



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: January 8, 2011**

**The family was not known to  
any public or private child welfare agency**

**Date of Report: May 16, 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. 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. Delaware County Children & Youth Services 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>
[REDACTED]	Victim Child	[REDACTED]/2010
[REDACTED]	Twin Sister	[REDACTED]/2010
[REDACTED]	Half-Sister	[REDACTED]/2008
[REDACTED]	Mother	[REDACTED]/1988
[REDACTED]	Maternal Uncle	
[REDACTED]	Maternal grandmother	

*Other Family Members*

[REDACTED]	Father of [REDACTED]*	[REDACTED]/1986
[REDACTED]	Father of [REDACTED]	[REDACTED]/1979

\*Paternity has not yet been established

**Notification of Child Near Fatality**

On January 8, 2011, Delaware County Children and Youth Services received a call [REDACTED] concerning four-month old [REDACTED] was brought to Crozier Chester Hospital when he was found unresponsive in the middle of the night between 2:00 am and 4:00 am. The maternal grandmother began CPR and called 911. [REDACTED] to the Children's Hospital of Philadelphia (CHOP) on January 8, 2011. Upon admission, doctors noted that he did not have an infection and was [REDACTED] [REDACTED] was considered to be in critical condition. The doctors were unable to discover a cause for this. Victim child was determined to have some [REDACTED]. The doctor noted that the parent's description of the event at home did not match the infant's [REDACTED]. Upon inquiry, the mother denied that she was sleeping with the child. X-rays were completed of [REDACTED] which found [REDACTED] [REDACTED] Results were inconclusive as to when these occurred or if they were a result of immaturity.

[REDACTED]

### Summary of DPW Child Near Fatality Review Activities

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker. The regional office also participated in the County Act 33 Review Team meetings on February 9, 2011.

### Summary of Services to Family

#### Children and Youth Involvement Prior to Incident

Neither parent had any history with any public or private child welfare agency.

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

[REDACTED] and his twin sister, [REDACTED], were born at 25 weeks [REDACTED] at St. Joseph's Hospital [REDACTED]. When they were [REDACTED], both infants were to be on [REDACTED]. On January 8, 2011, [REDACTED] was admitted to CHOP after an unresponsive episode. He experienced [REDACTED] [REDACTED] as a result. [REDACTED] also was determined to have [REDACTED] that were not present at the time of [REDACTED] [REDACTED]

When the county worker went to the family's home on January 14, 2011, the worker observed that [REDACTED]. The mother also reported that [REDACTED] had [REDACTED] prior to January 8, 2011. The mother reported that the twins were not on the [REDACTED] as their physician had indicated that they were not necessary. The hospital contacted the primary medical providers who denied making that statement. The Safety Assessment determined that the mother had Diminished Capacities. The Safety Plan was immediate placement of the other two children out of the home with all visitations with the mother to be supervised.

On January 14, 2011, Delaware County Children and Youth Services [REDACTED] [REDACTED] of two-year old [REDACTED]; both children were placed in an agency approved foster home. [REDACTED] has been assessed and recommended for [REDACTED] [REDACTED] Services; she requires testing with [REDACTED] [REDACTED] has no medical issues and is current with her medical care.

On February 23, 2011, the county investigation was [REDACTED] [REDACTED] stated that the medical reports from CHOP could not identify the cause of the injuries. The doctors indicated that being on the [REDACTED] would have alerted the caregiver to the event but

could not conclusively state that this would have changed the child's current medical condition. When evaluated at [REDACTED] CHOP, the cause for the [REDACTED] could not be determined. The [REDACTED] could have been the result of everyday handling of a premature [REDACTED] infant.

### Current Case Status

February 15, 2011. Delaware County awarded physical custody of [REDACTED] to their father after paternity testing determined that he was the twins' biological father. The father lives with his mother. The family did not feel the need for services; the county did not assess any need for services.

March 15, 2011. [REDACTED] returned to the custody of her mother, [REDACTED]. No services were provided to the mother.

Recommended medical follow up for [REDACTED] is for [REDACTED]. [REDACTED] Also recommended is evaluation by [REDACTED]. [REDACTED] has been diagnosed with [REDACTED], and continues to need the [REDACTED].

[REDACTED] sister, [REDACTED], was referred to CHOP for [REDACTED] follow up, to [REDACTED] evaluation, and to [REDACTED]. Continued [REDACTED] was also recommended.

Risk assessment completed March 15, 2011 indicated that the overall level of risk is low. No visible safety concerns were identified in either parent's home. No needs were identified; the case was closed.

### 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. Delaware County Children and Youth Services convened a review team in accordance with Act 33 of 2008 on February 9, 2011.

#### Strengths

- Timely [REDACTED] investigation, including submission of [REDACTED].
- Timely provision of written and oral notification.
- Timely completion of Safety Assessment and Safety Plan.
- Collaboration with medical professionals.

#### Deficiencies

None noted.

### Recommendations for Change at the Local Level

Pediatricians need to provide clearly defined instructions for medically-involved children, especially infants born prematurely.

### Recommendations for Change at the State Level

None noted.

### Department Review of County Internal Report

The Southeast Region has reviewed this report and is in agreement with the findings.

### Department of Public Welfare Findings

#### County Strengths

- Timely ■ investigation, including submission of ■
  - Timely provision of written and oral notification.
  - Timely completion of Safety Assessment and Safety Plan.
  - Collaboration with medical professionals.
  - Contact made with ■ father who indicated that he could not be a resource for her at this time.

#### County Weaknesses

None identified.

#### Statutory and Regulatory Areas of Non-Compliance

County did not provide Regional Office with copies of CPS investigation at completion of CPS investigation (February 23, 2011) as required in the Bulletin. The county had multiple changes in senior management due to retirements in early 2011 which may have resulted in this delay.

### Department of Public Welfare Recommendations

The Department recommends that Delaware County Children & Youth Services train and refresh county staff on Act 33 of 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near fatalities as a result of suspected child abuse. The counties need to be in regular communication with the regions about cases that are identified as near fatalities/fatalities under Act 33.