



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF

████████████████████

BORN: █████ 2010
Date of Incident: 5/14/2010

**FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE
AGENCIES**

REPORT DATE: 03/31/2011

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(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 by Governor Edward G. Rendell. 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 has convened a review team in accordance with Act 33 of 2008 on 6/8/2010.

Family Constellation:

| <u>Name</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|-------------|---------------------|----------------------|
| ██████████ | Victim child | ██████████ 2010 |
| ██████████ | Mother | ██████████ 1967 |
| ██████████ | Father | ██████████ 1965 |

Notification of Fatality / Near Fatality:

On 5/14/2010 ██████████ received a call that three month old ██████████ had been transported to Children's Hospital of Philadelphia (CHOP) from St. Mary's Hospital in Langhorne with ██████████. The parents reported that ██████████ had been colicky with some recent improvement. According to the parents, the mother had left the home on 5/13/2010 to do some errands for about two hours. Father reported that he fed the baby, and could not get the child to burp. He described the child as fussy. Father reported that he began to give the child a bath, when ██████████ became very limp and unresponsive. Father stated that he began to do mouth-to-mouth at this time. Mother reported that she called father at this time. Mother called nearby family members to go to the home. Father called 911. Father was identified as ██████████ as he was the caretaker at the time the symptoms began. On 5/21/2010, a follow up call was made to ChildLine by CHOP indicating that this is a Near Fatality. ██████████ was determined to have ██████████ have caused him to be blind.

Documents Reviewed and Individuals Interviewed:

For this review the SERO:

- reviewed the county investigation case file.
- interviewed ██████████, the assigned ██████████ investigator from Bucks County Social Services Agency, and ██████████, ongoing worker.
- Attended the County's Internal Fatality Review Meeting regarding this case on June 8, 2010.

Previous CY involvement:

This family had no prior history with Bucks County Children & Youth Social Services Agency, or any other private or public child welfare agency.

Circumstances of Child's Fatality or Near Fatality:

On 5/14/2010 Bucks County Children & Youth Social Services Agency received a call from [REDACTED] about 3 month old [REDACTED]. The baby had been transported to St. Mary's Hospital by ambulance, and then transported to Children's Hospital of Philadelphia (CHOP) on 5/13/2010. Doctors determined that the baby had [REDACTED]. At the time of the call, [REDACTED] was in [REDACTED] at CHOP, having been transferred from St. Mary's Hospital in Langhorne. [REDACTED]'s medical condition included [REDACTED], with no history of trauma to explain the child's injuries. The parents reported that while the mother was out doing errands, the father was caring for the baby. Father stated that he had fed the baby, could not get him to burp, and described Cole as being fussy. Father reported that when he began to bathe the baby, [REDACTED] became limp and unresponsive.

On 5/14/2010, this [REDACTED] investigation was assigned. The worker contacted Dr. [REDACTED], at CHOP and obtained information about [REDACTED]'s medical status. A [REDACTED] continued to have [REDACTED], but was breathing on his own. [REDACTED] were scheduled for later that day. The county worker identified the Plan of Safety for the child being that he would not be discharged until Agency approval. The county worker obtained background information on the parents and [REDACTED] on the mother and father (PennDOT, ACYS, JNET, Domestic Relations).

On 5/14/2010, the county worker planned the investigation strategy with the Lower Makefield police. The police requested that the county worker not interview the parents about the injury, so as to not interfere with the police investigation, and the police agreed to share information gathered during interviews. The county worker would address the child's Plan of Safety with the family. The Safety Assessment was that child was currently safe with a comprehensive plan; the plan was that the child was safe in the hospital and that [REDACTED] would not be discharged from the hospital without Agency approval, pending the outcome of the [REDACTED] investigation.

On 5/17/2010, the Lower Makefield police executed a search warrant of the family home; nothing of note was discovered. Both parents had been interviewed. The detective indicated that Dr. [REDACTED] reported that the [REDACTED] were not accidental. Dr. [REDACTED] stated that the symptoms would have presented themselves within minutes, but not more than two hours, after the trauma. Dr. [REDACTED] told the detective that the [REDACTED] would be a result of shaking, throwing, or an impact.

On 5/20/2010, the county worker received an update on [REDACTED]'s medical status. [REDACTED]'s vision was not good. He was being [REDACTED]. He would need hospitalization for at least another week. Testing indicated [REDACTED]. Dr. [REDACTED] reported that [REDACTED] had very significant injuries to the outside of his brain and global tissue damage, calling this [REDACTED].” He may have a [REDACTED]. He was currently unable to swallow due to the [REDACTED]. He was on high doses of medication to control the [REDACTED], and was very sleepy. [REDACTED] was currently blind; the doctor is unsure if his vision will return. Dr. [REDACTED] expressed optimism that he will be able to recover due to his young age. The doctor reported the mother as being strong, but wondered if she was in some denial about the trauma. Upon discharge from the hospital, [REDACTED] will need physical and occupational therapies. [REDACTED] which would indicate a previous injury. The doctor could not date the injury, but it could be 5-7 days old, or even up to a month old.

