STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE19801-3341

CAPTA[1] REPORT

In the Matter of
J.M.
Minor Child

9-03-2012-00028

February 10, 2015

[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).

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.

The case information presented below is based on documents reviewed and presented from the treating hospitals, the Division of Family Services, the Office of the Child Advocate, Family Court, Law Enforcement, and the Department of Justice.

Case Synopsis

The infant was born at 40 weeks gestation, weighing 5 pounds 12 ounces. The infant was discharged home on the second day of life. Birth was an elective induction of labor, vaginal delivery, with clinical evidence of placental abruption but not corroboration by the pathology report.

In February 2011, 3 months prior to the near death incident, the infant (6 weeks of age) was brought to the Emergency Department (ED) due to concerns of bleeding from the mouth after she had fallen from the father's hands face first, onto a plastic bathing tub from about 1 foot in height. The bleeding stopped on its own per parents, but the infant had continued to be fussy and did not want to eat since the incident. On exam, the infant noted to appear distressed, fussy, increased nasal and oral secretions and with "gingival petechia with ulcerations on the posterior palate, no active bleeding noted." The infant had blood, urine and spinal fluid studies completed, as well as a study for respiratory syncytial virus (RSV) and influenza (negative). Cerebrospinal fluid was noted to be yellow. A computed tomography (CT) of the head was done due to the infant's continued fussiness and irritability. Results of the CT showed a "dense calcification in inferior aspect of left thalamus of uncertain etiology. Follow up magnetic resonance imaging (MRI) was performed." The attending also noted that "ulcerations on the palate appear unrelated to trauma, and may be related to calcification in thalamus and an infectious process." Due to concerns for a serious bacterial infection, antibiotics were started. A chest x-ray was completed and was reported as normal. During the hospital stay, the infant started to breastfeed well. The nurse recorded an incident where the infant had a bottle propped in its mouth by blankets while the infant lying in bed. The nurse advised mother to hold infant while feeding. On the day of discharge, 2 days after admission, the infant was afebrile, acting well, and feeding well. The infant was discharged home to the care of her mother.

In May 2011, the infant (five months old) was seen by her Primary Care Physician (PCP), who sent the infant to the children's hospital for x-rays (reportedly with a prescription) due to mother's complaint of clicking and popping noises in the child's back. That same day, mother took the child to the hospital for the x-rays and was reportedly told that the x-rays were normal and mother took the infant home. The following day, the infant was brought to the ED of a children's hospital by mother and maternal grandmother for the same complaints of a "popping noise in the infant's back." Mother and grandmother reported that they had noticed clicking and popping noises over the left posterior chest (back) approximately six days ago and noted the infant to be fussier than usual.

The attending physician at the ER noted "palpable crepitus over the left posterior thorax," noted no bruising or obvious bony abnormalities, and tenderness was noted on the pulmonary/chest exam but location was not noted. By history, no trauma or fall was noted by family. Review of the chest x-ray, from the previous day, noted acute posterior fractures of the left ribs 5th through 9th. A full skeletal survey was ordered in addition to blood work screening for additional abdominal trauma, anemia, and evidence of any metabolic bone disease. The fractures noted included: healing left clavicle fracture; acute fractures of the left posterior 5th, 6th, 7th , 8th and 9th ribs; healing posterior lateral right 3rd, 4th, 5th and 6th rib fractures; healing posterior fractures of the right 11th and 12th ribs; splaying of the anterior costochondral junction of the right 3rd,4th and 5th and the 7th, 8th and 10th ribs possibly consistent with healing fractures; splaying of anterior costochondral junction of the left 7th and 8th ribs possibly consistent with healing fractures; healing metaphyseal corner fractures of the distal right and left ulna; healing metaphyseal corner fractures to the distal left femur and early healing metaphyseal fractures of the proximal left tibia and fibula; healing metaphyseal corner fractures to the right distal femur and early healing metaphyseal fractures of the right proximal tibia and fibula.

There is no evidence in child's medical record of a report or reading of the x-ray that was taken the previous day, as requested by the PCP. However, documentation from the ED notes that a "comparison is made with the x-ray from the previous day" by the radiologist reading of the full skeletal survey done on the day of the near death incident. A computed tomography (CT) of the head was recommended and completed. Results showed no skull fracture and no intracranial hemorrhages. Due to the multiple fractures in various stages of healing, location and types of fractures, non-accidental injury in a non-ambulatory child was thought to be highly likely and a report was filed with the Division of Family Services (DFS) where custody was granted and upon discharge, the child was placed in a foster home. A guardian *ad litem* was appointed to represent the infant.

