pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/25/2013
Date of Incident: 06/19/2013
Date of Oral Report:6/19/2013

FAMILY KNOWN TO
PHILADELPHIA DEPARTMENT OF HUMAN SERVICES

REPORT FINALIZED ON:
March 9, 2015

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

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

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. 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 convened a review team in accordance with Act 33 of 2008 related to this report on 07/19/2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/25/2013
[redacted]	Sibling/Sister	[redacted]/2010
[redacted]	Mother	[redacted]/1989
[redacted]	Father	[redacted]/1988

Notification of Child Near Fatality:

The Philadelphia Department of Human Services (DHS) received a Child Protective Services report on 06/19/2013, alleging that [redacted] a 5 month old child [redacted] with failure to thrive as a result of both parents feeding her with formula which was prepared incorrectly resulting in her having a low sodium level. On 6/17/2013 [redacted] was admitted to Children Hospital of Philadelphia [redacted] were a result of water intoxication from the improper mixture of her formula. The report further states that the parents were unable to describe how to appropriately prepare the formula which was a definite cause of concern. Moreover, Dr. [redacted] certified the child to be in critical condition thus initiating this Near Fatality Report.

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, [redacted]. Follow-up interviews were also conducted with [redacted] and her Supervisor [redacted]. Also, information was received from [redacted] (Social Worker) from the [redacted] SERO did an extensive medical records review on the information received from Children's Hospital of Philadelphia (CHOP) pertaining to [redacted] medical concerns.

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

DHS received a General Protective Services (GPS) report on 12/13/2010. Mother [redacted] tested positive for marijuana after the birth of her child [redacted] on 12/12/2010. The family was assessed and at the time of delivery the home was determined safe. Therefore mother and child were allowed [redacted] Mother declined [redacted] A closing assessment through the [redacted] determined that the infant remains safe in the home with both parents. The general report was closed.

GPS report received on 01/25/2013; Bio-mother [redacted] tested positive for marijuana when she delivered victim child [redacted], however [redacted] test results were pending. Mother was admitted to the Hospital of the University of Pennsylvania on 01/24/2013 and she delivered victim child [redacted] on 01/25/2013 where she tested positive for marijuana and admitted that two weeks ago, on her birthday, she ate cupcakes and brownies that were made with marijuana. The report was investigated and findings were present (Findings meaning that the positive test results confirmed the THC in the mother's system along with her admission of taking the substance). However, there were no safety threats founded in her home as per a closing safety assessment on 2/27/2013.

Circumstances of Child Near Fatality and Related Case Activity:

It was reported that the victim child's parents were negligent in their responsibilities as it relates to the preparation of [redacted] formula. Also, they were not accustomed to taking their children regularly to medical appointments which resulted in missed immunizations as well as several missed pediatric appointments that are associated with infants under one year of age. Moreover, there was a death in the family's home (a drug overdose by a HHM) one day prior to [redacted] which confirms the usages of substances in the home. The mother [redacted] of testing positive for THC (marijuana usages) at the birth of both her children. When DHS visited the home on June 19, 2013 and they reported the home to be in deplorable condition (exposed pipes and wires, and the house was full of trash) which speaks to the type of lifestyle and well-being concerns facing the children in that home. [redacted] sister) D.O.B. 12/12/2010 also resided in the home and a safety assessment was completed on 6/19/2013 which found the child to be unsafe in the home. [redacted] . She was later placed into a [redacted] foster home with her sister, [redacted]

As for DHS's investigation, they did the appropriate interviews which included the perpetrators, family members as well as [redacted] pediatrician and CHOP's hospital officials. Also they did acquire extensive medical documentation for [redacted] as part of their medical evidence. Moreover, DHS did notify the Philadelphia Special Victim Unit (SVU) and worked with them within this investigation.

The CY-48 dated 07/19/2013 was determined to be Indicated by medical evidence and the Department of Human Services CPS Investigation. Both parents were aware of [redacted]

"Failure to Thrive" diagnosis and failed to comply with the child's medical follow-ups. They are both Perpetrators in this case.

Current Case Status:

It was reported [redacted] that [redacted] was presented in the CHOP emergency room on 06/17/2013 due to [redacted] were caused by water intoxication which resulted from [redacted] having very low sodium levels. According to hospital staff the parents could not describe how to appropriately prepare [redacted] formula. The hospital staff assessed that [redacted] is a 4 month old female [redacted] failure to thrive, delayed immunizations, [redacted] all raised concerns for the child well-being in the home. Furthermore, it was uncovered that [redacted] had only one well visit since her birth on 01/25/2013. The medical professional at CHOP and DHS asserted that all of those factors are associated to the causes of this child's near fatality experience. However, a skeletal survey [redacted]

Currently, both [redacted] are doing exceptionally well in a foster home under the supervision of [redacted] foster care agency and are receiving their immunizations as time progresses. [redacted] has gained weight while in care and continues to bond with her [redacted] foster care family. She has not missed a medical appointment since she been has been in care and she has a healthy appetite. Moreover, Per [redacted] Worker) [redacted] is thriving in her foster home and she has no need for early intervention [redacted] Both [redacted] continue to have supervised visits with their parents. Their parents [redacted] are attending parenting classes though the [redacted]. The children's goal remains reunification.

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

There was an Act 33 review Team convened on 7/19/2013. The determination of the CPS was indicated.

- Strengths: DHS felt that their team conducted a thorough investigation that was completely documented.
- Deficiencies: None identified,
- Recommendations for Change at the Local Level: DHS will explore engaging pediatricians around the concerns and/or issues of failure to thrive children as it relates to missed appointments and set-up guidelines for when DHS should be notified.
- Recommendations for Change at the State Level: No other recommendations at this time

Department Review of County Internal Report:

There was an Act 33 Review Team convened on July 19, 2013 as warranted by the Child Protective Services Law. The Act 33 report was sent to the Regional Office on 1/16/2014. SERO has reviewed the report and is in agreement with its findings.

Department of Human Services Findings:

- County Strengths: DHS did move quickly to secure the safety of the children within this investigation.

- County Weaknesses: The County stated that [redacted] were referred for the children, [redacted]. However in the documentation given to SERO, there was no documentation to support the referral in the record.

- Statutory and Regulatory Areas of Non-Compliance:

As stated in the County's Weaknesses section, it is documented in the record sent to SERO that the children [redacted] were referred for [redacted] However as per the [redacted] requirement [redacted] was not a part of the record received or reviewed by SERO. However the county has indicated that [redacted] are warranted for these children.

Department of Human Services Recommendations:

When a fatality or near fatality case has been sent to SERO all supporting documentation should be included in the file. In this case (specifically) documentation to support the assessment of the [redacted] referral was not a part of this record. It has been reported that no [redacted] are currently being rendered for [redacted].