



**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**BORN: 09/20/11**  
**Date of Incident: 02/18/12**

**FAMILY KNOWN TO:**  
*Chester County Department of Children, Youth and Families*

**REPORT FINALIZED ON:**  
**March 28, 2013**

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 has convened a review team in accordance with Act 33 of 2008 related to this report on March 21, 2012.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	victim child	9/20/11
[REDACTED]	mother	[REDACTED] 83
[REDACTED]	father	[REDACTED] /83
[REDACTED]	sister	[REDACTED] /08
[REDACTED]	sister	[REDACTED] /10
[REDACTED]	brother	[REDACTED] /10
[REDACTED]	Paternal Uncle	[REDACTED] /84

Others residing outside of the home:

[REDACTED]	Maternal Grandmother	[REDACTED] 61
[REDACTED]	father to [REDACTED]	[REDACTED] /81

**Notification of Child Near Fatality:**

On 2/18/12, Chester County Department of Children, Youth and Families received [REDACTED] report alleging that 5 month old [REDACTED] had a skull fracture. The child was initially taken to Brandywine Hospital via EMT unit. He was determined to be in cardiac arrest and barely breathing. The child's father, [REDACTED], reported that this was the second time that week that the child had difficulty breathing; however, no medical attention was sought the first time. He gave no explanation for the child's skull fracture. [REDACTED] was then transferred to Children's Hospital of Philadelphia (CHOP.) The child was in the care of his father at the time of the incident.

**Summary of DPW Child Near Fatality Review Activities:**

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation. SERO reviewed the county's investigation/assessment, structured case notes, safety assessments/management, In

Home worksheets and safety plans and risk assessment. SERO also reviewed the family service plan (FSP), primary care physician (PCP) records and hospital records. SERO spoke with the county social workers, social work supervisors, and administrators in the Intake and On-going units. SERO attended the Act 33 Review Team meeting on March 21, 2012.

### **Summary of Services to Family:**

#### **Children and Youth Involvement prior to Incident:**

On 12/29/10, the agency received a [REDACTED] report concerning the medical care of then 3 month old [REDACTED]. The report was [REDACTED] on 1/4/11. Family Preservation Services were provided from January 2011 to September 2011. [REDACTED] was receiving [REDACTED] services when they were temporarily discontinued due to the mother's medical condition. [REDACTED] was due to deliver her fourth child and was having pregnancy complications. [REDACTED] services were expected to resume in October 2011, however, [REDACTED] never resumed these services and the agency failed to follow up as well. During this pregnancy, [REDACTED] went to live with the maternal grandmother. This was an informal arrangement between the mother and maternal grandmother as the mother was stressed with caring for the three children and dealing with the pregnancy complications.

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

On 2/18/12 Chester County Department of Children Youth and Families (CCDCYF) received a [REDACTED] report alleging 5 month old [REDACTED] had a skull fracture. The child was determined to be in cardiac arrest and barely breathing when he arrived at Brandywine Hospital. As per the child's father, [REDACTED], it was the second time that week he had difficulty breathing, however, no medical treatment was sought after the first incident. He gave no explanation for the head injury. The child was in his father's care at the time of the incident. [REDACTED] was transferred to CHOP. The child had no history of [REDACTED] or other medical conditions. In the home on this night, were [REDACTED]  
[REDACTED]

On 2/18/12 the social worker went to the hospital to interview the medical staff and parents and to see the child. Dr. [REDACTED] reported the child's injuries included a [REDACTED] rib fractures on both sides of the body, numerous bumps, [REDACTED], bruises to the torso, cuts to the head and a skull fracture. Some of the injuries were old and others newer. An [REDACTED] was scheduled. The social worker and parents developed and reviewed the safety plan for [REDACTED]. The mother reported that the two oldest children were not home at the time of the incident and were staying with the biological father of the oldest child. They would remain there as a safety resource. [REDACTED] would be going to the home of his maternal grandmother, where he frequently stayed.

On 2/21/12 the social worker contacted Detective [REDACTED] of the Coatesville Police who was assigned the police investigation. Detective [REDACTED] reported a history of domestic

violence between the parents and that they gave no valid reason for the child's injuries. The caseworker again contacted Dr. [REDACTED] stated the injuries to the child are inconsistent with the explanations given by the parents and suspects abuse. The [REDACTED] investigator conducted a home visit to the home at [REDACTED] Coatesville, PA 19320. The worker met with mother [REDACTED] father [REDACTED] and paternal uncle [REDACTED] who also resided in the home. Mother reported two previous times that [REDACTED] fell but states he did not have any injuries as a result. Parents stated the other three children continue to stay with the identified resource caregivers.

