pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/12/10

Date of Near Death: 06/05/13

Date of Oral Report: 06/05/13

FAMILY WAS KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

05/07/2015

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

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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. DHS had convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 review was held on June 21, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	05/12/10
[redacted]	Foster Mother	[redacted]/51
[redacted]	Foster sibling	[redacted]/71
[redacted]	Household member	[redacted]/12
[redacted]	Household member	[redacted]/10
* [redacted]	Mother	[redacted]/88
* [redacted]	Father	[redacted]/81
* [redacted]	Sibling	[redacted]/06
* [redacted]	Sibling	[redacted]/06
* [redacted]	Sibling	[redacted]/04

*Non Household members

Notification of Child Fatality:

The child was brought to St. Christopher Hospital by the social worker and foster mother [redacted]. The child was suffering from diarrhea and dehydration. The child's condition was serious when he was brought into the ER on 6/2/13, but was upgraded to [redacted] and certified as a near fatality on 6/5/13. There was also a second report [redacted]. The child had bruising to his face, ears, chest, abdomen, buttocks, arms legs and back.

Summary of DPW Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted, and the investigating caseworker determined the case to be indicated on 07/22/13. The SERO also attended the Act 33 review on 6/21/13.

Children and Youth Involvement prior to Incident:

The family was known to DHS prior to this incident. The family became known to DHS on September 5, 2008, as a result of a [redacted] report alleging the home was dirty. The report mentioned feces on the wall in [redacted] bedroom. The report also stated that the children picked up food from the floor and that they ate the food. It was also reported that there were dirty dishes in the kitchen sink and that there were clothes strewn all over the home. It was further reported that the child's mother, [redacted], would go outside without the children, and the whereabouts of the children were unknown. It was also reported that [redacted] wore diapers, and it was believed that both twin brothers would take feces out of their diapers and smear feces on the bedroom walls. It was reported that the children ate potato chips for breakfast. This report was found to be substantiated.

In an Investigation Summary dated August 7, 2008, DHS Intake Unit Social Work Services Manager 2 reported [redacted] had two positive drug screens. Her house was clean and appropriate, the children were supervised, the children were current with their well visits, and [redacted] did not test positive for drugs after DHS was contacted. [redacted], the children were in respite, and [redacted] was compliant with scheduling needed appointments. [redacted] was incarcerated. The case was closed and the family was referred to Community Based Prevention Services ("CBPS") because there were no safety issues at that time. The closing/transfer summary was dated October 7, 2008.

On August 8, 2009, DHS received a [redacted] report stating [redacted] was observed dragging [redacted] by the arms and legs up the stairs. It was reported she hit [redacted] head on a filing cabinet and it was unknown if he suffered any pain or impairment from the incident. It was reported that [redacted] and was unable to provide adequate supervision of the children. [redacted]

It was reported that [redacted] were both hyperactive and both suffered from [redacted] and would be evaluated. They were both born [redacted]. It was also reported that [redacted] might have been hearing impaired.

It was reported [redacted] was [redacted] prior to her pregnancy with the twins, and [redacted] during her pregnancy. It was reported that she resumed using [redacted] after she gave birth to the twins, and did not appropriately bond with the children. It was reported that her parenting and disciplinary practices involved violence.

The DHS Unit Hotline staff contacted the family on August 8, 2009, and noted the children appeared to be safe at that time. It was determined that findings were present and the report was substantiated. The case was referred to preventive services.

On January 9, 2012, DHS received a [redacted] report alleging [redacted] and [redacted] were physically abusing [redacted] and that they were unable to protect their children. It was reported [redacted] and that he had tied and beaten [redacted]. It was reported that [redacted] hit and shook one of the infants when one of them would cry. It was determined that findings were present, and the report as substantiated. The case was referred to [redacted].

On February 27, 2012, a Risk Assessment was done and the conclusion was that the overall severity and overall risk were low risk, and that [redacted] and the children were not victims of domestic violence at that time. [redacted] and did not plan to return to their home [redacted].

