



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA¹ REPORT

In the Matter of
Tabitha Sadler
Minor Child²

9-03-2006-00003

September 14, 2012

¹ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission (“CDNDSC”) was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child’s death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Tabitha Sadler is a case of physical abuse resulting in the near death of Tabitha due to abusive head trauma, perpetrated by her father. At the time of Tabitha’s near death, Tabitha was approximately three months of age and residing in the home of her father.

In September of 2004, the Department of Services for Children, Youth and Their Families’ Division of Family Services’ Child Abuse Reportline received a report alleging the physical abuse of Tabitha. That day Tabitha was brought to the Emergency Department around 2245 hours by father with the chief complaint that Tabitha had vomited after feeding and then stopped breathing. Father reported that he had picked Tabitha up from babysitter around 1800 hours. Father brought her home and let her sleep, but then woke her to feed. After giving her 2 ounces of formula, Tabitha began to vomit and appeared to stop breathing. Father performed cardiopulmonary resuscitation and Emergency Medical Services were called.

Upon further examination, it was revealed that Tabitha had a left frontal parietal subdural hematoma and retinal hemorrhages, fluid in the abdomen and an acute spleen laceration, inflicted chest trauma with multiple rib fractures, and a possible right high-parietal skull fracture. Tabitha also suffered from three seizures during her stay in the hospital that resulted in tongue abrasions. Medical staff found the child’s injuries to be consistent with abusive head trauma and that such injuries were a result of nonaccidental trauma. Injuries were in multiple stages of healing indicating long term abuse. Tabitha was transported to a children’s hospital for further evaluation and treatment.

Neither mother nor father were able to provide any explanation as to how Tabitha received her injuries. Father stated that he took Tabitha to the babysitter’s residence in the late morning, early afternoon and that he picked Tabitha up around 1800 hours.

Mother stated that on the morning of the incident, she woke up around 0800 hours to nurse Tabitha. Mother left for work that morning around 1000 hours and Tabitha was

happily watching television. Mother received a phone call from father around 2130 hours where father informed mother that Tabitha had choked on a few ounces of milk and stopped breathing. Mother further reported that three to four weeks prior to the near death incident, father had called paramedics because Tabitha had stopped breathing and her lips had turned blue. When the Emergency Medical Services arrived, Tabitha was observed and determined to be okay. Tabitha was not taken to the hospital for further evaluation.

Seven days after Tabitha's admission to the hospital, she is transferred from the Pediatric Intensive Care Unit (PICU) to the rehabilitation unit. Five days later, a safety plan was put in place with the Division of Family Services. The safety stated that father was not to reside in the home until the investigation was complete and that father was to have no unsupervised contact with Tabitha. It was noted that Tabitha would be visually impaired, deaf and mentally disabled. Tabitha was discharged in October of 2004 to the care of maternal grandmother.

During the course of the investigation by law enforcement, father, mother and babysitter were interviewed on more than one occasion. The babysitter was cooperative with police; however, Tabitha's parents became uncooperative during the investigation. The detective was unable to determine who inflicted the injuries and therefore no arrest was made. The detective noted that the case would remain active for five years and then would be closed.

The Division of Family Services (DFS) substantiated father for physical abuse, level IV.

System Recommendations

After review of the facts and findings of this case, the Panel determined that all systems met the current standards of practice and therefore no recommendations were put forth.

Ancillary Issues

- 1) CDNDSC recommends that a letter be sent to the on-call medical service proposing that medical documentation be time and date stamped and that follow up regarding the recommended care for the child occur when advised by the primary care physician.
 - a. Rationale: The on-call medical service recommended that the child be taken to the Emergency Department; however, there was no follow up to ensure that this occurred.
 - b. Anticipated Result: Follow up by medical practitioners.
 - c. Responsible Agency: CDNDSC