REPORT ON THE NEAR DEATH OF

Date of Birth: 1/17/2010
Date of Incident: 1/7/2013
Date of Oral Report: 1/7/2013

FAMILY KNOWN TO:
The family was not known to Chester County Department of Children, Youth and Families.

REPORT FINALIZED ON:
2/21/2014

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. Chester County convened a review team in accordance with Act 33 of 2008 related to this report on January 31, 2013.

1. 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></td>
<td>01/17/2012</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>/1970</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>/1982</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>/2002</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>/2011</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>/1996</td>
</tr>
<tr>
<td>Father of child</td>
<td></td>
<td>/1970</td>
</tr>
</tbody>
</table>

*Indicates that this individual is not a household member of the victim child's residence.

Notification of Fatality / Near Fatality:

On 01/07/2013, Chester County Department of Children, Youth and Families (DCYF) received a call from [Redacted] regarding the near death of child [Redacted]. The [Redacted] [Redacted] [Redacted]. The [Redacted] [Redacted] [Redacted]. The [Redacted] [Redacted] [Redacted]. The child was admitted to the hospital in critical condition suffering from injuries that she sustained while under her father's care. The child's medical examination showed [Redacted] [Redacted] [Redacted].

Documents Reviewed and Individuals Interviewed:

The Southeast Office of Children Youth and Families obtained the family's Chester County case record and the victim child's hospital and medical records. A review of the records and discussion of the same was held with the county's [Redacted] caseworker, supervisor, the ongoing case worker and the victim child's family. In addition, the Southeast Regional office was an active participant in the Chester County internal Act 33 near fatality review team meeting on 01/31/2013.

Summary of Services to Family:

Previous CY involvement:

Neither the victim child nor her family was known to Chester County DCYF prior to the 01/07/2013 near fatality report date. In the past the child's mother was referred to the Chester County Health Department for [Redacted] services while she was pregnant with the victim child and the victim child's sibling [Redacted] D.O.B. [Redacted] /2011. The parent declined to participate in those services.

Circumstances of Child's Fatality or Near Fatality:

The mother of the victim child is employed by [Redacted]. The victim child and her one sibling attend this center for day care services. On 01/07/2013, the child's mother arrived to the day care center for work and dropped her child off for day care services. Shortly after their arrival, the day care center director noticed marks on the child's head. The marks on the child started to swell and the child...
appeared lethargic. The mother's explanation, that the child's two year old sister had kicked her in the eye causing the injuries did not sit well with the center director. The child's face had turned a black and blue color as the day progressed. The center director feared that domestic violence might be occurring in the child's home and the paramedics were contacted. The medics transported the child to Al DuPont Hospital.

At the hospital, the child's mother continued to explain that the victim child's two year old sibling was behind the victim child, and that the sibling kicked the child, causing the injuries. The reporting source believed that the victim child's mother's story was not consistent with the child's injuries and that the mother never obtained medical attention for the victim child. The medic believed that the child's injuries were from trauma because when the child arrived to the day care center, her condition worsened throughout the day. The attending hospital physician for the victim child stated that the child's injuries were recent and that the mother's story that her two year old child pushed the victim child into the coffee table causing the victim child's injuries was not true. During the investigation, the mother gave inconsistent accounts of how the child was injured.

On 01/08/2013, Chester County DCYF initiated their investigation and visited the child in the hospital and interviewed the child's mother and to assess the safety of the other children in the home. During this interview, the child's mother revealed that she had no knowledge of how the victim child sustained the serious injuries and she did not report the incident of the victim child's two year old sister pushing her or kicking her.

The victim child remained in the hospital and her condition was severe. The victim child's father admitted to causing the child's injuries during his interview at the police station. The victim child's father admitted he became frustrated with her. He stated he dropped the victim child while he was bouncing the child on his knee, and her head hit the coffee table. The father then grabbed the victim child by both arms, throwing the child onto the bed.

The father was arrested by Chester County Police and charged with aggravated assault, simple assault and endangering the welfare of a child. The father was incarcerated at the Prison. Chester County DCYF completed a safety assessment of all children in the home and determined that the children were safe under the care of their mother with the county monitoring the home.

Current / most recent status of case:

The cast on the victim child's arm was removed and she was released from the hospital after making a full recovery from her injuries on 01/22/2013. The child's next follow up appointment was 04/12/2013.

Chester County DCYF indicated the child abuse case on the victim child's father only, based on medical evidence and the perpetrator's admission on 02/06/2013. The county determined that the mother was not aware of the father's actions that caused the child's injuries, and as such was considered to have protective capacities. The child's father remains incarcerated at the Prison.

The victim child was enrolled in services on 02/19/2013 with her mother's participation in the services. The child's mother also made an appointment with the Chester County Courts to obtain a protection from abuse order against the victim child's father on 03/22/2013. All the children in the family continue to be safe under the care of their mother and Chester County DCYF continues to monitor the family.

Several recommendations were made at the county review related specifically to the victim child and her family:

- Services for the victim child
- For the family members to address domestic violence, substance abuse, and the trauma to the victim child.
- Ongoing assessment of the mother's response to this incident
- Monitoring the mother's ability to meet the children's needs
- When the mother is being presented with detailed medical information, a bilingual staff or a translator should be used to ensure that the mother fully understands the complexity of her child's medical needs.
County Strengths and Deficiencies as identified by the County’s 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. Chester County convened a review team in accordance with Act 33 of 2008 related to this report on 01/31/2013.

**Strengths:**

- Staff followed established procedures regarding safety assessment and planning. The victim child was determined to be safe in the hospital; the safety of the other children was assessed in their home under their mother’s supervision.
- An intensive In-Home worker was assigned to monitor the child’s care and safety. This worker will have ongoing contact with the family and will be making collateral contacts to ensure that the mother is securing necessary medical services.

**Deficiencies:**

- None identified.

**Recommendations for Change at County level:**

- During the initial response in a CPS investigation, Chester County DCYF and law enforcement need to communicate about the need for joint investigations. Chester County DCYF has addressed this by ensuring that their afterhours emergency staff have been made aware that their responsibilities in a CPS investigation include making an in-person response.

Department Review of County Internal Report:

The Southeast Office of Children Youth and Families obtained the family’s Chester County DCYF case record and the victim child’s hospital medical records. A review of the records and a discussion was held with the county’s CPS caseworker, supervisor, the ongoing case worker of the victim child and the victim child’s family. The Southeast Region was an active participant in the Chester County DCYF internal Act 33 near fatality review team. The Southeast Region is in receipt of the County’s Act 33 review, and has reviewed it. The Department is in agreement with the findings.

Department of Public Welfare Findings:

**County Strengths:**

- The county provided follow up with public and private stake holders from the onset of the CPS report and investigation.

**County Weaknesses:**

- None identified

**Recommendations for Change at County level:**

- In an effort to prevent future child abuse of young children born in Chester County, the county could benefit from referrals from the Chester County Health Department. There should be an ongoing two way communication between the Chester County DCYF and the Chester County Department of Health pertaining to mothers to be, who are referred to the health department for prenatal care, but do not keep appointments or refuse prenatal care services.
Department of Public Welfare Recommendations:

Improved collaboration and communication between the various county agencies, specifically the county children and youth agency and the health department could benefit the families of very young children. In this case, a pregnant woman did not follow through with prenatal services. While a young woman without any children would not be eligible for services through the county child welfare agency, perhaps the counties and state could develop programs that would make outreach and provide support to these young women.