



**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: December 23, 2003**  
**Date of Near Fatality Incident: May 12, 2010**

**The family was known to**  
**Delaware County Children & Youth Services**

Date of Report: August 5, 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. Delaware County convened a review team in accordance with Act 33 of 2008 related to this report on June 9, 2010.

### Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	12/19/2003
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Sibling	[REDACTED] /2008
[REDACTED]	Sibling	[REDACTED] /2006
[REDACTED]	Sibling	[REDACTED] /2002
[REDACTED]	Sibling	[REDACTED] /2000

#### *Non Household Members*

[REDACTED]	Victim Child's Father	[REDACTED] /1971
[REDACTED]	Maternal Grandmother	[REDACTED] /1956
[REDACTED]	Maternal Grandfather	[REDACTED] /1953

### Notification of Child (Near) Fatality

On May 12, 2010 Delaware County Children and Youth Services (CYS) received a [REDACTED] report that alleged the mother was administering the wrong dosages of [REDACTED] to the victim child. The mother was advised by the medical doctor to transport the child to the emergency room. When the child arrived at the hospital, she was [REDACTED].

### Summary of DPW Child Near Fatality Review Activities

On February 17, 2011 the Southeast Regional Office received [REDACTED] from Delaware county and the case file. The regional office conducted telephone interviews with [REDACTED], CYIS Intake Worker, [REDACTED], CYIS Supervisor, [REDACTED], CYIS Supervisor, and [REDACTED], CYIS Intake Supervisor.

### Summary of Services to Family

#### Children and Youth Involvement Prior to Incident

##### **September 15, 2004**

On September 15, 2004 Delaware County CYIS received a [REDACTED] report that the mother did not obtain the blood work and allergy testing necessary to determine what foods the child was able to eat. Based on the medical evidence the child suffered from medical neglect. The case was [REDACTED] and the mother was identified as the [REDACTED]. The children were placed in kinship with maternal grandparents. They were returned to the mother in 13 months. The family received SCOH services and [REDACTED] services. According to the documentation the family appeared stable and the case was closed in March 2007.

##### **May 12, 2010**

On May 12, 2010 Delaware County CYIS received a [REDACTED] report that the mother was treating the victim child's [REDACTED] without following the prescribed instructions of the doctor. The doctor reported the mother was aware of the victim child's respiratory symptoms and [REDACTED] since the victim child was an infant.

On April 9, 2010 the victim child was [REDACTED] as a result of [REDACTED]. According to the documentation, if the mother hadn't taken the victim child to the hospital she would have died. The doctor made the [REDACTED] report on May 12, 2010 because he was concerned that the mother was not treating the victim child's medical condition seriously.

#### Circumstances of Child Near Fatality and Related Case Activity

On May 12, 2010 Delaware County CYIS received a [REDACTED] report that alleged the mother was inappropriately treating the victim child's medical condition. The victim child suffered with severe [REDACTED] and allergies.

On April 9, 2010 the mother called the doctor and requested [REDACTED] for the victim child. The mother informed the doctor that she had administered three [REDACTED] treatments back to back to the victim child. According to the medical doctor, three [REDACTED] treatments should only be administered by a trained medical person. The mother was advised by the doctor to immediately escort the victim child to DuPont Hospital emergency room. When the victim child arrived at

the hospital she was [REDACTED]. She suffered from [REDACTED]. She was [REDACTED] the hospital on April 13, 2010. The mother received [REDACTED] instructions to follow up with the [REDACTED] and to call 911 if the victim child experienced any signs of distressed breathing.

On April 28, 2010 the mother reported she called the doctor and requested at home training for administering medication to the victim child. The mother reported she asked the doctor to deem her daughter as medically unstable. According to the mother, the doctor refused to write the letter.

On May 12, 2010 the mother called the doctor and told him that the victim child stated she wasn't feeling well and she wanted to go to the doctor. The mother escorted the victim child to the pediatrician's office. When the victim child and her mother arrived, the victim child was found to be in severe respiratory distress. The pediatrician called 911 and the child was transferred to DuPont Hospital. This hospitalization was reported to ChildLine. CYS conducted [REDACTED] investigation. Initially, CYS reported this investigation was [REDACTED]. CYS documented that the investigation did not determine that three back to back [REDACTED] treatments contributed to the child's hospitalization and [REDACTED]. According to CYS, this case did not rise to the level of [REDACTED].

On July 14, 2010 CYS consulted with the victim child's pediatrician and the case was certified as a Near Fatality. Based on the medical evidence the pediatrician reported, due to the mother's poor insight and judgment, the victim child could have died. The medical team reported that the mother was aware of the victim child's [REDACTED] complications since the victim child was three months old. Therefore, CYS changed the [REDACTED].

On August 13, 2010 the victim child was [REDACTED]. The victim child was removed from the mother's care and placed with the maternal grandparents. The siblings remained with their mother. According to CYS there were no safety concerns with the siblings. While the victim child was with the maternal grandparents, she gained a significant amount of weight and displayed no symptoms of respiratory distress. [REDACTED]. There was one stipulation; the mother was not allowed to take the victim child out of the home. According to CYS the father assists with the victim child on the weekend and will transport the child to doctor appointments.

On February 22, 2011 the victim child was returned to the mother with a safety plan in place. To ensure that the child received daily medication as prescribed, the mother would escort her to school every day. When the mother and the child arrived at school, the school nurse would meet them in the nurse's office and the

mother would administer the medications to the child under the supervision of the nurse. The nurse and the mother would sign off on a daily medication log. On the weekends the maternal grandmother agreed to go to the mother's home and supervise her to ensure the medication is administered to victim child. CYS conducts weekly visits to the school and home to ensure compliance with the safety plan.

### **Current Case Status**

- On February 22, 2011 the victim child was returned home with the mother. The mother continues to receive additional support from the maternal grandparents. During the summer months the family received in-home services. During the case worker visits parent education and life skills are discussed. The case manager visits the home twice a week.
- The case manager closely monitors all medical appointments and receives follow-ups from the doctors. The mother has been compliant administering the victim child's medication as prescribed. The victim child has had no further hospitalizations.
- On August 4, 2011 [REDACTED] that the victim child remain home with the mother and the case will be closed. According to CYS, the mother has been compliant with the current family service plan.

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

Strengths: CYS collaborated with the victim child's pediatrician and the case was certified as a Near Fatality. CYS was responsive to follow up interviews with the Department.

Deficiencies: None.

### **Recommendations for Change at the Local Level and State Level**

The Department recommends that county children and youth agencies continue to explore and institute alternative ways to educate the community on child abuse and the damaging effects on families and communities.

### **Department Review of County Internal Report:**

On June 9, 2010, Delaware County CYS submitted a County Internal Report to the Department. The medical personnel received technical support from CYS on

referring [REDACTED] reports to CYS. CYS will continue to discuss and review [REDACTED] with medical personnel.

### **Department of Public Welfare Findings**

County Strengths: CYS collaborated with the family members to ensure the child was placed with the maternal grandparents. In-home services were provided twice a week as discussed in the safety plans.

County Weaknesses: None.

Statutory and Regulatory Areas of Non-Compliance: None

### **Department of Public Welfare Recommendations**

The Department recommends that the CYS train and refresh county staff on Act 33 of 2008. This Act amends the CPS law and sets standards for reviewing and reporting child fatality and near fatality as a result of suspected child abuse. The counties need to be in communication with the regions about cases that are identified as near fatalities/ fatalities under Act 33.