REPORT ON THE NEAR FATALITY OF:

Date of Birth: [Redacted]/09
Date of Near Fatality Incident: 3/6/10

FAMILY KNOWN TO:

Bucks County Children and Youth Social Services Agency

Report Submitted: 3/31/2011

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. 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 related to this report.

**Family Constellation:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>victim child</td>
<td>father</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Maternal Grandfather, alleged perpetrator</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Maternal Grand mother, alleged perpetrator</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Sibling</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>mother</td>
<td>88</td>
</tr>
</tbody>
</table>

Mother is deceased (date of death 2/23/10)

**Notification of Child Near Fatality:**

On March 6, 2010 an After Hours call to Bucks County Children and Youth was received from the Police Department regarding the family. Reported that maternal grandmother, who is legally blind and is prescribed Valium, split a pill and missed the bottle putting the other half of the pill in the bottle. It dropped on the floor and the child ingested it earlier today. maternal grandfather, was playing with the child, watched it happen, and could not prevent it. ingested it. Grandparents took the child to Holy Redeemer Hospital where he was checked and discharged; grandparents were told to check on him every half hour. That night at 9:45 pm when they checked on he was unresponsive. They called the ambulance and police. When paramedics arrived, they administered CPR, and took him to Frankford Torresdale Hospital. Child was not able to breath on his own and was placed on a ventilator. He was taken to St. Christopher’s Hospital. St. Christopher’s Hospital’s Child Protection Unit had determined this situation to be a near fatality.
Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to this family. The regional office also participated in the County Internal Fatality Review Team meetings on March 30, 2010.

[Redacted names of individuals] presented a summary of the circumstances surrounding the near fatality. The SERO also reviewed the Family File for previous services that the family received from Bucks County Children and Youth.

Children and Youth Involvement prior to Incident:

11/14/09 – [Redacted]

The first referral concerning [Redacted] was received on November 14, 2009 from Room. Child, [Redacted], at the time age 10 months, was taken to hospital by EMS after ingesting 2 packets of dish detergent. The investigation revealed that the sibling, [Redacted], who at the time was 2 years old, had given a packet of dish detergent to [Redacted] thinking that it was some kind of candy. The box of detergent had a picture of a cartoon character on the side of it. Victim child, [Redacted], became violently ill from ingesting the detergent. There was no lasting effect on the child. This case was closed on December 7, 2009 as it had been that this was accidental in nature.

1/4/10 [Redacted]

A report came to the Agency on 1/4/10. RS stated that the mother was on drugs and the children are not safe. Children and mother are living with the maternal grandparents of the children. Mother does have drug history and receives services through Northwestern Human Services. Bucks County Children and Youth did [Redacted] and on 1/13/10 transferred the case to [Redacted] unit for further assessment to address and monitor the situation. The agency required that mother refrains from using illegal drugs and mother attends, participates and completes drug and alcohol treatment program to address her substance abuse issues. The initial safety assessment was completed and determined that the children were Safe. No safety plan was needed.

2/2/10 [Redacted]

While the [Redacted] unit was following up with the [Redacted], a new [Redacted] report came into the agency. [Redacted] report stated that mother was a drug user and MGM was very ill and had to watch children. During the follow up of this report, on 2/23/10 Mother (MGM) died from a possible overdose. Plan was to keep children with MGM and MGF. The case was [Redacted]
Circumstances of Child Near Fatality and Related Case Activity:

Report came into on call from that 1 year old was taken to hospital for ingesting prescription medication of the caregiver (grandparent). Child had been sleeping and then was unresponsive. Child was taken to the Frankfort-Torresdale hospital by ambulance, placed on ventilator and transferred to St. Christopher’s Hospital. Lower Southampton Police department and Bucks County C&Y conducted The other child in the house was at a babysitters house and could stay as long as necessary during the or until a family member was identified. VC, tested positive for Benzo’s and Opiates. Bucks County C&Y After Hour’s Caseworker followed up on initial report with the hospital and Caseworker met with the family to discuss safety plan and ensure safety of the other child in the home. Sibling was placed with his bio-father, and VC was in the hospital until 3/18/10. was placed in a medical foster care home from the hospital.

Police and DA have not filed criminal charges against the Perpetrators.

Current Case Status:

This case is for . Both grand parents are identified as . The Agency held a Dependency hearing and Bucks County Children and Youth took custody of the child. Due to the grandparents’ deteriorating health and the grandmother’s deteriorating eye sight, the agency continues to explore other family members’ care for the child.

The agency had a difficult time locating the father of . He was on State Parole and he was being pulled from the program for violations with a possibility of going back to jail. On 3/10/10 showed up at the hospital. He was informed that his son was being placed in a Bethanna foster home. understood and was glad his child was no longer in the care of the Maternal Grandparents.

did go back to prison for the violation of parole.

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 March 30, 2010.
Strengths:
- The safety assessment completed at each interval used the current safety tools and accurately assessed the family’s functioning.
- Staffing of this case was done immediately due to seriousness of child’s medical condition. When it was determined that the grandparents were not able to care for the children, an aunt was identified as a resource for [redacted]’s sibling until reunification with his father. [redacted] was placed into the agency’s custody and into medical foster care. Family resources are being explored for [redacted].

Deficiencies:
- Interview with three year old sibling was not done. However, caseworker determined that he did not have sufficient language skills to be interviewed.

Recommendations for Change at the Local Level:
- If possible, a medical recommendation is that when a child this young presents with a similar medical condition that the child should be immediately taken to CHOP or St. Christopher’s, where they are trained to handle pediatric crisis.
- Agency staff will be instructed to request toxicology screens for children who are unconscious and unresponsive, a toxicology screen should be done.
- Agency [redacted] Manager will send correspondence to the manufacturer of dishwashing detergent to strongly suggest that they change the design to be less appealing to young children.
- Improve the communication between BCCYSSA and the drug and alcohol providers in the area.
- Improvement of services by drug/alcohol providers by prioritizing services to mothers of babies/young children.

Recommendations for Change at the State Level:
- None identified

Department of Public Welfare Findings:
- County Strengths:
  Bucks County Children and Youth completed a thorough assessment of the family. Through Family Finding, the agency located the biological father of VCs sibling. [redacted] was placed into the agency’s custody and into medical foster care. Family resources continue to be explored for [redacted]. Child continues to be in foster care with Bethanna foster care.

- County Weaknesses:
  None identified.

- Statutory and Regulatory Areas of Non-Compliance:
  None identified.
Department of Public Welfare Recommendations:
The Department agrees with the Recommendations that were made during the Act 33 Review of the County.