COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:

[redacted]

DATE OF BIRTH: 06/21/1995
DATE OF NEAR FATALITY: 03/19/2013
DATE OF ORAL REPORT: 03/19/2013

FAMILY HAS PRIOR HISTORY WITH:
THE DEPARTMENT OF HUMAN SERVICES

REPORT FINALIZED ON: 02/04/2014

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. Philadelphia County has not convened a review team in accordance with Act 33 of 2008 related to this report due to the case being unfounded within 30 days.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/21/1995
[redacted]	Maternal Grandmother	[redacted]/1946
[redacted]	Maternal Grandfather	[redacted]/1940
* [redacted]	Maternal Grand Uncle	[redacted]/1956
* [redacted]	Mother	[redacted]/1961

Notification of Child Near Fatality:

[redacted] was admitted to Children's Hospital of Philadelphia (CHOP) on March 13, 2013. The child has developmental delays and was diagnosed with [redacted] in 2010. The child has to [redacted] The Maternal Grandmother (MGM) reported that she [redacted] before he gets on the bus each morning. [redacted]. The child contracted the flu around March 10, 2013 and he was not [redacted]. As a result, [redacted] became ill and [redacted] The MGM was the child's primary caretaker and it was reported that she had not fulfilled her caretaker duties with ensuring that [redacted] when he gets sick. As a result, Dr. [redacted] certified the child to be in critical condition based on suspect abuse/neglect.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation case notes conducted by DHS investigator, Ms. [redacted]. Follow-up interviews were also conducted with Ms. [redacted] and her supervisor Ms. [redacted]. SERO did an extensive medical records review on the information received from St. Christopher's Hospital for Children pertaining to [redacted] medical condition.

Children and Youth Involvement Prior to Incident: (2 previous Involvement)

DHS received a [redacted] report on November 17, 1995 alleging that [redacted] mother [redacted] tried to choke her mother [redacted] and threatened her with a knife. The MGM stated that [redacted] mother threw a bottle at 5-month-old [redacted] and that she is unfit to properly care for the child. This report was investigated and findings were present.

DHS received a Child Protective Services investigation alleging that [redacted] had been harming the child for the past two weeks. She has been picking up the child by his head, lying on top of him making him cry and feeding him hot sauce and grits. The MGM was the primary caregiver for both [redacted] and his mother at that time. [redacted] mother was diagnosed [redacted] and became extremely violent when she [redacted] The MGM did not allow [redacted] in the home while she worked and she had a babysitter at her home caring for [redacted]. However, [redacted] had gotten drunk and was threatening the babysitter. This report was investigated and findings were present [redacted] was placed into foster care from December 1, 1995 to February 2, 1996 through [redacted] was returned to his MGM and their case was finally closed on May 13, 1996.

Circumstances of Child Near Fatality and Related Case Activity:

On March 19, 2013, DHS received a CPS report alleging that [redacted] was in critical condition at CHOP due to what hospital officials believed to be medical neglect thus certifying the child's condition as a near fatality. The victim child [redacted] has serious cognitive delays which prevents him from being able to [redacted] into CHOP on March 19, 2013 and [redacted] on March 21, 2013. However, while the child [redacted] at CHOP his MGM was ordered to have no contact with the child. Her primary duty was to work with the hospital staff as well as the DHS nurse learning the importance of the child's fragile health concerns and medication maintenance.

The MGM (age: 67) and her husband [redacted] aged: 73) are [redacted] primary caregivers and they at times have forgotten to [redacted]. Nevertheless, the investigation revealed that both the caregivers in fact love [redacted] very much but have had some difficulties keeping up with the child's [redacted] through their poor memory. However, the MGM was fully compliant with

[redacted] scheduled medical appointments. Equally important, when MGM found the child unresponsive on March 18, 2013 she immediately called 911 for assistance with the child; but, she did not administer him [redacted]. In her defense, she reported that [redacted] so she opted to call 911. She also added that there were problems with [redacted]

Philadelphia DHS completed the investigation appropriately, with interviews of all parties (alleged perpetrator, family members as well as hospital officials) in addition to utilizing their [redacted] services for two home visits to monitor the family with [redacted] DHS also referred the family to [redacted] The child [redacted] from CHOP on March 21, 2013, with [redacted]. He was seen at home by [redacted] on March 22, 2013 and [redacted] on March 26, 2013. The Safety Plan was for the MGM and her brother (who lived close by) to be trained to [redacted] The child's [redacted] was changed to best support the child's ability to stay consistent with his [redacted]

The CY-48 Dated 4/18/2013 was determined to be Unfounded. Per DHS finding there was no evidence to support medical neglect. Once the [redacted] training were completed the case was closed by DHS. There was no police action taken.

Current Case Status:

This CPS was determined to be Unfounded and no on-going services were assessed to be needed for this family. DHS last visit with the family was on May 31, 2013 and [redacted] was found to be safe. The [redacted] both consulted on this case and confirmed that the family understood how [redacted] has turned 18 on July 21, 2013 and he needed to be registered with the [redacted] unfortunately missed. As a result of him missing that appointment it is understood by the family that he will have to wait one year before he could try again to receive those services. We (SERO) are not sure if this information received from the MGM is accurate and will look into this matter further. On a lighter note, the child currently continues to attend school daily at [redacted] High School where it is said that he's doing well.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

There was no Act 33 review Team convened due to the case being completed prior to 30 days and the determination of the CPS being unfounded.

Department of Public Welfare Findings:

- County Strengths: DHS conducted a thorough investigation.

- County Weaknesses: Due to the seriousness of ensuring that [redacted] completed the process associated with securing the benefits though the [redacted], DHS may have closed its case on this family prematurely. Per DHS assessment, [redacted] needed to be registered with the [redacted] **prior** to his 18 birthday. However, the **child turned 18 on 06/21/13** and DHS reported that **its last visit with the family on was on 5/31/2013**, prior to the child's 18 birthday. As we now know, the child was unsuccessful with completing the process of receiving services though the [redacted] and will have to wait a year before reapplying.

- Statutory and Regulatory Areas of Non-Compliance: DHS was in compliance with all Statutory and Regulatory areas within this investigation.

Department of Public Welfare Recommendations:

Prior to case closure, the agency should make sure that all referrals for identified supports and services are completed and have been followed through.