



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:



BORN: December 18, 2010
NEAR DEATH: April 1, 2011

FAMILY WAS KNOWN TO:
CHESTER COUNTY C & Y

REPORT FINALIZED ON:

July 11, 2013

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. Chester County convened a review team on 4/26/2011 in accordance with Act 33 of 2008.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	12/18/2010
[REDACTED]	Mother	[REDACTED] 1984
[REDACTED]	Sibling	[REDACTED] /2008
[REDACTED]	Sibling	[REDACTED] /2010
[REDACTED]	Sibling	[REDACTED] /1999
[REDACTED]	Maternal Grandmother	[REDACTED] /1963
[REDACTED]	Maternal Grandfather	[REDACTED] 1958
[REDACTED]	Father	[REDACTED] /1979

[REDACTED] father, is the only family member listed above that is not a household member. [REDACTED] is the bio-child of [REDACTED], and sibling to [REDACTED]; however, [REDACTED] has been adopted by the maternal grandparents.

Notification of Child Near Fatality:

On 04/01/2011, Chester County Children and Youth received a report [REDACTED] concerning the victim child. The report stated that the victim child was born 12/18/2010, 25 weeks premature and [REDACTED] which was to be used at all times. On 03/12/2011, the victim child was taken to Pottstown Hospital because she was not breathing. From Pottstown Hospital, she was taken by helicopter to Children's Hospital of Philadelphia (CHOP). When she arrived at CHOP, she was limp, cold, had a low heart rate and had to be resuscitated. The victim child's mother admitted she took the child off [REDACTED] for two days because it kept beeping. The mother had taken the victim child to a new pediatrician two days prior to the child's admission to CHOP, but never told the pediatrician that the child was on [REDACTED]. The victim child did not appear to have [REDACTED], but was listed as being in critical condition.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the case record pertaining to this incident, interviewed the caseworker about this incident and about C&Y's prior involvement with the family. SERO also attended the Act 33 review meeting on April 26, 2011.

Children and Youth Involvement prior to Incident:

- 12/21/2010- Chester County Children and Youth received an initial referral from [REDACTED] concerning the mother and her newborn child (the victim child), born December 18, 2010. The social worker reported concerns about the child who was born at 25 weeks gestation and noted that the mother reported that she had no prenatal care as she did not know she was pregnant. The mother also tested positive for marijuana at the time of the child's birth. The child did not test positive for any drugs, but she had low birth weight, [REDACTED] and, as a result, was admitted to the [REDACTED]. The hospital reported that the child would remain in the [REDACTED] for months, due to her low birth weight.
- 12/30/2010-Chester County C&Y intake worker met with the mother at Christiana Hospital. [REDACTED]. Upon questioning from the caseworker, the mother admitted to the occasional use of marijuana; but states that she does not smoke it around her children. The mother reiterated that she did not know she was pregnant with the child. The child's father was at the hospital on this day but was not able to be interviewed because, while the mother was being interviewed, the father left the hospital and was not available.
- 01/06/2011- Chester County C&Y caseworker visited the family at their home, where the mother resides with her parents and her other 3 children. The caseworker reported that the children appeared well cared for and the home appeared safe and appropriate.
- During the month of January, 2011-The caseworker visited Christiana Hospital to see the child. Her health was slowly improving; she was [REDACTED]. The mother reported that she and her mother received infant CPR training and [REDACTED] training at Christiana Hospital in preparation for the child's discharge.
- During the month of February, 2011- The caseworker visited the family home and offered the family services. The mother was cooperative with C&Y's plan to provide [REDACTED] and, on March 1, 2011, the family was accepted for ongoing services.

Circumstances of Child Near Fatality and Related Case Activity:

