pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/29/2017
Date of Incident: 10/31/2017
Date of Report to ChildLine: 10/31/2017
CWIS Referral ID: [redacted]

Family was not known prior to Delaware County Children and Youth or within the preceding 16 months,

REPORT FINALIZED ON:
09/20/2018

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 the Office of Children, Youth and Families (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 Children and Youth Services has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/29/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	06/29/2017
[redacted]	Mother	[redacted]1981
[redacted]	Father	[redacted]1985
[redacted]	Sibling	[redacted]2017
[redacted]	Sibling	[redacted]2014

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the child and family. SERO staff reviewed various reports, assessments and case documentation provided by the Delaware County Children and Youth. SERO staff attended the Act 33 on November 29, 2017.

Children and Youth Involvement prior to Incident:

There was no children and youth involvement prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/31/2017, the county received a report regarding 4 month old victim child. The referral was from a hospital for children. The report stated that mother and father of the child brought the child into the emergency room regarding the child's abnormal behavior. The parents reported that the child was not acting like himself and the child was lethargic. They described that their son was having episodes of unresponsive and would turn a gray color for 10-15 seconds at a time. The child had been discharged earlier that morning from the same hospital following [redacted] and at the time of his discharge, he was in stable condition.

The child was having seizure activity while in the emergency department and he was admitted to the intensive care unit. The child received an MRI and the results showed bilateral subdural brain hemorrhages, bleeding on both sides of the brain and fluid was on his spine. The child was intubated and placed on a ventilator. The parents did not report any incident involving head injury or trauma to the child at that time. It was determined that the injury was a result of trauma. The child remained hospitalized until 11/07/2017.

On 11/03/2017, [redacted]. The county [redacted]. This [redacted] was a safety plan decision based on the county recommendation.

The family is receiving ongoing SCOH (In-home) services. The parents of the child live in the home of the maternal grandmother. There is a safety plan that parents are supervised by safety person in the home.

The child is receiving [redacted] services and the child is progressing. The child [redacted].

The investigation assessment outcome for the near fatality was submitted on 12/29/2017 as indicated.

There was a criminal investigation open at the time of the county investigation determination. The criminal investigation subsequent closed with no arrests being made.

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

- Strengths in compliance with statutes, regulations and services to children and families; None identified.

- Deficiencies in compliance with statutes, regulations and services to children and families; None Identified.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; There is an identified need for education to be provided to parents and caregivers surrounding serious issues sustained by impact against soft surfaces. Additionally, it is recommended all mothers participate in post-partum screening routinely and for an ongoing period following the birth of the child.

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

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

Department Review of County Internal Report:

The Department received the County report on 04/10/2018 and

Department of Human Services Findings:

The county provided a comprehensive report of the near fatality.
The Act 33 was held on November 29, 2017 however, the full county report was not received until April 10, 2018.

- County Strengths: The County completed an extensive investigation. The County worked effectively with the law enforcement regarding the investigation.

- County Weaknesses: There was a delay in submission of the county's Near Fatality Review Report. The county's Act 33 review process continues to be a strengthening practice.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  None identified.

Department of Human Services Recommendations:

The Department recommends public service announcement regarding the care and parenting of pre-mature infants to avoid blunt force trauma and shaking baby syndrome.