



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## **REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: 1/15/11**  
**Date of Incident: 6/15/14**  
**Date of Oral Report: 6/16/14**

**FAMILY KNOWN TO:**  
**Montgomery County Children and Youth Services**

**REPORT FINALIZED ON:**  
**July 09, 2015**

Unredacted 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. 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. The County did not convene a review team in accordance with Act 33 of 2008 related to this report. [REDACTED]

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	victim child	01/15/2011
[REDACTED]	mother	[REDACTED]/1982
[REDACTED]	father	[REDACTED]1968
[REDACTED]	sibling	[REDACTED]/2009

**Notification of Child Near Fatality:**

On 05/15/2014 at 7:30 pm the victim child, VC, was taken by the emergency medical services, EMS, to Pottstown Hospital [REDACTED]. The mother did not accompany the VC to the hospital and was not present when the VC was evaluated and treated. The mother reported that the VC was healthy and normal all day and the VC was playing outside and went on errands with the mother. Around 7:30 pm when the VC was starting to fall asleep, the mother noticed that the VC was taking shallow quick breaths. Then the VC started gurgling and her lips turned blue. The mother said this went on for approximately ten minutes. The mother started CPR and gave the VC some of the father's [REDACTED]. The mother called EMS and they arrived after approximately two minutes. The mother stated that she did not think the VC was breathing at all during those two minutes. The VC [REDACTED] and taken to Pottstown Hospital [REDACTED] where the VC tested positive [REDACTED]. (It was reported on 06/17/2014 that the [REDACTED] was given at Pottstown Hospital [REDACTED] to try to stabilize the VC. The VC was given [REDACTED] and transferred to Children's Hospital of Philadelphia (CHOP). The VC was admitted to the CHOP's [REDACTED] around 11:00 pm. The VC was purposeful in her movements upon arrival to CHOP; she was agitated and [REDACTED]. Her eyes were still unfocused. She was able to begin [REDACTED] after approximately one hour at CHOP. It is unclear whether the VC has suffered [REDACTED] says this is more difficult to determine as she already has developmental delays). The VC was certified to be in serious and critical condition by [REDACTED] attending physician who suspected that the injuries are a result of neglect. The mother stated that she does not know how the VC ingested [REDACTED].

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

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Administrator [REDACTED] and Ongoing Caseworker [REDACTED]. The County did not have an Act 33 review. The case was unfounded on 07/11/14.

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

GPS 06/01/09- The Mother gave birth to a child who [REDACTED]. No intervention was needed. This case closed 06/25/2009.

GPS 01/18/11- The VC was born [REDACTED]. The family received services and closed on 02/23/2011.

GPS 03/31/12- The Stepmother reported that the mother was using drugs. This case was unfounded; services were provided to the family for one year and then closed 04/26/2012.

CPS 04/11/13- [REDACTED] services called stating that the father yanked the VC out of the car and the VC fell to the ground while the father was yelling at the mother, This case was unfounded on 05/01/2013.

CPS 04/25/2013- The case was opened because the father was arrested for DUI. The children were not secured in a car seat. The case was opened for services. In 06/2013 the mother moved out of the home due to domestic violence issues and moved in with the children's maternal grandfather. However, the mother continues to go back to the apartment where the father resides making this an unsafe place for the boys. The case remains open.

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

The VC was born with development delays and has been [REDACTED]. The family has had a long history with Montgomery County Children and Youth. The family was receiving services when the incident occurred. The worker stated that the area in which the family resides is drug infested and the VC could have picked up something off the street. The children play outside and they are supervised by the mother. The VC has some delays and may have picked up something from the street and put it in his mouth. At that time, the worker continued to see the family once a week.

**Current Case Status:**

The mother was residing between her apartment and her father's home [REDACTED]. [REDACTED] The father remains in mother's apartment but may be arrested on DUI charges. The mother tested positive for drugs and may be arrested for violation of probation; the children will be placed in foster care if that happens. Since this report has been initiated the mother has agreed to reside with her father so that [REDACTED] can be started again. The mother has been [REDACTED].

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

- **Strengths:**  
It was noted that the MDT Social Work Service Manager did an excellent job investigating this case and; the Police Department, DHS and Medical Examiner's Office worked well together.
- **Deficiencies:**  
None Identified.
- **Recommendations for Change at the Local Level:**  
None Identified.
- **Recommendations for Change at the State Level:**  
None Identified.

**Department Review of County Internal Report:**

The county did not convene a county review because the case was unfounded on 07/11/14.

**Department of Public Welfare Findings:**

- **County Strengths:**  
The investigation was done in a thorough manner with the police, the hospital and family members being interviewed.
- **County Weaknesses:**  
None Identified.
- **Statutory and Regulatory Areas of Non-Compliance:**  
None Identified.

**Department of Public Welfare Recommendations:**

The Department recommends that the county children and youth agencies continue to institute alternatives ways to educate the community on their understanding of what constitutes child abuse and the damaging effects it may have on families and the community.

The Department recommends continuous Drug and Alcohol education with particular emphasis on the effects on young children, including accidental and intentional ingestion by children.