On 2/22/12 the social worker made a visit to the maternal grandmother's home in Lancaster, PA to assess the safety of [REDACTED]. He remained safe in her care. [REDACTED] was seen on 2/23/12 at CHOP by the worker. He remained in critical condition and was diagnosed with a severe brain injury. The worker and Detective met with Dr. [REDACTED] again who reiterated that the injuries appear to be inflicted by someone. Both parents were interviewed at the Coatesville Police Department on 2/22/12; mother was interviewed a second time on 3/1/12. She requested a polygraph for both her and her husband. However, the parents later declined to submit to the polygraph.

On 2/24/12 the case was accepted for In-Home Services. A home visit to [REDACTED] was made. Worker met with mother, father, [REDACTED]. A safety assessment and plan were conducted for all the children in the home. The children were deemed safe with a plan. [REDACTED] would remain in the care of [REDACTED] biological father, and [REDACTED] would continue to stay with the maternal grandmother, [REDACTED] remained at CHOP. All parties signed the safety plan.

On 2/29/12 the caseworker scheduled appointments for the other three children to receive physical exams at CHOP. Appointments were made for 3/6/12. No physical concerns were noted on the other children. CHOP also reported that [REDACTED] had stabilized and that he would need to go to a rehab facility. [REDACTED] was transferred to the Seashore House on 3/5/12.

On 4/12/12 the [REDACTED] on both parents. Neither parent was able to explain how the injuries occurred to the child; both were responsible caretakers during the time the inflicted injuries occurred.

### **Current Case Status:**

The case was transferred to Intensive Brief Services on 3/6/12. The FSP was developed on 3/19/12. The goals are consistent with the identified safety threats and needs of the family. [REDACTED] was discharged from the Seashore House on 5/3/12 to the care of his maternal grandmother. He currently resides there with his brother, [REDACTED]. His sisters, [REDACTED], remain in the home of [REDACTED] biological father. The mother is due to deliver her fifth child in August and the agency is preparing for placement of that child. The parents continue to be non-compliant with their FSP goals and lack of cooperation with the county agency. The father has not been visiting with any of the

children. The mother has supervised visits in their resource homes. [REDACTED] receives services through the Intermediate Unit of Chester County. [REDACTED] have [REDACTED] through Lancaster County. Services have not begun for the parents due to the fact they are non-compliant with FSP goals and recommendations. The county has offered and recommended services, however, they are not cooperating with the county agency. The mother and father were to have assessments related to drug and alcohol abuse, but have not followed through on this. The father has not been visiting with [REDACTED]. The mother visits sporadically with the children. When she visits her behavior is disruptive to the family's functioning. The county continues to work with the family to improve these visits. Per the Coatesville Police Department, the criminal investigation is still pending.

**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. Chester County has convened a review team in accordance with Act 33 of 2008 related to this report.

- Strengths:
  - The agency noted that they followed established procedures as soon as the referral was made to them. Safety assessments and plans were made for all the children throughout the investigation and whenever a change in circumstances took place. Ongoing In-Home services have been implemented to monitor the safety and care of the children. Appropriate referrals were made for the family.
- Deficiencies:
  - None identified.
- Recommendations for Change at the Local Level:
  - The agency will follow up with assessments for the children and the need for referrals for services in areas in which they reside.
  - The county will explore ways to arrange visits between the siblings since they are not currently residing together.
  - Utilizing Family Group Decision Making to empower the family to make a plan for the safe care of the children, as well as identifying an appropriate caregiver for the unborn child due later this year.
  - Another area involves the county providing services for a longer time period for some families to observe parents' ability to meet the needs of their children over time.
  - The agency will review all cases of children who experienced near fatalities to determine the need to file a dependency petition.

- Addressing the need for other systems to contact Department of Children, Youth, and Families (DCYF) to report concerns even if the agency has ended services to the family.
- Requiring parents and caregivers to routinely receive training on infant/child CPR prior to newborns discharge from the hospital.
- Recommendations for Change at the State Level:
  - None identified.

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

The Department has received and reviewed the report provided by the county, and is in agreement with the county's findings.

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

- County Strengths:
  - The county provided clear documentation in the case notes and investigation report. The worker conducted a thorough investigation and all children were seen in a timely manner. Referrals were made for appropriate services and there was good collaboration with other agencies, including the local police department.
- County Weaknesses:
  - None identified.
- Statutory and Regulatory Areas of Non-Compliance:
  - None identified.

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

Recommendations include better collaboration between County Departments through Systems of Care and other initiatives by the county, as previously identified by the county, as a result of a prior near fatality report. This area was again addressed with the agency.