



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

CAPTA¹ REPORT

In the Matter of
Kayla Lane Radon
Minor Child²

9-03-2009-00002

September 16, 2011

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 Kayla Lane Radon was reviewed by the Child Abuse and Neglect Panel as a near death. Kayla was born full term and hospitalized at six days of age for one week. It was suspected that the infant had an enterovirus infection. A throat culture did confirm that the infant had an enterovirus infection. Child was seen for follow up visits at three weeks and five weeks of age. Child was doing well developmentally prior to the incident. The near death occurred when the child was seven weeks of age due to physical abuse, perpetrated by Kayla’s alleged father, resulting in traumatic brain injury. At the time of the near death, Kayla was residing in the home of her mother, alleged father, and maternal grandmother. However, on the day of the near death incident the child was under the sole care of her father. He called mother stating that he could not get Kayla to stop crying.

On the day of the near death, Kayla was brought to the Emergency Room by the mother for concerns about her breathing. The Emergency Room noted that Kayla had possible seizure activity. Kayla was intubated and placed on a ventilator. An initial CT of the Kayla’s head revealed subarachnoid and subdural hemorrhages. Kayla was transported via helicopter to a children’s hospital for further evaluation and treatment.

Upon arrival to the children’s hospital, Kayla was observed to have bruising of the left temporal region. She was admitted to the Pediatric Intensive Care Unit (PICU) where seizures continued and anti-seizure medication was administered. Further evaluation of Kayla, by Ophthalmology and Neurology, demonstrated extensive bilateral retinal hemorrhages, baseline seizure activity, and probably evidence of a stroke. It was later determined that the child was also suffering from a previous intracranial hemorrhage.

Nineteen days after the near death, Kayla was transferred to the acute rehabilitation floor for intensive rehabilitation and therapy. Kayla was discharged from the hospital approximately forty-seven days after admission. Upon discharge, the mother was instructed by medical personnel that the child would require ongoing therapy and suffer life long complications due to the extent of the injuries that she had received.

Records for the Department of Services for Youth, Children and Their Families (DSCYF) revealed that at the time of the near death the child's family was not active within DSCYF. However, further inquiry as to the mother's social history revealed that the mother was active with the Division of Family Services when she was an adolescent due to the separation of her parents. Mother was assessed by the Department of Child Mental Health and referred to outpatient services and managed care approximately three years prior to the Kayla's birth.

The Division of Family Services' Child Abuse and Neglect Report Line received an urgent referral alleging physical abuse with a secondary allegation of Shaken Baby Syndrome. The report was accepted and a joint investigation between the Division of Family Services and law enforcement began. The investigation concluded with Kayla's alleged father confessing to inflicting the injuries to Kayla. The Division of Family Services substantiated the Kayla's alleged father for physical abuse, level IV. Additionally, a no-contact order was put in place and alleged father was to have no contact with children under the age of eighteen.

Criminal prosecution resulted in Kayla's alleged father pleading to assault in the second degree. He was sentenced to eight years Level V, suspended after six years to six months Level IV.

System Recommendations

After review of the facts and findings of this case, the Panel determined that all systems did meet the current standards of practice and therefore no system recommendations were put forth. However, an ancillary issue that was noted pertained to the age and vulnerability of victims not being considered when bail is determined. As a result, bail is being set too low and children are not being protected. This has been an ongoing issue of concern.