



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:

[REDACTED]

BORN: [REDACTED] 2010
Date of Near Fatality Incident: 07/13/2010

FAMILY KNOWN TO:
Family not known to any Public or Private Agency

REPORT FINALIZED ON:

Draft 01/10/2011

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 Children and Youth Services convened a review team on 8/11/2010 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim child	██████████/2010
██████████	Mother	██████████/1990
██████████	Father	██████████/1990

Notification of Child Near Fatality:

On 7/13/2010 Delaware County Children and Youth Services received a call ██████████ stating that 2 month old ██████████ was transferred to Children's Hospital of Philadelphia from Crozer Chester Medical Center due to being diagnosed with pneumonia and ██████████. Prior to his admission to the hospitals, the child had been taken to his primary care physician due to a five day history of decreased feeding and no stools. After being evaluated at his primary care physician's office, the victim child was referred to Crozer Chester Medical Center ER because of his being lethargic and being in respiratory distress. While at Crozer Chester Medial Center, lab work was done on the victim child, as well as a chest x-ray. Due to his condition, the victim child was transported to CHOP. While at CHOP, the x-rays were reviewed which revealed that he had ██████████

██████████. The victim child had ██████████. Due to the child having old and new ██████████ and not having any medical condition to explain the presence of the injuries and no known history of accidental or inflicted trauma to explain the injuries, the doctor concluded that the injuries were due to inflicted trauma. Both mother, ██████████, and father, ██████████, were the primary caregivers for the child at the time the injuries occurred. Neither parent was able to explain how the child received his injuries; therefore, both parents were named ██████████.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current records pertaining to this family. The regional office participated in the County Internal Fatality Review Team meeting on 08/11/2010. SERO conducted phone interviews with the Delaware County Children and Youth Social Worker, as well as the caseworker from Bethanna, the agency through which the victim child was placed into foster care.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

No prior Children and Youth involvement.

Circumstances of Child Near Fatality and Related Case Activity:

On 7/13/2010 the victim child was transferred to the [REDACTED] at CHOP from Crozer Chester Medical Center due to child having severe respiratory issues. X-rays taken at CHOP revealed that the victim child had [REDACTED], both new and healing. The victim child had no history of reported trauma by the parents. [REDACTED] [REDACTED] could not be done at the time child was taken to the [REDACTED] because the child's condition was not stable. Once the skeletal survey was completed, child had [REDACTED].

On 7/21/2010 child was discharged from the hospital and placed in foster care. The victim child was later placed in kinship care with his grandmother where he remains at this time.

On 8/5/2010 the victim child received another [REDACTED] which revealed the following injuries: [REDACTED]

Current Case Status:

- The father was arrested on 8/20/2010 on charges of aggravated assault, simple assault, and endangering the welfare of children. He is being held at George Hill Correctional Facility.
- Mother was [REDACTED], but not arrested.
- The victim child was placed with the maternal grandmother 10/19/2010 and is doing well.

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. Delaware County Children and Youth Services convened a review team on 08/11/2010 in accordance with Act 33 of 2008 related to this report.

- Strengths:
The investigation was conducted timely and included strong collaboration with medical professionals throughout the investigation. There was joint interviewing done and strong collaboration with the Parkside Police Department.
- Deficiencies:
Safety assessment requirements were not done timely; however, this issue has since been addressed.
- Recommendations for Change at the Local Level:
To send a nurse into the home when a newborn is discharged following its birth. The parents of the newborn could benefit from medical and teaching aspects of caring for their baby. This could possibly result in preventing abuse and neglect.
- Recommendations for Change at the State Level:
To send a nurse into the home when a newborn is discharged following its birth. The parents of the newborn could benefit from medical and teaching aspects of caring for their baby. This could possibly result in preventing abuse and neglect.

Department Review of County Internal Report:

The Department has reviewed and is in agreement with these recommendations.

Department of Public Welfare Findings:

- County Strengths:
 - Timely investigation
 - Use of kinship resources
 - Collaboration with police departments
 - County retrained all agency staff in a two day refresher training on safety assessment.
- County Weaknesses:
To assure that the safety assessment be conducted in accordance within the required time frame.
- Statutory and Regulatory Areas of Non-Compliance:
Safety assessments were not conducted timely; however, all agency staff has since been retrained in this area.

Department of Public Welfare Recommendations:

None identified.