



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: [REDACTED]/10

Date of Near Fatality Incident: 3/6/10

FAMILY KNOWN TO:

The Family was not known to Delaware County Children and Youth Services

REPORT FINALIZED ON: 03/31/2011

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.

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

Family Constellation:Name:

██████████
██████████
██████████

Relationship:

Victim Child
Mother
Maternal grandmother

Date of Birth:

██████████ 2010
██████████ /1976
72 years old

Notification of Child (Near) Fatality:

On 3/6/10 the Delaware County Children and Youth Services (CYS) received a ██████████ report that alleged the mother gave birth to ██████████ in the bathroom while the mother was on the toilet. The mother cut the umbilical cord to ██████████. Afterwards the mother discarded ██████████ out of the bathroom window. According to the maternal grandmother, she heard a baby crying in the bathroom. The maternal grandmother stated she went back into the bathroom and didn't see the baby. The mother told the maternal grandmother that there wasn't a baby in the bathroom, she heard children playing outside. The maternal grandmother reported when she looked outside the bathroom window she saw the baby on the ground. The maternal grandmother reported after she saw the baby in the plastic bag on the ground she called 911. When the emergency team arrived, the mother and the victim child were transported to Crozer Chester Medical Center (CCMC), Chester PA. for medical care. Based on the severity of the injuries, the VC was transported via helicopter to the Children's Hospital of Pennsylvania (CHOP)

Documents Reviewed:

The Southeast Regional Office (SERO) received the oral report on 3/6/10. On 3/6/10 and 3/7/10. The regional office made telephone contact with the Delaware County on call caseworker ██████████. The regional office attended the review on 4/4/10. On 6/23/10 the regional office conducted follow up interviews with ██████████, Caseworker, ██████████, Administrator, ██████████, Assistant Director and ██████████ Caseworker.

Previous CY Involvement:

Prior to the near death incident on 3/6/10 the family was not known to the Delaware County Children and Youth Services or any other child welfare services.

Circumstances of Child (Near) Fatality and Related Case Activity:

On April 6, 2010, Delaware County Children Youth Services (CYS) received a [REDACTED] report for victim child, [REDACTED]. According to the CY case worker the mother and the maternal grandmother were interviewed by CY. The mother reported during the interview that she gave birth to the victim child in the toilet. The mother reported she cut the umbilical cord with a pair of manicure scissors. The mother stated after she cut the umbilical cord she put the child, umbilical cord and the placenta in a plastic bag and tied the bag. The mother reported she didn't tie the bag too tight because she wanted the child to breathe. The mother dropped the baby out of a bathroom window which was six feet high. The child fell into a frozen flowerbed. The MGM stated she heard a baby crying and asked the mother if a baby was crying and the mother stated it was the children outside. The MGM looked outside and saw a plastic bag. The MGM went outside to retrieve the plastic bag. The MGM called 911. The MGM did not open the plastic bag until the paramedics arrived. While the MGM waited for the paramedics she wrapped the VC in a blanket, while still in the plastic bag. When the paramedics arrived the VC and the MO were taken to Crozer Chester Medical Center (CCMC). The VC was medically assessed at CCMC and determined to have a skull fracture and severe brain bleed. The VC was transported via helicopter to the Children's Hospital of Pennsylvania (CHOP) and placed in [REDACTED]. According to CY the MO appeared emotionally unattached to the VC; she displayed no concern for the VC during the incident. The MO was hospitalized on the CCMC [REDACTED] for four days and then [REDACTED] to the CCMC [REDACTED] unit. Upon [REDACTED] from the [REDACTED] unit she was required to attend the [REDACTED] program Monday through Friday. The MO was diagnosed with [REDACTED] and was prescribed [REDACTED] CY filed for custody of the child on 3/29/10. The VC remained at the hospital for 31 days. During the hospitalization the child required intensive medical attention. The child experienced feeding dysfunctions due to her brain injuries. The MO began to visit the VC after she was in the hospital for three weeks. The visitation was supervised by CY. The MGM was always present during each visit. On 4/6/10 the VC was [REDACTED] from the hospital and placed in a foster home.

Current Case Status:

- The child was [REDACTED] on 4/6/10 and was placed in a foster home through Children's Choice.
- The child was [REDACTED] bottle fed and there were no immediate medical needs
- The child will continue to be closely observed and required to have wellness visits and early intervention screenings.
- CY [REDACTED]
- The mother resides with the maternal grandmother and attends the [REDACTED] program at Crozer Chester Medical Center.

- Weekly visits for the mother and the maternal grandmother are held at CYS.
- Initially the mother and the maternal grandmother refused to disclose the father's name. On 5/11/10 CYS made contact with the father of VC. The father reported he needed to establish paternity before he became involved with the VC. As of this date paternity has been established and he is the biological father. The father has supervised visits with the VC.
- Criminal charges are still pending.
- On 4/8/10 CYS did complete the [REDACTED] and the report was filed [REDACTED]. According to the medical professionals, the VC suffered a significant head trauma including a [REDACTED] that are all consistent with blunt impact trauma.

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 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 has convened a review team in accordance with Act 33 of 2008.

Strengths: CYS collaborated with the medical staff and mental health professionals to ensure mother and resource family received additional services to ensure the needs of the child and family are met. CYS will seek out resources such as public service announcements or advertising to educate the community on the seriousness of pregnancy denials in mothers and the prevention of child abuse.

Deficiencies: There were no areas of concern identified.

Recommendations for Change at the Local Level and State Level:

The review team recommended that CYS continues to explore and institute alternative ways to educate the community on child abuse and the damaging effects on families and communities. The review team discussed the advantage of public service announcements to provide information on Planned Parenthood and the Safe Haven Laws.

Department Review of County Internal Report:

The CYS staff collaborated with the medical team to ensure the appropriate treatment for the child's discharge. The resource family for the child will receive additional services and support due to the trauma experienced by the child. CYS will update and continue to train staff on the policies and procedures governing the Safety Assessment Policies.

Department of Public Welfare Findings:

This family was not known to child welfare. CYS conducted the review timely and the review team exemplified expertise in prevention and treatment of child abuse. CYS will continue to conduct periodic training for the staff to maintain compliance with the Safety Assessment and Management Process. CYS will continue to communicate with individuals or resources that will be instrumental in the continuity of care for the families served by CYS. The mother, child and resource family would benefit from continued [REDACTED] services.

Department of Public Welfare Recommendations:

There were no recommendations.