



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:



BORN: 05/02/2008
DATE OF NEAR FATALITY: 08/25/2010

FAMILY KNOWN TO:
Philadelphia Department of Human Services
(DHS)

REPORT FINALIZED ON:
August 24, 2011

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. 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. The Act 33 of 2008 meeting was held on September 17, 2010; there was also a follow up meeting on October 1, 2010.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	05/02/2008
[REDACTED]	Biological brother	[REDACTED] 1999
[REDACTED]	Biological mother	[REDACTED] 1981

<u>Non-Household Members:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Biological father of [REDACTED]	[REDACTED] 1978
[REDACTED]	Maternal great aunt	[REDACTED] 1953
[REDACTED]	Maternal grandfather	[REDACTED] 1960
[REDACTED]	Maternal step-grandmother	[REDACTED] 1961
[REDACTED]	Maternal grandmother	[REDACTED]
[REDACTED]	Paramour of [REDACTED]	[REDACTED] 1976 also gave [REDACTED] 1977

Notification of Child Near Fatality:

On August 25, 2010, the Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging that [REDACTED] was [REDACTED] the [REDACTED] at the Children's Hospital of Philadelphia (CHOP) for [REDACTED] to his [REDACTED]. The injuries that [REDACTED] sustained included [REDACTED] and [REDACTED], a possible [REDACTED] and a [REDACTED]. It was noted that [REDACTED] was also [REDACTED] in June of 2010 for a [REDACTED] and a [REDACTED]. The current injuries were recent and unrelated to that prior [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the caseworkers, [REDACTED] and [REDACTED] and the Supervisor [REDACTED]. The regional office also participated in the Act 33 Fatality Review meetings on September 17, 2010 and October 1, 2010. The files of Carson

Valley Children's Aid were reviewed and interviews were conducted with the [REDACTED] staff responsible for the [REDACTED] family. The social worker, [REDACTED], Supervisor [REDACTED] and the Director [REDACTED] were interviewed.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

February 10, 2010

On February 10, 2010, the Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging that [REDACTED] had [REDACTED], [REDACTED] and swelling on both [REDACTED] and fingerprint marks on both [REDACTED]. The injuries were [REDACTED]. The case was [REDACTED] by the DHS intake unit; the allegations were [REDACTED]. The case was closed. In discussion with DHS, the reason the case was determined [REDACTED] was that the severity of [REDACTED]'s injuries did not meet the [REDACTED]; [REDACTED] did

[REDACTED] There was discussion regarding policy and procedure as to addressing cases [REDACTED] injuries to a child. It was determined that the policy for [REDACTED] injuries is to have the caregiver/parent participate in a [REDACTED] evaluation. This evaluation did not take place for any of the caregivers of [REDACTED].

June 7, 2010

On June 7, 2010, The Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging [REDACTED] was transferred from Children's Hospital of Philadelphia to DuPont Hospital in Wilmington, Delaware. [REDACTED] sustained a right [REDACTED] injury and [REDACTED] of the [REDACTED]. The injuries were believed to have occurred between May 20th and June 5th 2010. There had been multiple incidents between April and June: [REDACTED] had been hospitalized four times since April 2010. During this period of time, it was reported through [REDACTED]

[REDACTED]. The [REDACTED] was [REDACTED] based on medical evidence and named [REDACTED] as the [REDACTED]. In response to this report, DHS implemented [REDACTED] through Carson Valley Children's Aid.

Circumstances of Child Near Fatality and Related Case Activity:

On August 25, 2010, DHS received a [REDACTED] report alleging that [REDACTED] was [REDACTED] into the [REDACTED] of Children's Hospital for Children with [REDACTED] injuries. [REDACTED] was unresponsive and on [REDACTED]. The mother reported that she put the child to bed and when she went to wake the child, he was unresponsive.

██████████ was informally placed with his maternal grandmother, ██████████, on June 15, 2010. This was the safety plan in response to the ██████████ investigation of June 7, 2010. ██████████ was then placed with his maternal grandfather and step-maternal grandmother, ██████████ and ██████████, on June 28, 2010 and finally with his maternal great aunt, ██████████, on July 8, 2010. This is the location of the most recent incident. The ██████████ of Carson Valley Children's Aid breached the safety plan of 7/8/2010 that stated maternal great aunt, ██████████ would provide ██████████ with all daily living, and would supervise ██████████ at all times, and would supervise him while he is visiting with his mother.

