



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF**



**BORN:** [REDACTED]/2007  
**Date of Near Death: 2/02/2010**

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

**REPORT DATED 06/10/2010**

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 No. 1147, now known as Act 33 was signed on December 30, 2008 and went into effect 180 days from that date. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

**1. Family Constellation/Household composition:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
██████████	victim child	██████/2007
██████████	mother	20 years old
██████████	mother's paramour*	18 years old
██████████	maternal grandmother	44 years old

\*Paramour was a friend of the mother's from high school. He had been living in the home for several months.

Other Family

██████████	father	██████/1987
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**Notification of Fatality / Near Fatality:**

On 2/02/2010, ChildLine received a referral about almost three year old ██████████. ██████████ had been airlifted to DuPont Hospital. The mother's paramour reported to mother that the child was unresponsive. Police and ambulance arrived, and found the child barely conscious. His left eye appeared to be swollen. He had a "thumb print bruise" on his forehead. He had finger tip bruising to both arms and his abdomen. The doctor certified that child was in critical condition, and that the child was "clearly abused." ██████████ had old and new ██████████

The mother's paramour had been alone with the child, and called mother when he found ██████████ unresponsive.

**2. Documents Reviewed and Individuals Interviewed:**

For this review the SERO reviewed the family's county case file.

SERO interviewed the county caseworker and supervisor who have previously worked with the family and are still employed by the agency. The regional office attended the County's Internal Fatality Review Meeting regarding this case on 2/25/2010.

**Case Chronology:****Previous CY involvement:**

12/13/2009 [REDACTED]

Closed 1/15/2010

On 12/12/2009, Chester County Department of Children, Youth and Families (DCYF) received a referral about [REDACTED] being brought to the ER of Chester County Hospital (CCH) with an unknown rash on his body. The triage nurse noted a bruise near the child's ear and three red marks on the child's buttocks area; these marks were suspicious, possibly hand or finger marks. When questioned, the parents reported that he had fallen at the laundromat just shortly before being brought to the ER. [REDACTED] was fussy, and his parents reported a recent change in sleeping behavior. Parents reported a history of [REDACTED]. Pediatrician was identified as [REDACTED]. The family left prior to being seen by a physician (after being at ER for two hours). The ER attempted to reach them by phone several times, and later that day [REDACTED].

On 12/14/2009, DCYF social worker conducted an unannounced home visit to the family home and met with the mother. The social worker inquired about the purple marks on [REDACTED] body. The mother stated that it was a rash, and that he had gotten purple rashes in the past. She reported that the maternal grandmother had watched [REDACTED] Saturday night (12/12/2009) while she had gone out line-dancing. She stated that the child had awakened briefly when she came home at 2 a.m., but he had gone back to sleep. The mother reported that his sleeping patterns have not changed (different than what the hospital had reported). She believed that the rash did not come from food as he had not eaten any new foods, although he did have a brand of chocolate that he had not had before. The mother reported that [REDACTED] had gotten a new jacket, and had worn it before she washed it. When the mother bathed [REDACTED] on Friday night, she noted only a bug bite that he received when they were in Florida with her boyfriend. As the social worker interviewed the mother, some inconsistencies in her report appeared. The mother later said that she had returned home about 11 p.m. She had taken [REDACTED] with her on Sunday morning (12/13/2009) to the laundromat. She noticed that his face was turning red, but he had been running around playing. [REDACTED] ran into a dryer door; the mother showed the social worker a bruise on the fold of his ear. When they arrived home from the laundromat, she noticed that his skin was turning purple. She called her pediatrician, who instructed her to take him to the ER. The mother reported that the triage nurse accused her of beating her son, so she left the hospital and planned to take him to the pediatrician that day. She was aware of a small bruise on his buttocks, but reported that he had fallen while playing with his cousin. The mother called the doctor's office during the home visit, and was given an appointment for that evening. The social worker photographed the marks on victim child's body. The Safety Assessment stated that the child did not seem fearful of his mother, and that the mother and maternal grandmother do not use drugs or alcohol.

The DCYF social worker contacted the pediatrician on 12/15/2009 to confirm that the mother had brought the child in for an appointment. [REDACTED]

██████████ stated that she had sent them to A.I. DuPont for evaluation because she believed that the purple marks may have been bruises.

12/15/2009

1/14/2010

On 12/15/2009 ChildLine received a call about ██████████. The mother had brought ██████████ to CCH, and had been referred to their PCP for what they described as a suspicious bruise. ██████████ A.I. DuPont examined the child, and was unable to determine if the marks were bruising or a rash. ██████████ reported on the ██████████ that the bruising on the buttocks did not look like a hand print, so he was unable to determine a cause. A ██████████ was completed, which was negative. Reporting source stated that child had unspecified delays.

On 12/15/2009, the DCYF social worker conducted a home visit and met with maternal grandmother. The social worker observed that the purple marks on ██████████ skin were almost gone. Photographs were taken again.

On 1/14/2010, the DCYF social worker completed the ██████████ this ██████████. The explanation was that the ██████████ the child's injuries were "caused by an allergic reaction." The county case file does not contain any written documentation from a physician that these marks were an allergic reaction, only conversations with physicians who could not explain the injuries.

**Circumstances of Child's Fatality or Near Fatality:**

On 2/02/2010, ██████████, almost three years old, was home alone with the mother's paramour (who was considered the ██████████). The paramour called the mother and stated that the child was non-responsive. ██████████ was transported to A.I. DuPont Hospital where his injuries were further evaluated. The doctor certified that the child was in critical condition, and that the child was "clearly abused." Injuries consisted of his left eye appearing to be swollen, a "thumb print bruise" on his forehead, finger tip bruising to both arms and his abdomen, ██████████

Police had gone to the home when the 911 call was placed. Upon arrival at the home, they determined the injuries were suspicious and began their investigation. The paramour initially told the mother that ██████████ had vomited into the toilet, and fallen and hit his head on the toilet. He reported that this happened twice.

