pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/15/2017
Date of Incident: 07/07/2017
Date of Report to ChildLine: 07/08/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS

Bucks County Children and Youth Social Services Agency

REPORT FINALIZED ON:
01/09/2018

Office of Children, Youth, and Families, Southeast Regional Office
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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 08/04/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	02/15/2017
	Mother	[redacted]1994
	Maternal Sibling	2013
	Maternal Grandmother	1973
	Maternal Grandfather	1973
*	Father	1994
*	Babysitter	1995

*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:

For this review, the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation, including the investigation/assessment, safety assessments, and safety plan. SERO spoke with the county caseworkers, medical staff and law enforcement. SERO attended the Act 33 team meeting on 08/04/2017.

Summary of circumstances prior to Incident:

The child resides with her mother, half-sibling and maternal grandparents. The father of the child is minimally involved with the child. A family friend was acting as the caretaker for the child in the caretaker's home at the time of the incident. This is the first referral for the agency concerning the child, family and/or the alleged perpetrator.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/08/2017, Bucks County Children and Youth Social Services Agency (BCCYSSA) received a Child Protective Services (CPS) referral that the child was transported and then admitted to the hospital [redacted] the child's symptoms were consistent with "shaken baby." The report named the child's caretaker, a family friend, as the alleged perpetrator.

The child's mother stated that on the date of the incident, 07/07/2017, she woke the child and the child was fine. She then took the child to the family friend to care for the child while she went to work. The regular babysitter was not available until later that day. A few hours later the mother called to check on the child and was informed the child appeared sleepy all morning and the caretaker had difficulty waking the child. The mother was concerned and left work to see the child. When she arrived, the child was shaking so the mother began to transport the child to the hospital in her own vehicle. She called the child's grandmother while in transit, and she advised her to pull over and dial 911. The ambulance met the mother on the side of the road and continued to transport the child to the hospital. The child [redacted] and then was transferred to another hospital [redacted]

The agency worker arrived at the hospital to initiate the investigation and assess for safety. Law enforcement also conducted interviews at the hospital. The family friend had left town on a previously scheduled trip but was contacted by law enforcement via telephone and stated she would return to the area to be interviewed. Law enforcement met with her at the police station for an initial statement. She described a situation where she got into the bathtub fully clothed to give the child a bath while she was caring for her. She agreed to submit to a polygraph test at a later time. She then obtained legal counsel and has since refused to take the polygraph or give any further statements regarding the allegations. The agency has not been able to interview her.

On 07/10/2017, the agency worker assessed the child's half-sibling for safety. The half-sibling had been staying with another family friend since the incident due to the family remaining at the hospital with the victim child. Since it was yet to be determined who caused the injuries to the child, or how they were sustained, the agency implemented an informal safety plan where the half-sibling would remain with this family friend until it was determined the family was not the cause of the injuries. All interaction with the half-sibling would be supervised. The mother submitted to a polygraph and was ruled out as to causing the child's injuries. Interviews with the grandparents also determined they did not cause the injuries. The informal safety plan was no longer needed.

There are no children residing in the home of the alleged perpetrator; however, she at times will care for a nephew in her home. This nephew's parent was contacted by

the county and advised of the investigation and the need that the child cannot be left unsupervised with the alleged perpetrator during the course of the investigation.

On 07/20/2017, the victim child [redacted] into her mother's care. The child is doing well and there are no signs of delays or ongoing issues at this time. The child has had follow up appointments [redacted] The agency has not identified a need for services. The agency submitted their investigation outcome decision on 08/21/2017. The CPS investigation is Pending Criminal Court at this time due to the ongoing criminal investigation and the agency's inability to interview the alleged perpetrator.

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:

Collaboration amongst BCCYSSA, the district attorney, and [redacted] Police Department began immediately subsequent to the referral.

[redacted] Police Department Detective's ability to arrive at the hospital within one hour after the referral was received.

BCCYSSA Second Shift response and action on the referral

Cooperation with CHOP (Children's Hospital of Philadelphia) including [redacted] participation in the Act 33 review.

Deficiencies in compliance with statutes, regulations, and services to children and families:

None noted.

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

Develop/provide available and affordable (sliding scale fee), safe, 24/7, child care.

Create funding to support subsidized child care.

Initiate change in the Child Protective Services Law to allow/require anyone applying to be a child care provider to voluntarily obtain ChildLine and State Police clearances to provide to prospective consumers.

Continuation of provision of information regarding child abuse prevention and education.

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

None noted.

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

Collaboration amongst all involved entities- [redacted] Police Department, the Bucks County District Attorney's Office, CHOP and BCCYSSA were exemplary.

Department Review of County Internal Report:

The Department has received and reviewed the county report dated 10/11/2017. Clarification was received concerning the recommendation regarding clearances for caretakers for prospective consumers. It was clarified that the recommendation is that parents be able to obtain clearances on caregivers not required to be licensed or registered with the Office of Child Development and Early Learning (OCDEL). Further, a private babysitter be able to obtain clearances under the voluntary provision. The Department is in agreement with the county's findings.

Department of Human Services Findings:

County Strengths:

There was clear documentation in the case notes. There was good collaboration and the safety was ensured for not only the victim and half-sibling, but another child that the alleged perpetrator will care for at times.

County Weaknesses:

None noted.

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

None noted.

Department of Human Services Recommendations:

There could be more outreach in the community for resources to deal with stressful situations in effort to alleviate the circumstances which could lead to shaken baby syndrome.