██████████ had a history of taking ██████████ to the Jefferson Hospital and DuPont Hospital in the state of Delaware for various complaints. She insisted that ██████████ had an ██████████ that caused ██████████ bruising. In June of 2010, the DuPont Hospital determined that the ██████████ injuries were ██████████

On August 24, 2010 the ██████████ social worker made a decision to allow the maternal great-aunt to spend the night and stay in the home of the mother, ██████████. The Carson Valley ██████████ social worker did not contact DHS to inform them of this decision. This decision was made as ██████████ and ██████████ reported they were tired after having ██████████ at the doctor's office, food shopping and filling prescriptions for ██████████. The doctor's visit was with the primary care physician, ██████████, at Lankenau Hospital. The physician prescribed an ██████████ for ██████████. Her medical notes/reports ██████████ ██████████. It was decided by Carson Valley Children's Aid ██████████ worker that mother and ██████████ would sleep upstairs in a bedroom while maternal great aunt, ██████████, would sleep on the living room couch. The decision was a breach of the safety plan. Through further ██████████ it was determined that mother's paramour, ██████████, was also in the home at the time of the incident. The Special Victims Unit reported that on the night of the incident, ██████████ was seen running out of the home and stated "I don't know what is going on in there." According to the police report, he kept on running. As a result of this breach of safety plan, ██████████ sustained ██████████ injuries. ██████████ sustained right and left ██████████ and ██████████. Upon ██████████ investigation, ██████████ reported that on August 24, 2010 she put ██████████ bed and when she woke up he was unresponsive. This statement indicates that the safety plan was breached as ██████████ was not to have unsupervised contact with ██████████

Current Case Status:

On September 20, 2010 the ██████████ was ██████████ for ██████████. The mother ██████████, mother's paramour, ██████████, and maternal great aunt, ██████████, were named as the ██████████ sustained ██████████ injuries. The ██████████ evidence determined that he ██████████ and ██████████ and ██████████ in both ██████████.

On October 29, 2010, the [REDACTED] granted full custody of [REDACTED] to his father, [REDACTED]. The case has been referred to Lehigh County Children and Youth to provide assistance with the transition process of [REDACTED] and his father. The county will also provide direct supervision for visit with [REDACTED] and his mother. [REDACTED] receives [REDACTED] day care and [REDACTED] services. [REDACTED] is on a [REDACTED], he is [REDACTED] and he is [REDACTED]. He will require lifetime [REDACTED] including [REDACTED] and [REDACTED].

[REDACTED] continues to be in [REDACTED] with supervised visitation with his mother.

The case continues to be under investigation with the Special Victim Unit. There has [REDACTED] made to date.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) 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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 on September 17th and October 1, 2010. There was a need for the Act 33 team to meet again to further explore the circumstances regarding the [REDACTED] family.

Compliance with Statutes and Regulations

The team felt that the MDT Social Work Team did a thorough job [REDACTED] the current [REDACTED] report.

Implementing [REDACTED] for the family, Safety Assessment and Safety Plans

The team was concerned about several issues regarding the safety plans: safety threats were not recognized, and safety plans were not being monitored.

The policy for [REDACTED] injuries, concerning the first report February 10, 2010, was not followed. The case was closed even though the mother could not explain how [REDACTED] the injuries. DHS did not [REDACTED] [REDACTED] on the caretakers, and could not identify the caretakers responsible for [REDACTED] at the time of the injury.

A [REDACTED] report was not sent to the Philadelphia Police Department for the June 2010 report. This should have been reported as [REDACTED] suffered [REDACTED] [REDACTED], [REDACTED] and [REDACTED]

The father of [REDACTED] was not explored as a possible resource for parenting.

