



## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 12/18/14**  
**Date of Incident: 5/5/15**  
**Date of Report to ChildLine: 5/5/15**  
**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:**

Chester County Department of Children, Youth and Families

**REPORT FINALIZED ON:**  
01/27/16

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.  
(23 Pa. C.S. Section 6349 (b))

**Reason for Review:**

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Chester County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on - 05/27/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	12/18/14
[REDACTED]	Half-Sibling	[REDACTED]/09
[REDACTED]	Half-Sibling	[REDACTED]/11
[REDACTED]	Mother	[REDACTED]/87
[REDACTED]	Father	[REDACTED]/85

**Summary of OCYF Child Near Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SERO) attended the Act 33 Review Team meeting on 05/27/2015. SERO also spoke with the social worker on 06/30/2015, and reviewed the case record, including case notes, medical records, and assessments.

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

On 07/20/2010, a report was made stating that the child's half-sibling, age 18 months at the time, was wandering in the street unsupervised. It was determined that this was an isolated incident, and that the child was in the care of an 84-year-old grandmother. Mother installed locks on the doors and did not leave the children with the grandmother any longer.

On 03/13/2015, a report was made stating that an elderly relative was caring for the children, and that there were some environmental concerns. The case was closed, as the conditions of the home did not pose a threat to the children, and the mother was moving to another home.

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

On 05/05/2015, the Chester County Department of Children, Youth and Families (CCDCYF) received a Child Protective Services report stating that the 4-month-old child had [REDACTED]

[REDACTED] There was no history of significant trauma that would have explained the injuries.

The mother had brought the child to a 4-month well visit on 04/30/2015, where the pediatrician had found that the child's head circumference was abnormally large for his age. [REDACTED] was completed on 05/04/2015 at the Children's Hospital of Philadelphia (CHOP), [REDACTED] facility. The child was found to have [REDACTED]. The mother was told to take him to the main CHOP facility. [REDACTED]

When medical professionals questioned the mother about the possible causes of the child's injury, the mother reported two possible incidents. One incident was a prenatal incident. The mother stated that she was assaulted when she was pregnant, which caused her to go into labor 3 weeks early, according to the Intake Supervisory Review. She stated that the father was in the Poconos, and that she heard rocks being thrown at her window. She went outside to look into it, and she was "physically assaulted by an unknown male."

The other incident occurred when the child was in the car seat. She had the child at the cash register in a store, and a can of refried beans fell on his head while he was in the car seat.

CHOP medical professionals theorized that the child was injured shortly before he was taken to the hospital in March 2015, when the mother reported that the child was having trouble breathing. She took him to the Brandywine [REDACTED], where he was [REDACTED]. He was admitted to AI Dupont (Nemours) [REDACTED] 4 days later with [REDACTED]. He was vomiting and had diarrhea, and he was not easy to console. He was [REDACTED] to her care, and he acted normally after that. There was some concern by CHOP professionals that these symptoms could be symptoms related to head trauma, and the child did not appear to have been evaluated for head trauma at that time.

[REDACTED] Currently, the child is placed in a Chester County foster home. [REDACTED]

[REDACTED] The county worker has reported that the mother has been very proactive in completing service plan goals. The parents have ongoing life skills training, which includes parenting skills and budgeting. The parents are going to [REDACTED]. They are being tested for drugs to ensure sobriety, and the mother is [REDACTED]

[REDACTED]

The child is doing well, with some follow-up [REDACTED] He is learning to crawl. A referral was made [REDACTED]

The county assessed the safety of the other children, and they were found to be safe with no concerns or need for protective services. The other children remain with their parents.

The county also interviewed the father, and a friend of the mother's who was in a caretaking role. There was no evidence pointing to a specific perpetrator, as there was no clear timeline for the injury, and none of the individuals interviewed admitted to causing the injury.

On 06/12/2015, the CCDCYF indicated the report with an unknown perpetrator, because there was no specific evidence of which individual caused the child's injury.

Law enforcement professionals have interviewed family members, and the investigation is ongoing. To date, criminal charges have not been filed.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

- Strengths in compliance with statutes, regulations and services to children and families;

One strength that was noted in the collaboration between children and youth services and law enforcement, as law enforcement visited the victim child's home on the day of the referral to assess the safety of the other children in the home.

The pediatrician's office at Children's Hospital of Philadelphia [REDACTED] was noted to have implemented their "protocol to consult with their child abuse team in specific situations, including this one involving a very young child with a serious head injury that had no clear accidental explanation."

- Deficiencies in compliance with statutes, regulations and services to children and families;

None identified

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

It is recommended that Nemours Alfred I. Dupont Children's Hospital ■■■■■■■■■■ ■■■■■■■■■■ revise their protocol to "rule out head trauma when a young child like the victim child presents with facial bruising and vomiting." A medical professional from CHOP has reached out to Nemours A.I. Dupont, and that hospital was receptive to revising their protocols.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None identified

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

The Pennsylvania Department of Human Services concurs with the Chester County Internal report.

### **Department of Human Services Findings:**

- County Strengths: The county staff coordinated well with the police, medical professionals, parents, and others to complete the investigation and to coordinate services.
- County Weaknesses: None identified
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.  
None identified

### **Department of Human Services Recommendations:**

It is recommended that all local children's hospitals create and implement a protocol to rule out head trauma for any young child presenting with facial bruising and vomiting, if such a protocol does not already exist.