet with the victim child in school on this date; however, both the victim child and the middle child were absent. The worker made an unannounced visit to the home to meet with the biological mother and her paramour and the children; no one answered the door. The worker spoke with referent who stated that the victim child was at her home and his eye was swollen shut. Referent stated that the mother is "high on serious drugs." The worker met with the victim child and his girlfriend; the victim child was staying at [redacted] home. The victim child said he was coming out of the bathroom on 02/22/2017 when he bumped into his biological mother spilling her hot coffee and he was scratched by his biological mother's nails on his forehead, eye lid, and cheek. The girlfriend commented that she has seen the biological mother and her paramour smoking marijuana. The victim child's mother stated that she must have grazed him with her nails. The worker requested the mother to take a drug test but the mother refused. Decision was made to transfer this referral to General Protective Services for further follow-up.

On 03/29/2017, the GPS caseworker attempted to reach the biological mother by telephone (voice mail full) and by text message to schedule an appointment. On 04/03/2017, the caseworker made an unannounced visit to the home, no one was home; however, the older sibling arrived home with his girlfriend while the caseworker was there.

On 04/04/2017, a GPS referral was received. The referral stated a senior student at the older sibling's high school confronted a junior student regarding a video of the junior student "huffing an inhalant called dusters." In the video, the senior student was heard encouraging the junior student to huff the inhalant. In addition, the

senior said that he received the drug, [redacted], from the older sibling, and that the older sibling's girlfriend delivered the [redacted] to him, the older sibling was the supplier, and that the middle sibling was present when the transaction took place.

The caseworker followed up with [redacted] regarding the middle and youngest siblings, and met individually with them on 04/05/2017 and 04/06/2017. The youngest sibling admitted that his mother and her boyfriend yell at each other a lot. The caseworker noted when he interviewed the boys that they have difficulty getting in contact with their mother. The oldest sibling said his mother did not check her phone frequently, and the middle sibling stated his mother's phone was out of minutes. Both boys were given business cards asking them to have their mother contact the caseworker.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/09/2017 at 12:24 AM, the County received a CPS referral.The victim child, [redacted] was not feeling well for a few days and had been begging his mother to take him for medical help since 04/6/2017. The victim child's girlfriend had been with him and provided history of what had been occurring. It was stated that the victim child's mother did not know anything about the victim child's medicine and did not seem to care. All day on 04/07/2017, the victim child had episodes of vomiting, had laid flat on the floor, and had not been able to speak coherently since the evening of 04/06/2017, [redacted] On Friday night, 04/07/2017, the victim child was found with his eyes rolling back in his head and was very cold. The mother took the victim child to St. Luke's Hospital in [redacted], and the victim child was then transferred to St. Christopher's Hospital, Philadelphia. A doctor at St. Christopher's ruled the victim child's condition as a near fatality, and it was reported that the victim child could have died [redacted] The victim child had not been seen [redacted] since July 2015; [redacted] The victim child's girlfriend stated she has never seen him take any medicine [redacted] The reason for the head trauma was unknown at the time of the referral.

On 04/09/2017 at 1:35 AM, another CPS referral was received. This referral was regarding the victim child needing dental attention as his teeth were in "terrible condition and it appears as he has never brushed them."

The 24 hour contact was completed by a caseworker. Another caseworker also saw the victim child the same day. [redacted]

Upon receipt of this CPS report, the Agency contacted St. Christopher's Hospital to gather information about the victim child's prognosis. [redacted]

A significant concern for the victim child's [redacted] was it was not being appropriately managed or monitored. He had not been seen by [redacted] since June 2015, which was when he lived in Ohio. He also has [redacted] The victim child moved to Pennsylvania around June of 2015, and since then has only been seen once by a pediatrician, one to two times by a dentist, and once by an [redacted] There is concern regarding the victim child's ability to [redacted] and concerns regarding the biological mother's ability to [redacted] it was necessary for the victim child and the foster parents to complete a training to educate them [redacted]

The victim child [redacted] St. Christopher's Hospital on Tuesday, 04/25/2017, and placed into foster care with his girlfriend's parents. He attended school each day until school ended for the school year. The victim child is doing well medically and has been cooperative with medical appointment follow-up and services suggested by the agency. [redacted] The victim child's siblings are residing with other family member for the summer. The biological mother has been resistant to obtaining services which would include [redacted] parenting education, and in-home family preservation services.

[redacted] Police Department did not press charges against the biological mother.

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, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations:

Although the CPS reports on this case came in on a weekend, there was excellent collaboration amongst after hour's workers from the time of receipt of the reports. The caseworker had made multiple attempts to contact the mother and had met with all children. Communication amongst Agency

departments was efficient; all staff was on the same page in regards to information sharing. Outreach had been made to the children's pediatrician.

- Deficiencies in compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations:

This case exemplifies the difficulty in meeting the demands of the ongoing increase in referrals and need for 24-hour response times. The agency staff is spread thin, and their ability to more fully attend to family issues that are not readily apparent has been reduced. Additional review of work processes is ongoing and is intended to decrease staff overload.

Past history from family's residence in Ohio should have been obtained more expeditiously.

Multiple General Protective Services (GPS) referrals should cause staff to be more cautious and take additional time to assess families. Previous referral (10-12-16) should have been set up for ongoing General Protective Services to provide more effective service provision and monitoring of the family.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

NONE

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies.

NONE

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

BCCYS has traditionally demonstrated good collaboration amongst Bucks County police departments and community agencies. Additional collaboration between County [redacted] professionals and BCCYS would strengthen service delivery to families.

Department Review of County Internal Report:

The Department received the County's report dated 04/17/2017 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

The Team felt that a competent CPS investigation was completed by Bucks County Children and Youth Services. The Team felt that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

County Weaknesses:

Services and monitoring should have been put in place when prior General Protective Services (GPS) referrals where received.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:

Continue with the additional review of work processes intended to decrease staff overload.