Summary of Safety Assessments and Safety Plans:

Safety Plan 6/9/2010: Safety visit, Safety Threat #3 was identified. This safety assessment and plan were in response to the report of June 7, 2010 for the injuries that [REDACTED] sustained, the [REDACTED] injury and the [REDACTED]. The assessment determined that [REDACTED] was safe. The assessment determined that [REDACTED] was safe with a comprehensive safety plan. At this point [REDACTED] was informally placed with his maternal grandmother, [REDACTED] on 6/15/10.

Safety Plan 6/19/10: Safety visit, Safety Threat #3 was identified. This was a safety visit. The responsible person to ensure the safety of [REDACTED] was maternal grandmother [REDACTED]. Subsequently [REDACTED] was placed with his maternal grandfather, [REDACTED] and maternal step-grandmother, [REDACTED] on 6/28/10

Safety Plan 6/28/2010: Safety visit, Safety Threat #3 was identified. It was determined that [REDACTED] does not have a [REDACTED] condition that would cause injuries. [REDACTED] insisted that [REDACTED] had some type of [REDACTED] condition that caused him to have injuries. [REDACTED] and [REDACTED] (maternal grandfather and maternal step-grandmother) were the responsible parties for implementation of the safety plan. The maternal step-grandmother decided that she did not want to provide on-going care; she was there to support maternal grandmother, [REDACTED]. On 7/8/10 [REDACTED] was placed with his maternal great aunt [REDACTED]. DHS did not take custody and no court action was taken. [REDACTED] through Carson Valley Children's Aid were implemented on 7/7/10. [REDACTED] were to take place in the home of [REDACTED], the maternal great-aunt.

Safety Plan 7/8/2010: transfer case visit: Safety Threat #3. [REDACTED] (maternal great-aunt) was the responsible party for implementation of the safety plan. This safety plan was not signed by the county supervisor. Therefore, the safety plan was not valid.

Safety Plan 7/26/2010: There is no revised safety plan as this plan expired in 21 days. The safety plan expired August 16, 2010.

Safety Plan 8/25/2010: This plan was developed in response to the near fatality of [REDACTED]. The safety assessment identified safety threats #3, #9 and #10. The assessment determined that [REDACTED] was not safe and determined [REDACTED] safe with a comprehensive safety plan. On 8/27/10 a shelter hearing was held and [REDACTED] was placed into foster care. [REDACTED] was safe in the Children's Hospital of Philadelphia (CHOP) with a comprehensive safety plan. This safety plan included [REDACTED] father [REDACTED] as he expressed interest in parenting his son [REDACTED]. The plan required that [REDACTED] have direct supervision while having contact with [REDACTED] and [REDACTED]

The safety assessments and safety plans were a major concern for the Act 33 team. The safety plans were not appropriately implemented or monitored. There was no active safety plan from August 16th to August 25th the date of the near fatality. The safety threats were not clearly identified to all parties involved with the [REDACTED] family. The Carson Valley Children's Aid reported that they were not aware of the safety threats and the intensity of the case. DHS reported that Carson Valley Children's Aid was aware of the safety threats and the intensity of the case. The lack of clarity and poor communication resulted in [REDACTED] being re-abused and receiving [REDACTED]. Both Carson Valley Children's Aid and DHS are responsible for this lack of clarity and communication. During the Act 33 review meetings there was intensive discussion regarding policies, procedures, best practices and regulations regarding this family. The team was concerned with the communication between the county agency and the private provider agency. There was also poor communication with the extended family members that were responsible for implementing the safety plan.

During the Act 33 meeting, it was stated that the county staff were not aware of the DHS policy to refer parents for a [REDACTED] evaluation in response to [REDACTED] injuries of their children. In response to allegation that county children and youth staff were not aware of the policy; the Commissioner of DHS reports they will be implementing an electronic policy receipt confirmation process where managers will be able to determine who has not reviewed a recent issued policy. In addition, the Commissioner has met with the provider agencies that contract for [REDACTED] to reinforce the expectation and remind them of the intensity of the safety service.

