pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Zahra Collins

Date of Birth: 08/18/2015
Date of Death: 11/21/2015
Date of Report to ChildLine: 02/06/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Delaware County Children and Youth

REPORT FINALIZED ON:
09/13/2017

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Delaware County convened a review team in accordance with the Child Protective Services Law related to this report. The county Act 33 review team was convened 03/01/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Zahra Collins	Victim Child	08/18/2015
[redacted]	Mother	[redacted]1986
	Father	[redacted]1969
	Sibling	[redacted]2013
	Sibling	[redacted]2006

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) reviewed case notes and medical records of the victim child, siblings and family. Interviews were conducted by the county social worker and the county detective. The case was determined to be [redacted] on 03/01/2017.

Children and Youth Involvement prior to Incident:

On 08/13/2013, the county received a [redacted] report stating that the newborn child tested positive to [redacted] drugs at birth. The mother reported that [redacted] The new born child [redacted] and was hospitalized for a short time [redacted] The case was assessed and closed in intake in September 2013. The family had no other involvement with the county.

Circumstances of Child Fatality and Related Case Activity:

On 11/21/2017, the victim child was rushed to Crozier Chester Medical Center's Emergency (CCMC) Department and pronounced dead due to respiratory and cardiac arrest.

The Medical Examiner's office determined that there was no suspicion of abuse or neglect. [redacted] After her demise a skeletal survey was completed and a skull fracture of the right frontal bone was revealed. [redacted] the Delaware County Child Fatality review team questioned the Medical findings. On 02/06/2017 the agency received a [redacted] investigation for bodily injury related to death of the victim child as suspicious.

The Delaware County Review Team was developed to review fatality cases and had concerns that the physician missed the fact that this child had a hair line fracture. On 03/01/2017 the Multi-Disciplinary Team meeting was held. The Delaware County review team spoke with the medical examiner who determined that the child died of respiratory and cardiac arrest. He further explained to the review team that the victim child did not have a hair line fracture but a suture. The Medical Examiner reviewed the file and again confirmed his findings. The review team accepted the findings.

An extensive discussion took place regarding the systemic concerns regarding fatality cases. The review team should have contacted the medical examiner before opening another case with Children and Youth, the police and the family who is trying to recover from the loss of a child. The [redacted] based on the ruling of the Medical Examiner.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  The social worker and supervisor did a good job investigating the allegations again. The worker was concerned that the family would be uprooted again after the initial report was [redacted] and for over a year. They handle the family with great care and explained the circumstances. This was a very sensitive and complex case and I thought the county handled it well.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  No deficiencies reported.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  No recommendations reported.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  No recommendations reported.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  No recommendations reported.

Department Review of County Internal Report:

The Department reviewed the county Act 33 report on 05/25/2017 and concurs with the findings of the report as noted.

Department of Human Services Findings:

- County Strengths:
  The notes and documentation were good. All parties involved were interviewed timely and the review team who re-opened the case did a good job in questioning the findings. The family is still healing from the death of their child and the county is offering [redacted]

  County Weaknesses:
  No weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.
No areas of non-compliance identified.

Department of Human Services Recommendations:

The county and the Department felt bad about opening up the investigation that occurred over a year ago. We are suggesting that the Fatality Review Team continue to review cases but contact should be made to the Medial Examiner who made the findings and rule out the discrepancy before a report is called in and the family relive the trauma again.