



OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



Date of Birth: 11/7/2006
Date of Near Fatality Incident: 01/27/2012

FAMILY KNOWN TO:
Bucks County Children & Youth Social Services Agency

REPORT FINALIZED ON: 01/30/2013

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))

Summary of DPW Child Near Fatality Review Activities:

The South East Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the case of the victim child and his family. Follow up interviews were conducted with the Caseworker and her supervisor on February 21, 2012 and March 20, 2012. The regional office also participated in the County Internal Fatality Review Team meeting on February 21, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

12/25/1987 [REDACTED]

Report involved the maternal grandmother, as the case mother. Grandmother's paramour was the [REDACTED] Maternal grandmother's child, then age 2, was struck in the head causing [REDACTED]. The services provided as listed on the [REDACTED] report were protective and preventive social counseling. The child was removed from home and law enforcement was notified,

2/24/2011 [REDACTED]

[REDACTED] was initiated when a report came in regarding bruises on [REDACTED]. Child's mother hit him with a fly swatter leaving bruises. Child had bruising on his face and back. Mother admitted to hitting child with fly swatter because child was attempting to put a toy in an electrical socket. Mother agreed to use alternative methods for discipline. The child's injury did not meet specifications for serious physical injury, and case was [REDACTED]. There were no additional services offered the family at this time.

Circumstances of Child Near Fatality and Related Case Activity:

1/27/2012 [REDACTED]

The initial report for [REDACTED] was made on 1/27 2012. The child was unresponsive to attempts to wake him. The report was made [REDACTED]. There were allegations that the child was able to get into the grandmother's prescribed medicine. The medicine was easily accessible to children and was not stored in child-proof containers. A [REDACTED] investigation was initiated, the family was interviewed and the home was visited by Bucks County C&Y services. Medical staff was also contacted by Bucks C&Y for confirmation of the reason for child's unconsciousness. Initially there was no confirmation or verification that the child's condition was due to taking the grandmother's medicine

1/30/2012 [REDACTED]

[REDACTED] admitted to a doctor at St Christopher's Hospital that he did take medicine from grandmother's prescription. The child had been unresponsive for a full day on January

27, 2012. In the hospital the child remained in [REDACTED]. Tests were conducted at the hospital consisting of [REDACTED] testing. Child was alert and conscious on January 28, 2012. The report was [REDACTED]

2/1/2012 [REDACTED]

It was determined after follow-up interviews and a home visit that caretakers were still not meeting the goals of the safety plan completed and signed on 1/30/12. The safety plan that was in place was that the grandmother was not to be unsupervised with the case children. The family had also received a visit to the home from the Catholic Social Services. The Catholic Social Services had been previously working with the family primarily to help with [REDACTED] for [REDACTED]. There were interviews conducted with the case children by the Children Advocacy Center (CAC). From the visits to the home and interviews it was realized that there were new safety threats. There were allegations of physical discipline, inadequate shelter, lack of food, lack of supervision and possible sexual abuse. In addition the grandmother was found to be unsupervised with case children in defiance to the safety plan. These allegations and observations led to [REDACTED]. The Agency conducted an assessment, [REDACTED] and opened the case for services to address the needs for [REDACTED] intervention for the case mother.

3/13/2012 [REDACTED]

[REDACTED] was completed with a case [REDACTED] for the case involving a near fatality where child was taken to hospital on 1/27/2012.

Current Case Status:

The current status of the case is that the children are [REDACTED] since February 1, 2012. All children are [REDACTED] with the exception of the half-sibling brother, who is living with his bio-father, [REDACTED] and paternal grandmother. [REDACTED]

[REDACTED]. There were two safety plans completed during the investigation. On January 12 the safety plan was that the maternal grandmother was not to be with the children in the home unsupervised by agency approved caretakers. [REDACTED]

[REDACTED]. Services offered during the investigation were counseling and parenting. The children are currently [REDACTED]

[REDACTED]. The current Placement Permanency Plan goal has the placement goal that children should return home and has the following primary objectives; Improve child supervision in care, Participate in appropriate treatment, Improve school attendance/performance, Ensure safety and well being of child, Improve

parenting skills and the/parent-child relationship, and Develop an alternate permanent plan for the child. The alternative plan calls for Long term placement.

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

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 related to this report on 2/21/2012

- Strengths:
The agency staff worked diligently with hospital to locate medical personnel who could substantiate that the child had ingested medication.
- Deficiencies:
A coordinated effort between the hospital and the agency to get information related to this near fatality had not been established. Efforts are now in place to resolve these type issues needing coordinated efforts sooner in the future.
- Recommendations for Change at the Local Level:
The county will include in initial interviews with families a review of the necessity of safe storage of medication; this effort will also include the need for child proof caps on medication bottles, and provide medication lock box if necessary. There will be continued agency participation with Prescription Drug Give-Back events and community education regarding safe storage of prescription medication. Increased collaboration with medical providers is another area where the county will anticipate changes that will reduce the likelihood of future child abuse in response to this near fatality.
- Recommendations for Change at the State Level:
None identified

Department Review of County Internal Report:

The Department of Public Welfare received the county report on April 30, 2012. The County was diligently trying to determine the cause of the child's unresponsiveness immediately after being notified of child's condition. Delays in the decision of abuse and safety impinged on the ability of the medical staff to relay the cause and results of testing. Once it was determined that child had taken improper medication, safety was properly assessed and action was taken to ensure child safety.

Department of Public Welfare Findings:

County Strengths: - Immediate action was taken based on confirmed knowledge at the time actions were taken. The County initiated a prompt response upon receiving a report of the serious condition and near fatality of [REDACTED]. Family interviews and assessments were conducted promptly, appropriately as required. Interviews were set up and conducted by the CAC. The interviews conducted by CAC confirmed problems in the home for children and also identified other issues involving safety for the children. The County also reached out to and made contact with the fathers of all case children.

- County Weaknesses: Relationship with medical personnel did not support immediate decision making, to allow for the most appropriate action to take place early on for the service of the child.
- Statutory and Regulatory Areas of Non-Compliance:
None identified

Department of Public Welfare Recommendations:

The Department of Public Welfare agrees with the County that there should be a contact person or persons at a hospital for situations where medical information would be needed. In this manner vital medication information needed in making safety decisions would be provided much faster.

The Department recommends that the County will initiate a campaign to review with families the necessity of safe storage of medication, the need for child proof caps on medication bottles and whether a medication lock box is necessary would also be helpful in mitigating issues of children taking improper medication of caretakers.