



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:



DATE of BIRTH: 08/14/2011
DATE of NEAR FATALITY: 05/28/2011

FAMILY KNOWN to
Philadelphia Department of Human Services

REPORT FINALIZED ON: 05/02/12

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 [REDACTED]. 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. The Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	08/14/11
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Father	[REDACTED] 1983

Non Household Members

[REDACTED]	Sibling	3 years old
[REDACTED]	Sibling	12 years old
[REDACTED]	Sibling	Unknown

The mother does not have custody of her three children: [REDACTED] is presently in [REDACTED], [REDACTED] has been adopted, and [REDACTED] lives with father in Florida. The mother and father are the primary caregivers of [REDACTED]

Notification of Child Near Fatality

On 5/28/11 the Department of Human Services (DHS) [REDACTED] concerning victim child, [REDACTED]. The report alleged that the victim child had swallowed the father's medication. The medication was [REDACTED] is used to [REDACTED]; the initial report stated the mother was in another room and the whereabouts of the father were unknown. The mother reported she called 911 because she found victim child blue in the face. It was reported that when the paramedics arrived the victim child had stopped breathing. The paramedics revived the child and transported him to Temple University Hospital, Philadelphia PA. The child was later transferred to St Christopher's Hospital for Children. The medical team at the

hospital reported the child was in critical condition and certified the incident as a near fatality. The child was admitted to [REDACTED] and expected to live.

Summary of DPW Child Near Fatality Review Activities

For this review, the regional office reviewed the structured progress notes provided by DHS. The regional office interviewed [REDACTED] DHS SW, regarding the initial [REDACTED] investigation. The regional office interviewed [REDACTED], DHS SW to discuss the [REDACTED] investigation conducted on 10/28/10. The regional office attended the ACT 33 review Meeting held on 6/17/2011. The regional office conducted follow up calls with [REDACTED] to discuss preliminary findings. The child was [REDACTED] On 5/31/11 and placed in [REDACTED]. On 7/21/11 the regional office interviewed [REDACTED] from Catholic Services to discuss the services provided for the child.

Children and Youth Involvement prior to Incident:

The mother has a dependent and delinquent court history. The mother became known to DHS as a minor. She was placed in a Bethanna foster home from April 18, 1991 through June 21, 1995. The mother was then placed in a [REDACTED] through Youth Services, Inc. The mother was discharged from the [REDACTED] on July 31, 1995. On November 10, 1995 through June 25, 1996 the mother was [REDACTED] through Devereaux Foundation. The mother received [REDACTED] through the Juvenile Justice Center and the Youth Advocate Program. The mother's case was closed October 07, 1996.

The father has dependent and delinquent history as a minor. On 4/3/1992 the father was committed to DHS. The father received [REDACTED] through Intercultural Family Services, Lutheran Children and Family Services, and was [REDACTED] Wordsworth Academy. The father remained committed to DHS until 12/09/1994.

On 5/03/2003 the father was arrested and charged with burglary, attempted theft by unlawful taking, receiving stolen property, criminal trespassing and car theft. The father was sentenced to three years for the conviction. On August 10, 2010; the father was arrested for delivering and possessing controlled substances. The father pled guilty to the charges and was sentenced to 23 months. Prior to his release from prison, he was ordered to serve eight months house arrest. The court stipulated the father to seek employment and to adhere to random drug screening.

10/28/10 [REDACTED]

The family became known to DHS as adults on 10/28/10 as a result of a [REDACTED] report alleging that the mother was actively using drugs. The reporting source stated she was living in New Jersey. She returned to Philadelphia because while she was living in New Jersey she lost custody of her three children through

DYFS (The Division of Youth Services is New Jersey's child welfare agency). The reporting source stated that the mother still had custody of the victim child, [REDACTED]. On 10/29/10 DHS conducted a safety visit to the home. According to DHS, the mother stated she relocated to Philadelphia from New Jersey in May 2010. The mother reported to DHS that she [REDACTED]. DHS made contact with DYFS social worker. According to DYFS they were unaware that the mother had relocated to Philadelphia. DHS provided DYFS with current information on the family. On 11/29/10 and 12/30/10 DHS completed a safety assessment-there were no safety threats present and the child was safe. On 12/21/10 DHS sent a letter to the mother and father to advise them that the case was [REDACTED] and the case would be referred to [REDACTED] to assist with supportive services such as [REDACTED]. The mother agreed to cooperate with the plan.

On 01/13/11, DHS received a telephone call from [REDACTED] that reported the mother was using drugs and leaving the child unsupervised. DHS attempted a home visit and telephone contacts with the mother. The mother eventually called DHS, and informed DHS that she had moved and was living with the child's father. On 01/21/11, DHS conducted a home visit to ensure the child's safety and to close the investigation. According to DHS there were no safety concerns and the home evaluation was completed. On 03/02/11, DHS conducted another safety assessment with mother and father. Father and mother denied drug usage and there were no safety threats. DHS explained to mother and father they will be referred to [REDACTED]. The mother and father willingly accepted the services. According to DHS the referral for [REDACTED] was submitted 03/18/11.

