



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 07/11/12  
Date of Incident: 10/12/12

### FAMILY KNOWN TO:

*Not known to any public or private child welfare agency*

### REPORT FINALIZED ON:

June 4, 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))

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. 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 on November 15, 2012 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Mother	01/09/1987
██████████	Father	██████████/1987
██████████	Victim Child	██████████/2012
██████████	Maternal Grandmother	██████████/1952
██████████	Cousin	██████████/1993

**Notification of Child (Near) Fatality:**

Bucks County Children and Youth received a referral ██████████ on October 12, 2012 for ██████████, who was 3 months of age at the time. Child had been seen at Aria Hospital because the parents observed the child having problems with bowel movements; he was not breathing properly and appeared to be having seizures. The child had a Computed Tomography scan (CT-scan) which revealed ██████████ in various stages of healing.

**Summary of DPW Child Near Fatality Review Activities:**

The Department of Public Welfare South East Regional Office of Children Youth and Families obtained and reviewed documentation of the case of near fatality for the victim child. The Regional Office participated in the County Internal Fatality Review Team meeting on November 15, 2012 at the County office in Doylestown, PA. At the time of the meeting it was revealed the father of the victim child had confessed to causing the injuries found on the victim child. The victim child was shaken by the father because he would not stop crying. The father stated he had done this on several occasions. Actual dates of the incidents were not provided. It was determined that the father must have committed the acts between the three month period after child was born, between 7/11/12 to 10/ 12/12. The father had been charged by the police, arraigned and was out on bail. The victim child's health has been improving and will be continuing ██████████ services at St Christopher's Hospital. A follow-up interview was conducted by the County caseworker on 12/20/12. The mother of the victim child did not know anything about the father's involvement until he confessed. The mother has been cooperating with her plan and was receiving ██████████ and evaluation services.

**Summary of Services to Family:**

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

There was no Children and Youth involvement with this family prior to the incident.

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

On 10/12/12 the [REDACTED] investigation began. The result of this [REDACTED] investigation was [REDACTED] by the County on 12/6/12. The investigation began after the victim child was taken to Aria Hospital by his parents because victim child had breathing problems. The victim child was also reported by the mother to have had problems making bowel movements and possible seizures. The hospital performed the CT scan and it revealed that the victim child had [REDACTED] in various stages of healing. Childline was contacted [REDACTED] because of the injuries. A perpetrator was not initially identified but referred to as an unknown household member. Therefore, initially the Alleged Perpetrator was listed as unknown. The County initiated a [REDACTED] investigation immediately. Calls were made to Hospital staff and police. Later the same day at 4pm a visit was made to the hospital where the child was. The child was moved from Aria Hospital to St Christopher's Hospital in Philadelphia and safety of the child was assessed. The parents were also at St Christopher's hospital and they were interviewed. The victim child remained at the hospital.

Father made a confession to hospital staff at St Christopher's Hospital and also to the police that he had been shaking the child on more than one occasion. Father was then identified as the alleged perpetrator. Hospital reported that the victim child remained in the [REDACTED] but that the victim child should be stepped down to the [REDACTED] today. Mother called the County to inform them that she recently found out that the father confessed to shaking the child and she is asking him to move out. Hospital had concerns about the condition of the child and rate of improvement but they felt that there was improvement and they were taking steps to clear the child for release from the hospital. County started assessing concerns regarding child's return home. The County needed to ensure that everyone understood that safety plan that was signed and that they would be providing full cooperation. The County worker will be meeting with the family weekly. The County informed the family that if the Agency becomes aware that the safety plan is broken at any time that the Agency may petition the court for emergency custody of the child. [REDACTED] was modified at Childline to near fatality per County's request. Child's medical history was received from pediatrician.

County made a home visit to interview other household members and to also conduct a Safety Assessment of the home where victim child resides. Assessment was that child was safe with a comprehensive plan. Plan required that victim child's father have no contact until further notice from the County. The plan also required victim child and the mother to reside with a family friend who will be also assisting in plan as supervisor for mother in the care of the victim child. County contacted victim child's father and he was told that he should not have any contact with his son for a minimum of 60 days and that he will have to cooperate with law enforcement. The no contact requirement for at least a minimum of 60 days is part of the safety plan provided to victim child's mother and was also discussed and provided to other caretakers of the child. Victim child was released to the care of his mother by the hospital on 10/17/12.

