



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: [REDACTED], 2010**

**Date of Near Fatality Incident: June 23, 2010**

**The family was not known to any  
County or any Children and Youth Agency**

**Date of Report: January 25, 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))



## Summary of Services to Family

### Children and Youth Involvement prior to Incident

The family has not had any involvement with children and youth prior to the incident.

### Circumstances of Child Near Fatality and Related Case Activity

- On June 23, 2010 Delaware County Children and Youth received a referral from [REDACTED]. It was reported that [REDACTED] was brought into Crozer Chester Medical Center Emergency Room on June 21, 2010. The father of [REDACTED] reported that she had been fussy for the past few days. He reported that on June 21, 2010 when he picked [REDACTED] up out of her bouncy seat she was limp. He further reported that he gave [REDACTED] a slap on her back and a rescue breath and called 911. When the emergency response arrived they stimulated [REDACTED] to breathe and she was transported to Crozer Chester Medical Center.
- On June 22, 2010, [REDACTED] was transported to DuPont Hospital from Crozer Chester Medial Center. While at DuPont, the doctors first thought [REDACTED] had suffered a seizure and they ordered an [REDACTED] which indicated that her [REDACTED] brain was covered with blood bi-laterally (all-over). Doctors also stated that there was both acute (new) and sub-acute (old) blood. It was stated that acute blood is a result of trauma which occurred less than three days from the time she was hospitalized. The sub-acute blood is the result of a trauma which occurred two weeks prior to [REDACTED] being hospitalized. It was reported that the sub-acute blood was more pronounced than the acute blood. [REDACTED] also suffered multi-layered [REDACTED] injury. It was reported that there are three layers in the eye and that in all three layers of both of [REDACTED] eyes, she has [REDACTED], which means that there are too many [REDACTED] to count. [REDACTED] was examined by an Ophthalmologist, who confirmed that she had [REDACTED] which are a result of trauma. Both Ophthalmologist and Neurologist confirmed that [REDACTED] did not experience a seizure as initially thought. [REDACTED] was intubated and remained in the hospital for five days. She had a [REDACTED] which did not indicate any further injuries. However, throughout further testing it was determined that [REDACTED]'s third and fourth toes on her right foot were broken. There is clear medical evidence of [REDACTED]. [REDACTED] was discharged from DuPont Hospital on July 2, 2010.
- The parents suggested that [REDACTED] could have a medical condition that would result in the [REDACTED]. The parents reported possible Vitamin C and Vitamin K deficiencies. The parents also reported possible [REDACTED]. All of the medical tests results were normal. [REDACTED] does not have any medical conditions that would contribute to her medical condition.
- On August 18, 2010, Delaware County Children and Youth completed the [REDACTED] both parents ([REDACTED]) were [REDACTED] injuries were due to confirmed child abuse according to medical evidence. Her injuries are a result of non-accidental trauma and she suffered severe pain and impairment.

- Both parents were [REDACTED] but both denied inflicting or witnessing abuse toward [REDACTED]. [REDACTED] suffered multiple traumatic injuries. Neither parent offered any explanation for [REDACTED]'s injuries. Both parents stated that she is under their primary care and supervision. The parents received voice analysis through the police department. The results of the father, [REDACTED], indicated that his analysis determined that he is deceitful. The analysis of mother, [REDACTED], was normal.

### Current Case Status

- On September 28, 2010 [REDACTED] was adjudicated delinquent with custody awarded to Delaware County Children and Youth.
- [REDACTED]'s health is progressing; she has been downgraded from a medically-fragile to fragile. It was determined that she does not need a stroller as was initially thought. She will be receiving early intervention services.
- On October 1, 2010 [REDACTED] was placed with kinship, her great aunt [REDACTED] great aunt [REDACTED]. She is the paternal aunt of [REDACTED].
- [REDACTED] has moved out of the home with [REDACTED]. He does not know where she lives.
- [REDACTED]'s visitation with [REDACTED] was initially supervised. Currently visitation is unsupervised in the home of [REDACTED]. All of the visits have been without incident.
- [REDACTED] has completed evaluations and has completed parenting education.
- [REDACTED]'s permanency goal is reunification with her mother. The county is working toward reunification of [REDACTED] to [REDACTED]. The next court hearing is March 2011 looking for the court to return custody to the mother.
- [REDACTED] has been arrested and is currently incarcerated. He turned himself over to the police. December 2010 he was released on bail. He wears an ankle bracelet to monitor his whereabouts. He started supervised visitation with [REDACTED] in December 2010. The visits take place in the Delaware County Children and Youth Agency.

### County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report

Delaware County convened a review team in accordance with Act 33 on July 7, 2010 related to this report.

- Strengths: The review team did not identify any strengths.

- Deficiencies: The review team did not identify any deficiencies.
- Recommendations for Change at the Local Level: The review team did not identify any recommendations for change at the local level.
- Recommendations for Change at the State Level
  1. It was noted that the hospital that initially treated the child did not make a referral to children and youth services. It was recommended that there be communication with the hospital emergency department and that training about mandated reporting be offered. A representative from the hospital was present at this case review. The hospital representative later reported that she reviewed the matter with the chairman of the emergency department who followed up with the attending physician and the radiologist. The hospital representative has also facilitated contact between the Director of the Pediatric Residency Program and Delaware County Children and Youth in order to set up training about mandated reporting of child abuse.
  2. It was also recommended that information about the medical findings be communicated to the child's outpatient pediatrician. The mother phoned the pediatrician earlier in the month to report fussiness and irritability. Tylenol was prescribed. This was perhaps the time of the first [REDACTED]. During the initial investigation, children and youth services contacted the child's pediatrician to notify her about the medical condition of the child.

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

The county report was received on November 30, 2010. The report provided a comprehensive overview of the near fatality of [REDACTED]. The report provided a comprehensive overview of the outcomes of the [REDACTED] investigation.

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

- County Strengths: Delaware County Children and Youth completed a comprehensive [REDACTED] investigation. The county obtained all necessary medical/hospital documentation and collaborated with [REDACTED]'s pediatrician and the medical specialist regarding the child abuse incident. The county monitored the medical progress of [REDACTED]. The county obtained all necessary police reports and continues to be involved with the police department. The county interviewed all individuals involved with the maternal and paternal families.
- County Weaknesses: There are none identified
- Statutory and Regulatory Areas of Non-Compliance: As required by Act 33 the review team must submit a final written report on each child fatality or near fatality to DPW and a designated county official within 6340 (a) (11) of the CPSL within 90 days of convening the review. DPW received the written report from

Delaware County on November 30, 2010. The Act 33 full review was held on July 7, 2010.

**Department of Public Welfare Recommendations**

The Department agrees with the recommendation of the county regarding mandated child abuse reporting. It is of concern that the initial hospital that treated [REDACTED] did not report this to children and youth. The hospital did send a representative to participate in the Act 33 Review. The review process facilitated collaboration between the hospital professionals and the county children and youth agency, providing an opportunity for training of mandated reporters at the hospital. The region can monitor this through safety assessment reviews, licensing and evaluation.