Circumstances of Child Near Fatality and Related Case Activity:

On 5/28/11 the Department of Human Services [REDACTED] report alleging that [REDACTED] had ingested a toxic substance. The child swallowed [REDACTED]. This medication is used as a [REDACTED]. The medication belonged to the father; he has a [REDACTED]. The child was initially taken to Temple Hospital and later transferred to St Christopher's Hospital.

On 5/28/11 DHS conducted a safety visit to St. Christopher's Hospital to assess the victim child. DHS interviewed the mother and the medical team. The father did not accompany the mother to the hospital. The mother reported she and the father were in the bedroom having a "little argument" and the child was in the living room crawling on the floor. The mother reported while he was in the living room she heard him crying. The mother reported when she went into the living room, he was laying his head on his teddy bear. The mother reported the child appeared to be tired; therefore she laid him in his crib. The mother stated while he was lying in the crib she heard breathing harder than usual. The mother reported when she went to check on him, she noticed his tongue was at the top

of his mouth. The mother stated she thought he was having a seizure. The mother swept his mouth with her finger and she noticed his eyes were rolling in the back of her head. The mother stated she called 911. The ambulance arrived and transported the child to Temple Hospital. While at Temple the child had stopped breathing and had to be resuscitated. The child was later transported to St Christopher's Hospital for Children. The mother reported she did not know how the child was able to get the [REDACTED]. While at the hospital the doctor was unaware of a near fatality certification form used by Philadelphia DHS and one of the doctors refused to sign the form.

On 5/29/11 DHS met with the medical staff and the nurse reported the child was stabilizing; he was eating and sleeping without problems. On 5/31/11 DHS made a home assessment and interviewed the father and the mother. Both parents gave their account and they were unable to explain how the child ingested the [REDACTED]. A safety plan was completed by DHS and the parents were informed that the child would not return to the home because of safety threats. During the home evaluation the parents did not have food, baby food or baby formula, diapers and the toilet was inoperable. On 5/31/11, DHS obtained an Order of Protective Custody (OPC) for the child. The child was [REDACTED] on 6/1/11.

The parents reported they did not have any family or friends that could be a [REDACTED] for their child. Therefore, the child was [REDACTED] through Catholic Social Services.

Current Case Status:

- The investigation revealed that the child suffered severe pain as a result of [REDACTED]. On 06/14/11 the mother and father were [REDACTED] for Lack of Supervision Criminal Charges for the parents are still pending.
- The child was [REDACTED] on 06/01/11. His progress was good. He was [REDACTED] without medication and placed in a foster home through Catholic Social Services.
- According to Catholic Social Services the mother attends the supervised visits with her son at the agency. The SW from Catholic Services reported there were several occasions when the mother appeared under the influence of alcohol or drugs. The SW reported the agency visits are closely supervised and the father was inconsistent with visiting his son.
- On 08/09/11 a Family Service Plan Meeting was held and the parents did not attend the meeting. The parent's whereabouts were unknown and they did not follow through with [REDACTED]. On 09/09/11 a court hearing was held and the parents failed to show.

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

Strengths: The Act 33 Review Meeting was held. The DHS SW kept DYFS well informed about the family.

Deficiencies: DHS conducted a [REDACTED] for this family in October 2010. The Investigation was [REDACTED] in December 2010. The SW submitted the referral for [REDACTED] in March 2011, but services were never started. The DHS worker should have done follow up to ensure that this family was receiving services.

Recommendations for Change at the Local Level and the State Level: The Act 33 review team recommended that all medical doctors become familiar with the "Near and Death Fatalities", policy and procedure.

Department Review of County Internal Report:

According to the documentation, a medical doctor at St. Christopher's Hospital was not aware of a near fatality certification form (required by DHS). It was further noted that there was a doctor that refused to sign the form. The form was eventually signed by the Chief of Staff.

Department of Public Welfare Findings:

- County Strengths: DHS social worker completed safety visits as required .
- County Weaknesses: DHS determined the family would benefit from [REDACTED] supportive services. The case was [REDACTED] referral was not submitted timely.
- Statutory and Regulatory Areas of Non-Compliance: There were no areas of non compliance

Department of Public Welfare Recommendations:

DHS conducted a [REDACTED] for this family in October 2010. The investigation was [REDACTED] in December 2010 and the family was referred [REDACTED]. The referral was submitted on March 18, 2011 which suggests there was a three month delay in the referral. The Department recommends that families would benefit if DHS closely monitors referrals for [REDACTED] or institute a policy to establish time frames for [REDACTED] referrals.