Law Enforcement was contacted regarding the near death incident to J.M. Contact was made with the family that same day and the following day. Parents were not very cooperative with the investigation and retained an attorney. It was noted that J.M.'s Mother (MOB), Father of J.M. (FOB), and J.M.'s 16 year old step brother resided in the home. However, all denied causing harm to J.M. MOB indicated that she was the primary

caretaker of J.M., but FOB occasionally watched the baby. J.M. was never under the supervision of her step brother. Father had indicated that he had fallen with J.M. while trying to bathe her. It was also reported that two weeks prior to the incident, J.M. was at a party with family where another child began tugging and pulling on J.M. However, upon examination by Delaware's Child Abuse Expert it was determined that the injuries that J.M. sustained were not consistent with the alleged incidents. The defense of brittle bone disease was ruled out as J.M. has yet to sustain an injury since coming into care.

The step sibling had multiple behavioral issues. He was attending an alternative school and had recently moved into MOB and FOB's residence around the time of J.M.'s birth. The sibling had been previously living with his Mother. FOB was previously married in the 1990's to the sibling's Mother. Between 1992 and 1993, FOB was charged with assaulting his now 16 year old son.

Approximately one month after the near death incident, MOB and FOB were married as FOB was an undocumented alien. Once J.M. entered the hospital, she never went back to the care of her parents. Family had not been in regular contact with DFS and no extended family contacted DFS in regards to being a placement option. Termination of parental rights was granted and the child was adopted.

Family History

In January 2011, an urgent referral was received by the DFS Child Abuse Report Line alleging physical abuse of J.M.'s sibling by FOB. Reporter observed a red line under his eye, cut on his right ear under the lobe, and a bruised nose from where FOB allegedly punched him in the face. J.M.'s sibling stated that his nose was bleeding profusely when punched. J.M.'s sibling and FOB have been involved in several parent/child conflict situations. Upon response by DFS, J.M.'s sibling did not have bruising but did have a small red mark under his left eye. FOB and MOB both state that J.M.'s sibling was slapped by FOB for disrespect not punched. The sibling does see the school counselor but has refused a separate counselor. Case was closed with concern, inappropriate use of discipline and a lack of following up with child's medication for ADHD.

Five months later in June 2011 the near death incident occurred. Neither parent could offer an explanation.

Criminal/Civil Disposition

Mother and father were founded for physical abuse, level IV as neither parent could offer an explanation for the injuries sustained by the child. There were no criminal charges brought forth in this case as the evidence presented was considered circumstantial.

System Recommendations

After review of the facts and findings of this case, the Commission determined that all systems did not meet the current standards of practice and therefore the following system recommendations were put forth:

MEDICAL

a. CDNDSC recommends that when a child presents to a medical facility AND there is a suspicion of child abuse and/or neglect AND it is believed to have been inflicted by the parent(s) and/or caretaker(s) that transportation to the Emergency Department be conducted by an alternative secure transportation service, rather than the child's parent and/or caretaker.
    a. Rationale: child was initially seen by her primary care physician on 5/10, as mother had concerns for cracking/popping noises in the child's chest. The child's PCP immediately sent the child to the hospital and transportation was provided by parent. Further workup at the hospital revealed a fracture and flailed chest.
    b. Anticipated Result: to ensure the safety and continued medical evaluation and/or treatment of the child.
    c. Responsible Agency: American Academy of Pediatrics- through their newsletter and the Medical Renewal License online training
b. CDNDSC recommends that all Primary Care Physicians properly document all correspondences via telephone with a patient/family in their written or electronic documentation.
    a. Rationale: A stat x-ray was ordered and the child was sent to the emergency department. However, there is no documentation that suggests that the doctor called or was called for the results of the stat x-ray, or that x-ray was read as normal. Child was placed at great risk because she was still under the care of her parents and some injuries could have occurred after the x-ray was taken.
    b. Anticipated Result: Appropriate medical documentation and follow up as it pertains to the treatment of patients.
    c. Responsible Agency: American Academy of Pediatrics- through their newsletter and the Medical Renewal License online training