The case was closed on February 27, 2012 and ARS referred it to prevention to continue to monitor [redacted]

On March 1, 2012 DHS received a [redacted] report. It was reported that the children were being neglected. This report was rejected. It was noted that the report would be forwarded as an FYI.

On March 15, 2012, it was noted that [redacted] was to be provided by [redacted]. A joint visit was held on March 13, 1012 and the children appeared to be safe with appropriate care at that time. The case was closed with the implementation of [redacted] through [redacted].

On May 16, 2012, DHS received a [redacted] report alleging [redacted]. This report was rejected.

On May 17, 2012, [redacted].

On June 22, 2012 DHS received a [redacted] report. It was reported that there was no abuse or neglect. It was reported that [redacted] was overwhelmed with the behavior of [redacted] who were [redacted] services. This report was rejected. The family was referred to CBPS.

On June 27, 2012, DHS received a [redacted] alleging the children exhibited behavior problems [redacted]. It was reported that the children were destructive, undisciplined and unsupervised. It was determined that findings were present and the report was substantiated. [redacted]

On June 28, 2012, [redacted], but DHS was unable to locate [redacted] and her children. A police report was filed. [redacted] A private investigator search was provided, but the search failed to provide the whereabouts of family. The case was closed as unable to access.

On October 15, 2012, DHS received a [redacted] report alleging that [redacted] were found on a corner by the police. The children were reported to be filthy and were without shoes and jackets. It was reported [redacted] was not present the day of the alleged incident. [redacted] failed to respond to requests for an interview. This report was substantiated.

[redacted] and that their [redacted] issues were being met. Safety Assessments were dated October 16, 2012, October 19, 2012, and October 31, 2012. There were no safety threats identified in the assessments.

On January 5, 2013, DHS received a [redacted] report alleging [redacted] with her children on that day. She had been at [redacted] since October 12, 2012, [redacted]. The report was rejected because the information was insufficient to generate a report.

On January 30, 2013, DHS received an immediate response report. It was reported [redacted] could not remain at [redacted] due to a history of arson. It was further reported [redacted] was observed kicking the children while they were on the floor in the morning. There was an issue of inappropriate discipline and lack of supervision. She was also reported to not be in compliance with the rules. Her living area was dirty and she smoked in her room. Additionally, [redacted] was observed sticking an object in his ear, and [redacted] failed to act. [redacted] was observed with a leaky red ear on January 29, 2013 and was taken to Children's Hospital of Philadelphia ("CHOP"). He was [redacted]. It was reported that [redacted] was not compliant with [redacted] provided by the hospital.

On January 31, 2013 DHS worker spoke with [redacted] were determined to be safe with a plan. [redacted]

On February 15, 2013, DHS worker visited [redacted] at [redacted]. The children appeared to be safe residing with [redacted]

On March 6, 2013, it was reported that the family relocated [redacted]. On March 11, 2013, DHS worker went to the home of the children's maternal aunt. [redacted] stated she was residing with her temporarily with [redacted] was still [redacted]. It was determined the children were safe in the home of the maternal aunt on March 11, 2013.

It was reported [redacted] agreed to meet the DHS worker at [redacted] on March 12, 2013 to assist [redacted]. It was reported the family was evicted from the home of the maternal aunt on March 12, 2013. They were able to stay with a family friend.

On March 7, 2013 the family received [redacted], until April 3, 2013.

[redacted]

On April 2, 2013, [redacted] appeared to be under the influence of drugs and was not able to provide adequate care and supervision of her children. [redacted] remained with the aunt.

On April 3, 2013, DHS [redacted] and transported [redacted] to the same home as [redacted]

[redacted]

[redacted]

It was noted in the DHS file that [redacted] began residing at [redacted] on April 29, 2013.

On May 28, 2013 it was reported that [redacted]. There was a General report which was generated for Law Enforcement Only ("LEO"). It alleged [redacted] was involved sexually with an unknown 17 year old male while she was at [redacted]. The family did not receive services from DHS.