- On 03/04/2011, the Christiana Hospital [REDACTED] informed the Chester C&Y caseworker that the child [REDACTED] on 03/03/2011. [REDACTED] advised the caseworker that the hospital recommended that the child be seen by a pediatrician, that an [REDACTED] be scheduled, and that she remain on the [REDACTED] at night or when she is not under direct supervision. On March 9, 2011, during a phone conversation with the C&Y caseworker, the mother said she no longer wanted services. On March 15, 2011, the caseworker made an unannounced visit to the family home. The mother advised the caseworker that the child was hospitalized at CHOP. The mother stated that the child was not doing well on Saturday, March 12, 2011 and, when the mother woke up at about 7:30 am, the child was cold. The mother and maternal grandmother took the child to the Pottstown Hospital Emergency Room, arriving at 10:55 am. The mother said that she chose to go to Pottstown Hospital instead of the closer Phoenixville Hospital because she had taken the child to Phoenixville Hospital ER the prior week and felt that they had not listened to her concerns about the child. Once the child was seen at Pottstown ER on March 12, 2011, she was immediately transported to CHOP due to her medical condition. On March 18, 2011, the C&Y caseworker spoke with the CHOP [REDACTED] to get updates regarding the incident and the status of the child's medical condition. [REDACTED] advised that the child has [REDACTED] and that the [REDACTED], which the child was scheduled to use at night or when she was not under direct supervision, was turned off for 24 hours before the child arrived to the Pottstown Emergency Room. [REDACTED] also expressed concern that the child had not been seen by the pediatrician until nine days after her release from Christiana Hospital. On March 31, 2011 the C&Y supervisor assigned to the case contacted CHOP for additional information about the child's medical condition. The CHOP [REDACTED] confirmed that the mother admitted to turning [REDACTED] off because it kept "going off", meaning that [REDACTED] kept making a loud noise. An [REDACTED] was completed on the child and the results were negative, confirming that the child did not suffer [REDACTED] from this incident. The C&Y supervisor questioned the [REDACTED] not reporting the incident to C&Y on March 12, 2011, the day it happened. The [REDACTED] stated that she was on vacation, and [REDACTED] staff was unaware that they needed to make another referral, given that this case was already an open case with Chester County Children and Youth. The C&Y supervisor also spoke to the CHOP [REDACTED] who expressed the opinion that the child's serious medical condition could have been prevented. [REDACTED] further reported that the child arrived at Pottstown Hospital in critical condition and could have died from this incident. [REDACTED] [REDACTED] also stated that the mother did not mention to the child's pediatrician that she was having trouble with [REDACTED] and that it was not functioning properly. The physician believes that if [REDACTED] had not been turned off, the child's life would not have been at risk. The C&Y supervisor advised the CHOP [REDACTED] that under no circumstances was the child to be released to her mother

and that it was important that the hospital contact Chester C&Y prior to the child's discharge.

- On March 31, 2011, Chester County C&Y obtained [REDACTED] for this incident and on April 1, CHOP submitted a [REDACTED] which stated that when the child arrived at CHOP, she was limp, cold, had a low heart rate and had to be resuscitated after mother had taken her off the [REDACTED]. The child was admitted to [REDACTED]. ChildLine determined that this incident met the criteria for a "Child Near Fatality."
- On April 11, 2011, CHOP notified Chester C&Y that the child would soon be ready for discharge. On April 12, 2011, Chester C&Y met with the maternal grandparents of the victim child, to develop a safety plan. The maternal grandparents agreed to supervise the child at all times; including when she was receiving care by her mother. The maternal grandmother does not work and will provide 24 hour supervision of the child in the home and will take the child to medical appointments. The mother was not permitted to be left alone with the child.

Current Case Status:

On April 13, 2011, the child [REDACTED] to her grandparent's care and remained on the [REDACTED] 24 hours a day. The child receives follow up care from her pediatrician and from a [REDACTED]. The child was seen by the [REDACTED] on April 20, 2011 with no concerns noted and a recommendation to return in one year. The child was seen by the Chester C&Y caseworker who reported that the child was sleeping in her maternal grandparent's bedroom with [REDACTED] on. The current [REDACTED] was from CHOP and seemed to work properly. The [REDACTED] was at the home on April 17th and April 27th and reports that the child is doing very well. There have been no issues with [REDACTED] and, at that time, the child weighed over seven pounds. The family will continue to receive ongoing protective services through Chester C&Y to ensure that the child's medical and other needs are met. The [REDACTED] dated May 27, 2011, shows the [REDACTED], stating the mother did everything possible to seek medical attention for her premature infant.

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 on 4/26/2011 in accordance with Act 33 of 2008 related to this report.

- Strengths:
The county did a good job in discovering why this case was not reported in a timely manner and educated the hospital staff on their obligations as mandated reporters, even in open cases.
- Deficiencies:
None identified.
- Recommendations for Change at the Local Level:
 - The review team had a recommendation that centers on the reporting of child abuse by hospital and medical providers; both should be clear about what to report and when it should be reported.
 - The review team identified the need for parents to be educated in reference to the importance of using [REDACTED] or any other life saving medical equipment aids, as instructed.
 - The review team recognized a need for increased communication between medical providers and child welfare agencies to better coordinate and plan more support for families to better meet their children's needs in the area of discharge planning and medical care instructions.
 - The review team recommends that more training be offered to child welfare staff in the area of caring for premature and low birth weight infants.
- Recommendations for Change at the State Level:
None identified.

Department Review of County Internal Report:

The Department has reviewed the county report and is in agreement with the findings in the County Internal Report.

Department of Public Welfare Findings:

- County Strengths:
The county completed a thorough investigation, interviewing pertinent medical and law enforcement personnel.
- County Weaknesses:
None identified.
- Statutory and Regulatory Areas of Non-Compliance:
There were no areas of non-compliance identified.

Department of Public Welfare Recommendations:

The Department agrees with the county's recommendation concerning the need to improve and clarify the reporting requirements of hospitals. Hospitals need to be clear that each incident of abuse/neglect should be reported to ChildLine, whether or not the case is currently open to the county.

The Department supports the recommendation for more training for staff about the needs of premature/low birth weight babies.