Starting on 10/19/12 the County made follow-up contacts to check on child and mother after the release from the hospital. County reached out to mother to check on the child and the adjustment at the home. Mother reported that all was well and there were follow up appointments at the hospital that would be made. County worker also made appointment for another home visit. On 10/24/12 the victim child was examined by hospital at the follow-up visit at St Christopher Hospital. Hospital determined that there were new [REDACTED] in the right eye. Child was kept overnight by the hospital. The hospital did extensive checks and on 10/26/12 the hospital could not conclude that the [REDACTED] was indicative of a new episode of abuse. Therefore the victim child was released from the hospital and to the care of the mother.

County received information on 11/01/12 that the Police issued a warrant for the arrest of victim child's father. Father was arrested and held in the Bucks county prison after failing to post bail. He was charged with aggravated assault and endangering the welfare of a child.

Hospital confirmed mother kept a follow-up appointment with the victim child on 11/15/12. Hospital reported that child has [REDACTED]. Medical sources report that the cause of the [REDACTED] were not known for certain, but many of these problems may be due to [REDACTED] to the victim child. The medical source also state they will review [REDACTED] as well. Services initiated for the victim child through [REDACTED] is a local agency that provides in-home and [REDACTED] services. They will be providing services for the victim child to assess and help with his [REDACTED].

On 11/20/12 a home visit made by County worker to mother and victim child. Mother started services with [REDACTED] and they are working with her and the child and they are providing exercises and games with the victim child at home. Also there were scheduled services through [REDACTED]. On 12/24/12 the County called the mother of victim child to find out how the evaluation went with [REDACTED] agency yesterday. Mother stated it went well and was told by the evaluator that she was a good mother. The mother also felt that the evaluator was attentive to her. The County worker did receive follow-up from the agencies providing services to the mother. After reviewing the progress and cooperation the mother had with the in-home services the safety plan was lifted and on-going supports from the County was continued to be provided.

12/6/12  
[REDACTED]

**Current Case Status:**

Mother has been continuing to cooperate fully and has a willingness to work the [REDACTED] Division on-going to address the child welfare issues for general care for her son. Father continues not to have contact with child. An updated plan has been made to ensure that that victim child's father will have no contact with him. Current services for the family include, ensuring for the on-going care for the victim child, obtaining community resources, parenting, and maintaining mother's [REDACTED].

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

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**Strengths:**

The County conducted its investigation immediately to compile and assess the facts of the case to make its determination of the allegation reported by the Hospital. Services were provided to ensure the care and safety of the child and mother. Communication from the Hospitals, Medical Providers, Family and Law Enforcement was constant during the case service development.

**Deficiencies:**

No deficiencies are attached to this near fatality

**Recommendations for Change at the Local Level:**

The County has indentified the use of making follow-up contacts with area hospitals with giving specific attention toward child abuse (shaking\head) in pre-birth classes and prior to maternity discharge. Outreach to the community should show favorable outcomes and evaluations of this effort may be necessary to realize its effectiveness. A DVD informing parents of what to do when your baby cries has previously been distributed to area hospitals. The follow-up by County will review its distribution of DVD's with the hospitals. The County may also consider in person presentations to parents in pre-natal care and/or post delivery.

**Recommendations for Change at the State Level:**

None were identified

**Department Review of County Internal Report:**

The Department of Public Welfare received the county report on January 8, 2013. The County was diligent in its initial effort of conducting interviews with hospital staff and the family of the victim child. Early in the investigation, the perpetrator was unknown. The mother and the father provided no information as to how the victim child was injured. Three days after the report was made the father did admit to having caused the injuries that the victim child received. A Safety Plan was put in place and Assessments were completed. During the investigation it was evident that the child's safety was being adhered to.

**Department of Public Welfare Findings:**

**County Strengths:**

The County conducted its investigations timely and thoroughly during the processing of its [REDACTED]. Safety was assessed and ensured for the child properly. Follow-ups with family members and service providers appear to have been constantly made.

**County Weaknesses:**

There were no County weaknesses identified.

**Statutory and Regulatory Areas of Non-Compliance:**

There were no Areas of non-compliance for this report.

**Department of Public Welfare Recommendations:**

There are no recommendations from the Department of Welfare at the time