pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

Date of Birth: 3/24/13
Date of Incident: 7/22/13
Date of Oral Report: 7/23/2013

FAMILY NOT KNOWN TO:
Delaware County Children and Youth Services

REPORT FINALIZED ON:
June 25, 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 has convened a review team in accordance with Act 33 of 2008 related to this report on 08/07/13.

Family Constellation:

Name:	Relationship:	Date of Birth:
	Victim Child	03/24/13
	Mother	/84
	Father	/86
	Half-brother	/09

Notification of Child Near Fatality:

On 07/23/13 Delaware County Children and Youth Services received a call that the victim child, (VC), was being transported to Children's Hospital of Philadelphia, (CHOP), diagnosed with a . The victim child was having seizures. The case was certified as a near fatality by a physician at CHOP. The victim child arrived at the hospital with her father who reported that he was alone with the child and her sibling while the mother was at work.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office reviewed the medical records, county investigation records, Act 33 records and safety plan, interviewed the county caseworker, supervisor and reviewed the CHOP Child Protection Team Consultation notes. The review began on 08/08/2014 and the review continued throughout the month of August. The act 33 meeting was held on 08/07/2013. In attendance was Caseworker, , Casework Supervisor, Child Advocate, and , Supervisor South East Regional office.

Children and Youth Involvement prior to Incident:

The family was not known to the County Children and Youth Agency.

Circumstances of Child Near Fatality and Related Case Activity:

On 7/22/13 Delaware County Children and Youth Services received a Child Protective Services, (CPS) report that the VC was in the Emergency Room, (ER), at [redacted]. The VC is four months old and presented at the ER with a head injury. [redacted] showed evidence of [redacted]. The child was non responsive. The VC was listed in critical condition and the doctor reported that the child's injuries were non-accidental and abuse was suspected. The child was [redacted] following multiple seizures and transferred to CHOP.

The child was in good health until the morning of admission. The mother fed the child about 9:00 pm that evening and put the child to bed. The mother left for work in the morning and left the child in the care of [redacted] along with her half sibling, [redacted], who is 4 years old. [redacted] reported that he went to check on the child about 10:00 am. He changed her diaper and lifted the child out of the crib and placed her on his shoulder. [redacted] reported that the child became limp and appeared to stop breathing. [redacted] reported that he heard a gurgling noise and initially thought the child was choking. [redacted] stated that he called 911and was instructed to initiate CPR while waiting for the ambulance. [redacted] reported that the child seized multiple times.

The sibling was [redacted] by Nazareth Hospital on 07/24/2013. During this evaluation, the sibling reported to the medical staff that [redacted] (who is the alleged perpetrator, AP) told his sister, the VC, to "shut up" twice and that he saw the AP "shake" the VC. The sibling states he told the AP that he thought his sister was dead.

The CPS investigation was indicated on 09/10/13 [redacted] is named as the perpetrator and was arrested on 08/28/2013 for Felony 1 Simple Assault and Recklessly Endangering the Welfare of a Child.

Current Case Status:

The mother and sibling moved in with her paternal grandfather and his wife. The VC was [redacted] her mother on 08/05/2013. The VC was [redacted]. The child was referred for [redacted]. The child is receiving [redacted]. The child will [redacted]. The physician is not sure what will be the long term effects of the abuse but the child continues to make progress. The case was closed with Delaware County Children and Youth Services on 9/11/13.

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

Strengths:
The CPS investigation was completed in a thorough manner. The caseworker collaborated with the medical staff at [redacted], the physicians and nursing staff at CHOP and conferred with the police department to assist in determining the facts of the case and to indicate this report. The County reached out to the mother and her family and made sure that the mother received training on the care of the VC [redacted] and that all the equipment that was needed in the home for the VC's care [redacted].

- Recommendations for Change at the Local Level:
  The Act 33 review team had no concerns in this area. The family was not open prior to this report.

- Recommendations for Change at the State Level:
  The Act 33 review team had no concerns in this area.

Department Review of County Internal Report:
The Southeast Regional office reviewed the Act 33 Report and agrees with its findings. The report was received on 11/11/2013.

Department of Public Welfare Findings:

- County Strengths:
  The county social worker completed a thorough investigation.

- County Weaknesses:
  There were none identified.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of Non-Compliance.

Department of Public Welfare Recommendations:

This family was not known to the agency. The mother had a normal delivery and the victim child went home from the hospital with no medical issues. The County did a thorough investigation. The hospital and social worker provided support to the child and family upon the child's discharge. There are no recommendations.