During the ██████████, the mother and maternal grandmother were interviewed by DCYF on 2/3/2010 and 2/16/2010. They reported to the DCYF social worker that they had noticed two bruises on ██████████ buttocks about two weeks previously. The paramour had admitted to spanking him. Both mother and maternal grandmother emphatically told him that he was not to spank ██████████. They reported that he had been particularly helpful in caring for ██████████ as he volunteered to bathe and change him often.

The DCYF worker had frequent contacts with the police and hospital throughout the [REDACTED]

**Current / most recent status of case:**

- [REDACTED] to the mother's care on 2/15/2010. He will need follow up for speech and occupational therapy. Child has been referred to [REDACTED] to provide these services.
- [REDACTED] was arrested 2/5/2010 on charges of Aggravated Assault, Simple Assault, Endangering the Welfare of a Child, and Recklessly Endangering Another Person. He is currently incarcerated, awaiting trial. The mother reports that he has called her frequently from jail (at least 30 times) and has admitted to her that he punched [REDACTED] in the head and kicked him in the stomach. The mother and maternal grandmother report that he has been in drug rehab in the past, but they do not believe that he was currently using drugs.
- On 3/8/2010 the family was [REDACTED].
- On 3/10/2010, the [REDACTED] naming mother's paramour.

**Services to children and families:**

- On 2/22/2010, DCYF [REDACTED] to the family. This will include referrals to and collateral contacts with [REDACTED], Intermediate Unit, and Health Department [REDACTED]

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:**

**Strengths-**

- The review team agreed that appropriate referrals were made to DCYF, Early Intervention and the Health Department. These county departments provided services consistent with their mandates and in compliance with their regulations. While there were other supportive services offered and recommended, [REDACTED] did not take full advantage of these services.

**Deficiencies-**

- It was identified that services could have been better coordinated for this family, particularly by following up with [REDACTED] to see if the case was still active or any problems noted. Knowledge gained from this follow up might have raised red flags for further [REDACTED]. One recommendation is that collaboration between County Departments continues to be strengthened through the System of Care and other initiatives currently being implemented by the Chester County Human Services Policy Team. A more specific recommendation includes DCYF routinely requesting that parents sign releases for information from the Health Department and [REDACTED]. Services for all [REDACTED] investigations conducted on children under age five. This will ensure that all available information for a comprehensive assessment is obtained and that any needed services are well coordinated.

**County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:**

- A recommendation regarding all [REDACTED] investigations is to ensure that the Caseworker assigned to conduct the investigation makes every effort to contact the reporting source directly when the reporting source is a mandated reporter as defined by the Child Protective Services Law. This step will ensure that the assigned Caseworker receives complete and thorough information about the report directly from the source.
- Three additional recommendations are related to obtaining and using medical information when conducting an investigation. One is to seek expert medical consultation for all [REDACTED] investigations involving children under age 5 when the medical provider is uncertain regarding the cause of injuries. Another is to offer services whenever a [REDACTED] investigation of a child under age 5 is not [REDACTED] due to medical findings that the cause of injury can not be determined. The third is to consider a procedure used by OCYF to automatically request medical records from health care providers when conducting [REDACTED] investigations. The OCYF representative participating in the Review Team meeting agreed to determine if the letter OCYF uses for this purpose is appropriate for counties to consider using and to share the format for this letter with DCYF.
- Another recommendation is for Chester County to develop strategies to better inform grandparents about the services available for young children, and about the services available for parents or others caring for young children. This was identified as particularly important for grandparents who may have responsibility for parenting young children residing in their home, or for grandparents who may be in a position to help young parents take full advantage of available services.
- A final recommendation is for Chester County to develop additional strategies to help families better understand the benefits of accepting voluntary supportive services for themselves and their children. One idea for accomplishing this is to offer more Family Group Decision Making conferences that are now available to all families receiving services from any of the Chester County Human Services Departments. These conferences may provide an opportunity for the broader family system to play a role in helping parents, especially young parents, choose to participate in services that could help their children and assist them in safely caring for their children.

**SERO Findings:**

**County Strengths-**

- Investigations were timely and thorough.

**County Deficiencies-**

- In the Safety Assessment, it is recorded that the mother and maternal grandmother do not use drugs. The case notes do not document how this conclusion was reached. However, during the county review, the social worker stated that she

asked the mother and maternal grandmother about drug and alcohol use, and they denied any abuse. The social worker further stated that when she visited the home, she did not observe any apparent signs of drug or alcohol use.

- The [REDACTED] from the December 2009 investigation explains the DCYF [REDACTED] being based on the child's injuries being caused by an allergic reaction. The case file does not contain any medical reports that would support this.

**Statutory and Regulatory Compliance issues:**

- Risk and Safety Assessments were completed in a timely manner.
- Both [REDACTED] occurred in a timely manner. The December [REDACTED] included consultation with medical personnel who could not clearly identify the cause of the purple marks.
- Interviews were completed with all appropriate family members and collateral contacts.
- During the Act 33 Review, it was determined that this child had already been evaluated by and had previously received services through [REDACTED]. DCYF will obtain a copy of that developmental evaluation. [REDACTED] services will assist the mother and DCYF in a referral to the IU for [REDACTED] services as he is almost three years old.