Recommendations for Change at the Local Level:

- Provider agencies should be trained on how to interpret a safety assessment and how to assess the seriousness of safety threats.
- The team recommended that DHS explore the process of transferring cases from Intake to Ongoing Services Region, with specific regard to formalizing how the case information is transferred. Currently, the file information is transferred without any formal meeting between systems to discuss the particulars of the case.
- The Team recommended that DHS, Law Department, Special Victims Unit and the District Attorney's Office meet to explore how to improve information sharing between the various agencies.
- The Team recommended that staff be re-trained on filing a [REDACTED] with the police department. This training should include how, in what circumstances and the timeframes for filing a police report.

Recommendations for Change at the State Level:

There were no recommendations.

Department Review of County Internal Report:
Department of Public Welfare Findings:

County Strengths:

- The engagement of [REDACTED], father of [REDACTED], and the decision to have the father parent his son.
- The interview of mother's paramour, [REDACTED], and to have [REDACTED] him as perpetrator of the report.
- The interview of [REDACTED] brother, [REDACTED], who provided an understanding of the behaviors of his sister [REDACTED]. He reported that [REDACTED] or [REDACTED] ([REDACTED]) caused the [REDACTED] injuries to his nephew [REDACTED].
- The Philadelphia Department of Human Services completed a comprehensive [REDACTED] for the August 25, 2010 near fatality. The county obtained all necessary documentation that included police reports, medical examiners reports and medical/hospital reports. The county also collaborated with the Delaware State Children and Youth. Delaware State Children and Youth received a referral from [REDACTED] as [REDACTED] was in the DuPont Hospital located in the state of Delaware.

County Weaknesses:

- The February 10, 2010 [REDACTED] was not comprehensive. The [REDACTED] did not interview or assess the needs of the sibling, [REDACTED]. At this time, the father of [REDACTED] was not explored. Critical information regarding [REDACTED] health and well-being was not assessed. The [REDACTED] for the June 7, 2010 report did not contact law enforcement as required to report for [REDACTED] [REDACTED] [REDACTED] and [REDACTED]. The report was [REDACTED] based on [REDACTED] evidence.
- The DHS ongoing social work team did not follow through with Intake's recommendations to have [REDACTED] referred for a [REDACTED] evaluation in response to the June 7th incident of [REDACTED] injuries. At this time it was evident that [REDACTED] was in need of a [REDACTED] evaluation. The medical reports from DuPont Hospital indicated that [REDACTED] insisted that [REDACTED] had a [REDACTED] condition and that the condition contributed to his [REDACTED] injuries. On June 14, 2010, a meeting was held at DuPont Hospital. The purpose of this meeting was to discuss the June 7th incident and the injuries that [REDACTED] had sustained. At this meeting, it was determined that [REDACTED] injuries were a result of [REDACTED] trauma. [REDACTED] had a [REDACTED] ([REDACTED]) and a [REDACTED]. [REDACTED] was unable to provide an explanation for the injuries. At this point she should have been referred for a [REDACTED] evaluation.

Statutory and Regulatory Areas of Non-Compliance:

- The safety assessment dated for July 26, 2010 was signed by social work supervisor on August 13, 2010.
- The law enforcement was not notified on the June 7, 2010 report for serious [REDACTED] injury and [REDACTED].
- The safety plan was not implemented requiring supervision for [REDACTED]. It was determined through the [REDACTED] that she was having unsupervised contact with [REDACTED].
- There was no official safety plan from August 16th to August 25th 2011. The safety plan of July 26, 2010 expired August 16, 2010, there was not another safety plan developed until August 25, 2010, the date of the near fatality.

Department of Public Welfare Recommendations:

- To ensure that all human service agencies and facilities that are providing services to a child are aware of the county children and youth agency involvement. This includes but not limited to hospitals, day care centers and primary care doctors. It was determined that [REDACTED] day care center was not aware of the DHS involvement. Therefore, the day care center was not aware of the safety threats or plan that stated that the mother, [REDACTED], was not to have unsupervised visits/contact with [REDACTED]. [REDACTED] was picking up and dropping off [REDACTED] at his daycare. The day care center was not aware of the safety plan that [REDACTED]. [REDACTED] was only to have supervised visits and contact with [REDACTED].
- For the county agency to have on-going collaboration with provider agencies about their responsibility to ensure the safety and well being of the children under their supervision.
- To have re-training and on-going training for safety assessment and safety plans for county children and youth agencies and private provider agencies.