On May 6, 2013 [redacted] was placed in a [redacted] foster home.

On May 7, 2013, DHS implemented [redacted] These services were discharged on May 29, 2013.

On May 29, 2013 [redacted]. He was transported to [redacted]

On May 31, 2013, DHS received a [redacted] report alleging [redacted] foster parent left home for an extended period of time, and that [redacted] was left in the care of her 42 year old intellectually disabled daughter.

On June 2, 2013, DHS received an [redacted] report. The foster mother reported she discovered bruising on [redacted] back on June 1, 2013. It was reported that on the morning of June 2, 2013, the foster mother stated [redacted] had sustained bruising to his legs, hands, and the side of his face. He had old bruising and new bruising. [redacted] was extremely lethargic, suffered from diarrhea, and that he could not stand. [redacted] was reported to be nonresponsive. He was taken to St. Christopher's Hospital. [redacted] was determined to have [redacted], resulting from severe dehydration. The medical team believed the dehydration occurred over a period of time prior to the child's placement in the foster home.

A survey of CAT scans was conducted [redacted]. The foster mother had two other children in care in her home. They received skeletal surveys and CAT scans which were normal. The foster mother denied causing the injuries to [redacted].

On June 5, 2013, DHS received supplemental information to the report dated June 2, 2013. [redacted] in which the alleged perpetrator was unknown. On June 5, 2013 an alleged perpetrator was identified. [redacted] One was for the near fatality. The other report was for the bruising. [redacted] St. Christopher's Hospital for Children, [redacted] certified the report as a near fatality.

On June 3, 2013, DHS worker spoke with Special Victim's Unit (SV").

On June 4, 2013DHS worker visited [redacted] at the hospital. DHS worker attempted to visit [redacted] at his foster home, but no one was home.

On June 5, 2013, and June 7, 2013, DHS worker went to the foster home [redacted] resided in. No one was home.

[redacted].

[redacted] The whereabouts of [redacted] and the children were unknown. [redacted]

Circumstances of Child Fatality and Related Case Activity:

On June 2, 2013, DHS received [redacted] report. The foster mother reported she discovered bruising on [redacted] back on June 1, 2013. It was reported that on the morning of June 2, 2013, the foster mother stated [redacted] had sustained bruising to his legs, hands, and the side of his face; that he was extremely lethargic, suffered from diarrhea, and that he could not stand. [redacted] was reported to be nonresponsive. He was taken to St. Christopher's Hospital. [redacted]
On June 5, 2013, DHS received supplemental information to the report dated June 2, 2013. [redacted] in which the alleged perpetrator was unknown. On June 5, 2013 an alleged perpetrator was identified. [redacted] One was for the near fatality. The other report was for the bruising. [redacted] The child had old bruising that occurred prior to his placement in the foster home. The new bruising was explained by the child throwing himself out of his crib.

Current Case Status:

[redacted] The whereabouts of [redacted] and the children were unknown. [redacted]

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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. DHS had convened a review team on June 21, 2013, in accordance with Act 33 of 2008 related to this report. There was a [redacted] report and the family was opened for services. [redacted]

Department Review of County Internal Report:

DHS received the report on 6/2/13. The family was known to the agency. The record contained appropriate documentation of the family history. The Safety Plan and Investigations were completed within the appropriate intervals. The Department is in agreement with the findings of the county report.

Department of Public Welfare Findings:

- County Strengths:
  Collaboration with the medical team at St. Christopher's Hospital, along with the Special Victim's Unit.

  Timely and quality safety plan and investigation.

- County Weaknesses:
  The county failed to provide the foster parent with information regarding the child's health and needs upon placement.

- Statutory and Regulatory Areas of Non-Compliance:
  There were none identified.

Department of Public Welfare Recommendations:

The Department recommends that the County C&Y make every effort to provide foster parents with information regarding the child's history and medical needs upon placement.

The Department also recommends that the County, the Agency and or the foster parents examine the children in the areas a bathing suit would not over, upon acceptance for care.