



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE Near Fatality OF:**

[REDACTED]

**BORN:** [REDACTED] 2000

**Date of Near Fatality Incident: 12/27/2010**

**FAMILY KNOWN TO:**

*Chester County Department of Children, Youth and Families*

**REPORT FINALIZED ON:**

10/5/2012

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 by Governor Edward G. Rendell. 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 convened a review team in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	victim child	██████████/2000
██████████	brother	██████████1997
██████████	mother	██████████1975

**Other family members (not household members)**

██████████	father	██████████1974
██████████*	sister	██████████/1993

\*resides with maternal grandparents in Lancaster County

**Notification of Child (Near) Fatality:**

On 12/27/2010, ██████████ contacted Chester County Department of Children, Youth and Families (DCYF) concerning ten year old ██████████. ██████████ had presented at Brandywine Hospital with ██████████, and symptoms consistent with ██████████. ██████████ blood sugar level was 1239; normal blood sugar for children should be in the range of 80 to 180. The mother had been told previously by the hospital staff that she needs to bring her daughter to the hospital immediately if she begins vomiting. ██████████ had begun vomiting the night before 12/26/2010; but the mother did not bring her to the hospital until 12/27/2010. The mother reported that she thought that ██████████ had the flu, as the mother was experiencing flu-like symptoms herself. ██████████ was transported to A.I. DuPont Hospital on 12/27/2010.

The hospital was especially concerned as ██████████ had come to the hospital in similar condition on 10/17/2010, 10/22/2010 and 12/08/2010. On these occasions, she was also transported to A.I. DuPont Hospital for more intensive treatment.

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

The Southeast Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. Medical records from DuPont Hospital and Brandywine Hospital were reviewed by the Regional Office. Interviews were conducted with the Caseworker, and [REDACTED], social worker at DuPont Hospital. The regional office also participated in the County Internal Fatality Review Team meeting on 01/21/2011.

**Summary of Services to Family:**

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

04/01/2002 [REDACTED]

Both parents were [REDACTED]. The parents had not taken [REDACTED] to the clinic for necessary medical appointments (six appointments were missed). The parents were also not consistent with administering [REDACTED] prescribed [REDACTED]. As a result, her blood levels rose to a level that put her in a [REDACTED]. [REDACTED] briefly lived with other family members until the county determined that the parents were appropriately trained to care for their daughter. The county implemented in-home services at the conclusion of the [REDACTED] (Further information is not available as the county could not locate the case file from this incident.)

10/24/2010 [REDACTED]

Closed 10/24/2010

DCYF received a report [REDACTED] concerned about [REDACTED] hospitalization at DuPont Hospital. [REDACTED] was admitted to the hospital the previous week after going into a [REDACTED]. The reporting source could not provide specific details, but stated that he had previously been the child's caretaker.

The DCYF worker contacted DuPont Hospital, and spoke with the [REDACTED]. The hospital was not planning to report this case [REDACTED], and had not even informed their social work department about this. The hospital social worker reported that the mother had missed some appointments in the past, but the hospital did not have any concerns for the child and mother at this time.

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

After receiving notification of the child's medical condition on 12/27/2010, the County [REDACTED] worker saw the child, contacted the hospitals, interviewed family members, and reviewed medical files.

[REDACTED] had been diagnosed with [REDACTED] when she was eleven months old. [REDACTED] and her brother, [REDACTED], lived with their father from 2006 to June 2010 because of their mother's incarceration. When [REDACTED] was released from a half-way house in June 2010, she resumed physical custody of [REDACTED]. Prior to this, the father had been managing the [REDACTED] at a somewhat acceptable level, as described by the DuPont social worker, meaning no emergency room visits. The school nurse assisted the father in the care of [REDACTED] during the school hours. The father and

his grandmother provided [REDACTED], but it was suspected that she may have been sneaking snacks, which de-stabilized her blood sugars. The father ensured that [REDACTED] attended routine medical appointments at DuPont for her [REDACTED]

The initial Safety Plan was that [REDACTED] would reside with her father until the mother could demonstrate knowledge of the care needed for her daughter's medical care. The county was informed by the [REDACTED] nurses on 01/12/2011 that the father did not have adequate supplies for [REDACTED] monitoring. The father knows how to obtain these supplies; he would only need to call DuPont and they would have whatever was needed delivered, as he had done this in the past. (NOTE: The mother had recently told the father that he may not be the biological father of [REDACTED]. This news had caused him emotional turmoil. He was frustrated that he had been the primary caregiver for [REDACTED] and was court ordered to pay the mother child support, but that he may not even be her biological father.) On this date, the county made a new Safety Plan with the parents for the child to stay with a maternal aunt in Lancaster, Pennsylvania. The county worker met with the aunt to ensure she understood the care needed, and that the home was suitable.

#### **Current Case Status:**

On 01/25/2011, the mother was [REDACTED]. The mother had been previously informed by medical staff that she should bring her daughter to the hospital immediately if she should ever begin vomiting. She did not bring her daughter to the ER until the day after the vomiting began.

[REDACTED] continues to live with the maternal aunt in Lancaster, Pennsylvania. The mother is receiving individualized medical training in her home. The nurse reports that the mother has fallen asleep during the training sessions, so there is concern about her commitment to this educational process. Based on past history with the county and her criminal history, it is believed that the mother also may have untreated [REDACTED] issues.

#### **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 convened a review team in accordance with Act 33 of 2008 on 1/21/2011.

- Strengths:
  - DCYF followed established procedures. An initial safety plan was developed with the father, but had to be revised when the county became aware of safety threats.
  - DCYF assessed both siblings in their current family settings.
  - DCYF reached out to DuPont to understand the child's medical status.
- Deficiencies:
  - None identified.
- Recommendations for Change at the Local Level:
  - Increase the general medical knowledge base of DCYF caseworkers on [REDACTED] and other childhood illnesses such as asthma.
- Recommendations for Change at the State Level:
  - None identified
  -

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

The County invited the social worker from DuPont Hospital to participate in the review. His information about [REDACTED], and how to care for it, was invaluable. This social worker volunteered to provide training for social work staff at DCYF to assist them in their work with families.

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

- County Strengths:
  - Collaboration with medical community
  - Quick response to changes in safety threats
- County Weaknesses:
  - It should be noted that the county could not locate the file from [REDACTED] report. Because of other [REDACTED] files being misplaced, the county had already instituted a practice of using bright colored folders for [REDACTED] so they would be easily identified and not destroyed. These [REDACTED] files are also stored in a different location to prevent any other files from being misplaced.
- Statutory and Regulatory Areas of Non-Compliance:
  - The County was not able to locate their [REDACTED]. A Licensing Inspection Summary was not issued in this situation, as the county had already put into place a plan of correction.

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

County agencies should ensure that their staff have access to medical information and training related to child abuse and neglect.