On 5/21/2010, [REDACTED], which was less intensive than the [REDACTED] will have a new team of doctors caring for him, but Dr. [REDACTED] will continue on the team. The new team will work to stabilize [REDACTED] with medications and a feeding schedule. On this date [REDACTED]

On 5/25/2010, [REDACTED] would be completed of [REDACTED] later in the week. [REDACTED] was able to eat from a [REDACTED]. Dr. [REDACTED] described [REDACTED]'s injuries as a “[REDACTED]”, and that the injury was the equivalent of a car accident or falling multiple stories. The doctor believed that placement with a family member would be in his best interest. In order for [REDACTED] to be [REDACTED], his caretaker(s) would need to be trained for [REDACTED]

On 5/26/2010, the case was conferenced by the county staff with the county detectives and Lower Makefield police detectives. [REDACTED] may have other [REDACTED] which will be determined by another [REDACTED]. No time frame could be established for [REDACTED]. Neither parent was explaining the injuries that occurred. The revised Plan of Safety was discussed: no contact by Mr. [REDACTED] with [REDACTED], the mother's contact would be supervised. The detectives are taking no action on the previous injuries. The detectives provided a time frame of the events on May 13, 2010.

The mother left the home about 10 or 10:30 a.m.; exact time had not been established. She reportedly called home to ask about measurements for her laptop. This was when she learned of [REDACTED] difficulties. She phoned both of her parents separately; Mr. [REDACTED] called 911. Detectives report that 911 was called at 12:43 pm, and the ambulance had left the site by 12:56 pm. Mr. [REDACTED] reported he was performing [REDACTED]. It was reported that [REDACTED] was breathing during the

911 call. The detectives expressed concern why the father was performing rescue breathing if [REDACTED] was breathing. Detectives had taken pictures of the house but were informed that the family had cleaned up the home before they arrived. [REDACTED] initial symptoms began in the living room (downstairs), and continued in the bathroom (upstairs). Mr. [REDACTED] had given him a bath as he was acting colicky. Prior to this, [REDACTED] had not been bathed for 4 or 5 days, which was typical behavior for the parents. [REDACTED] acted sleepy after the bath. Mr. [REDACTED] reported taking the baby downstairs and swaddled him as he was acting fussy. Mr. [REDACTED] reported [REDACTED] was acting both stiff and limp. [REDACTED] pediatrician is Dr. [REDACTED]

Current / most recent status of case:

On 5/26/2010, a case conference was held at Seashore House in CHOP with the county worker and parents. The Safety Plan would be that the father would have no contact, and that the mother's contact would have to be supervised at all times. The parents were calm and agreed to the plan, understanding that the alternative would be foster care. The parents offered their mothers as resources to supervise in [REDACTED]'s home. The county worker met with both grandmothers in the family home and reviewed the Safety Plan. Both women agreed to be medically trained, cooperated with clearances, and understood that [REDACTED] safety was paramount.

On 5/28/2010, [REDACTED] was [REDACTED] on this date. His [REDACTED] had been removed before he left the hospital. [REDACTED] continued to make improvements. After 12 weeks, his vision cleared. [REDACTED] was referred to [REDACTED]

On 6/3/2010, a conference occurred between the county worker and the Lower Makefield detective. The detective reported that Dr. [REDACTED] determined that [REDACTED] did not have prior [REDACTED]. The worker informed the police of the schedule of the grandmothers supervising the mother's care of [REDACTED].

On 7/1/2010, after the worker spoke with the [REDACTED] the worker and supervisor reviewed the safety plan. They determined that the mother would be allowed unsupervised contact with her son. The worker contacted the mother, and arranged to stop by the home later in the day to have the mother sign the new Plan of Safety.

On 7/12/2010, a supervisory conference occurred to discuss [REDACTED] as the investigation revealed that the father was alone with [REDACTED] for two hours prior to the child displaying symptoms of injury. Medical evidence indicated that these symptoms would have appeared within two hours of injury. A referral was made

to [REDACTED] for ongoing services to supervise the Plan of Safety of the father having no contact with [REDACTED]

On 7/12/2010, this case was referred to [REDACTED] for ongoing assessment.

On 9/9/2010, the father was taken into custody and arraigned. He was being held on \$3 million bail for aggravated assault, endangering the welfare of a child, recklessly endangering another person, and simple assault.

Services to children and families:

- [REDACTED] receives [REDACTED] at his day care (connected to his mother's employment).
- The mother [REDACTED] arranged through her [REDACTED]
- The county agency's weekly visits have been reduced to every two weeks as the risk assessment determined this was no longer a high risk family. [REDACTED]'s mother is very attached to him. She makes conscious efforts to provide stimulation, and is very concerned about his quality of life.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

Strengths-

- Agency met the response time frames as per the Safety Assessment protocol.

Deficiencies-

- None identified.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

- Contact local hospitals and/or the Bucks County Hospital Improvement Partnership (BCHIP) to determine whether videos or information are presented to parents prior to or after birth of a child regarding educating parents on the risk of "shaken baby syndrome".
- Purchase DVD entitled "When Your Baby Cries- Ways to Soothe Your Baby" (produced by Fred Rogers Company for A Child's Place at Mercy, part of the Pittsburgh Mercy Health System) for distribution to hospitals.
- Contact local Agencies, such as Child Home & Community, United Way, Healthy Beginnings to review issues of child abuse risk ("shaken baby syndrome") and explore development of education for parents.
- Address child abuse prevention issues at local Child Death Review meetings (through American Pediatric Association)

SERO Findings:**County Strengths-**

- Frequent and ongoing contact with the hospital
- Collaboration with local law enforcement

Deficiencies-

- None identified.

Statutory and Regulatory Compliance issues:

- None identified.