pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/23/2013
Date of Incident: 12/15/2013
Date of Oral Report: 12/19/2013

FAMILY WAS NOT KNOWN TO

Delaware County Children and Youth Services

REPORT FINALIZED ON:
8/10/15

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, DHS 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. Delaware County convened a review team in accordance with Act 33 of 2008 related to this report on January 8, 2014,

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	07/23/2013
[redacted]	Biological Mother	[redacted]1977
[redacted]	Biological Father	[redacted]1969
* [redacted]	Biological Half Sibling	9 years old

[redacted] is the biological daughter of [redacted] does not reside in the home. She resides with her biological father, [redacted]

Notification of Child (Near) Fatality:

On December 19, 2013, Delaware County Children and Youth Services (CYS) received a report [redacted] regarding the victim child, [redacted] On December 17, 2013 [redacted] was transported to CHOP by his mother, [redacted] Upon arrival the child was observed having an episode of vomiting and lethargy. The mother reported that he had these symptoms from December 15, 2013 to December 17, 2013. The mother brought the child to the hospital due to the child's lack of improvement [redacted] The child [redacted] failure to thrive [redacted] medical neglect as the child had an abnormally low weight (12 pounds at five months); he had no medical care, and had not seen a pediatrician since birth. The child was able to gain weight while in the hospital.

The parents did not provide any explanation for the injuries. The mother reported that the victim child fell two times several months prior to the near fatality: once off a bed and once off a couch. The mother reported that she was not home at the time of either of these incidents and that the

child was in the care of his father when the incidents occurred. The hospital reported that these falls would not have caused the injuries. It was reported that the victim child's injuries were the result of non-accidental trauma. The report was registered as a near fatality.

Summary of DHS Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (OCYF) obtained and reviewed all current records pertaining to the [redacted] family. Follow up interviews were conducted with the Delaware CYS Caseworker [redacted] placement worker. The regional office also participated in the County Internal Fatality Review Team meeting on January 8, 2014.

Children and Youth Involvement Prior to Incident:

The family was not known to any private or public child welfare agency prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On December 17, 2013, the mother brought the victim child to CHOP for evaluation of lethargy. The mother reported to the hospital staff that on December 15, 2013 she left for work leaving the child in his father's care. The mother is a registered nurse and she is employed by [redacted] When she returned home, the child's father stated, "[redacted] is upstairs sleeping, you have to be rough with him because he fights sleep, so I picked him up like this and told him go to sleep." "I grabbed him and threw him on the bed." The father was the child's primary caretaker as the mother typically works overnights and on weekends. [redacted] was hospitalized at CHOP from December 17, 2013 to December 31, 2013 [redacted]

On December 20, 2013, the child's mother was interviewed by Delaware CYS and at that time she reported that on December 15, 2013 the father was the child's sole caregiver during the day while she was at work. She did inform the county what the father told her about the incident. The father refused to provide any pertinent information regarding the child's injuries to CYS or to CHOP.

[redacted] The child's sibling was assessed for safety in the home with her biological father and she was found safe with no areas of concern. She was also assessed for safety while spending the weekends with her mother and mother's paramour (the biological father of the victim child) and it was determined that she was safe. She was also physically examined at CHOP and it was determined that she had no injuries or any signs of abuse or maltreatment.

On January 16, 2014, Delaware CYS filed a CY48 finding both the father and mother indicated for physical abuse. CHOP determined that the victim child's injures occurred as the result of

non-accidental trauma on or around December 15, 2013. Both parents were in caretaking roles on that date. The mother was indicated for serious physical injuries as a perpetrator by omission and the father was indicated for serious physical injuries as a perpetrator by commission. In addition, the mother is indicated as it was determined that on November 20, 2013 she was present when the father was observed shaking the victim child. [redacted] the half-sibling to [redacted] and the daughter of [redacted] reported observing the victim child's father shaking the child around Thanksgiving. It was determined that the mother was present at the time of the incident and she did not intervene. In addition, the mother and the father admitted that they did not have the child examined by a physician for either well baby exams or vaccines after his birth. The parents offered no reasonable explanation for the child's lack of medical care and related failure to thrive. The county filed a second report for medical neglect [redacted] as failure to thrive naming mother as the alleged perpetrator as baby had no well physical or medical examinations or vaccines since birth.

Current Case Status:

- [redacted]The child remains in a medical foster home [redacted] The child has been in this home since February 12, [redacted] The maternal grandparents have also presented themselves as a kinship resources for the child. The results of their home study is pending. Mother continues to maintain housing in [redacted] and she is employed. Mother has completed a parenting class [redacted]
- [redacted] The child is making some developmental progress. He is walking and saying a few words. He does have delays in social response and interaction. [redacted] The father was arrested on April 9, 2014 and he remains incarcerated at [redacted] Correctional Facility. [redacted] The Assistant District Attorney reported that a court hearing was held on July 25, 2014 and the father was held on charges of simple assault and endangering the welfare of a child, both misdemeanors of the first degree and recklessly endangering a misdemeanor of the second degree. The father was arraigned in September 2014 in Common Pleas court. The court rendered a verdict of guilty for endangering the welfare of a child. The father is awaiting a criminal sentencing hearing. The father maintains contact with CYS and he is provided with updates and pictures of his child.

- The mother was arrested on April 14, 2014 and released on bail on April 16, 2014. [redacted]

The mother continues to participate in supervised visitation with the child. She participates in the care of her son.

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

The county held the Act 33 review on January 8, 2014.

- Strengths: The investigation was conducted timely and in compliance with all statues and regulations.
- Deficiencies: There were no deficiencies identified.
- Recommendations for Change at the Local Level: The review team noted the need for doctors to track and report when children miss medical appointments; however it was noted that this child was not connected to an ongoing treatment physician after his birth.
- Recommendations for Change at the State Level: There were no recommendations for change at the state level.

Department Review of County Internal Report:

The Department received the county report on March 28, 2014 and concurs with the county's recommendation.

Department of Human Services Findings:

- County Strengths: The County was available to the Department to answer any additional questions and concerns. The county's investigation was well documented and included medical reports and the CHOP's child protection team reports. The county utilized excellent collaboration skills with St. Christopher's Hospital for Children and law enforcement. The county interviewed the sibling of the victim child as she was in the home at the time of an incident in which she observed the father shaking [redacted]
- County Weaknesses: There were no county weaknesses identified.
- Statutory and Regulatory Areas of Non-Compliance: There are no areas of non-compliance.

Department of Human Services Recommendations:

- The Department should engage with the county agencies about developing methods to ensure that parents of young children receive information about childhood development and appropriate behaviors, such as about comforting their children during what appears to be excessive crying
- The Department recommends that social media (such as Facebook), transportation media and billboards be utilized as a mechanism to instruct and inform parents on parenting/safety of young children. The Children and Youth Agencies should collaborate with their local health department and Women, Infant and Children (WIC) offices to assist in providing information to the public.