



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT NEAR FATALITY OF:



Date of Birth: 01/02/2012
Date of Near Fatality: 05/01/2012
Date of Oral Report: 05/04/2012

FAMILY NOT KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON: 05/02/2013

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))

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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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on May 15, 2012.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED] (1)	Mother	[REDACTED]/1984
[REDACTED] (2)	Half-sibling sister	[REDACTED]/2001
[REDACTED] (3)	Half-sibling brother	[REDACTED]/2002
[REDACTED] (4)	Half-sibling sister	[REDACTED]/2008
[REDACTED] *	Victim Child	[REDACTED]/2012
[REDACTED] *	Father (1)	[REDACTED]/1981
[REDACTED] **	Father (4)	not provided
	Maternal Grandmother	not provided

*Fathers of the children were not members of the Household or living with children
**Maternal Grandmother is not a member of the household

Notification of Fatality / Near Fatality:

The Department of Human Services in Philadelphia (DHS) received a call [REDACTED] on May 4, 2012 concerning [REDACTED]. [REDACTED] (Victim child) was taken to Children's Hospital of Philadelphia (CHOP) on 4/30/12 due to the child having a fever and brought again on 5/1/12 because the child was more lethargic and not eating. Child was tested and found to have severe hypernatremia (very high sodium levels). Victim child was admitted into CHOP due to having the high level of sodium. The child was placed in [REDACTED] at CHOP and was having [REDACTED] related to the high sodium level. CHOP has found no underlying medical condition that would explain the high level of sodium. CHOP states the condition is consistent with salt intoxication through ingestion. Prior to being taken to CHOP, the victim child was being taken care of by her father at his residence and the mother was at work. The three siblings of the victim child were at home and being watched by their maternal uncle. The mother stated that one of the siblings of victim child was playing with a bottle of salt. The mother reports that the sibling emptied the bottle of salt all over the bed and bedroom floor. The same sibling (4yrs old) has had behavior problems and diagnosed with [REDACTED]. Some of the previous behaviors of this child were that she was found wandering the streets at night and stabbed another sibling in the home with a knife. The salt was cleaned up by the mother and father of victim child. Victim Child slept in the bed that was previously covered in salt. Mother does not believe salt got into formula of the victim child. It was not clear if salt actually got into baby's formula. Mother had been working and victim child was under care of her bio-father on 4/29/12 prior to the reported illness of the victim child. CHOP cannot state the salt poisoning was intentional but believes that lack of supervision was a consistent problem.

2. Documents Reviewed and Individuals Interviewed:

The Southeast Regional Office of Children, Youth and Families (SERO) after receiving [REDACTED] on May 4, 2012, regarding the near fatality, contacted DHS to receive all pertinent information in respect to the case and the family. Information was sent from DHS to SERO on May 8, 2012. Contact over the phone was made to Case Worker [REDACTED], and the supervisor, [REDACTED], regarding the initial steps taken, safety plan and current status.

Summary of Services to Family:

Previous CY involvement:

Circumstances of Child's Near Fatality:

DHS reported that the only involvement they had with the family was in the year 2002, when the mother was a minor and requested services. DHS stated that the services were not for dependency or initiated by a [REDACTED].

Current / most recent status of case:

5/4/2012 [REDACTED]

ChildLine was contacted by [REDACTED] because Victim Child had symptoms and diagnosis of high salt ingestion. DHS worker went to Hospital to meet with doctors and see child. Doctor at CHOP certified case as a near fatality. Mother and Father, [REDACTED] are listed as the [REDACTED]. Interviews were conducted with the parents and siblings of the child. During the interviews it was revealed that the 4 year old sibling of the victim child had emptied salt over the floor and bed where the victim child normally sleeps. The salt was reportedly cleaned up by the mother and father of victim child. The 4 year old sibling has previously been diagnosed with [REDACTED]. The mother of the children was to have follow-up with evaluations for the 4 year old sibling per requests by child's daycare provider, but the mother had not done so. At the time, the 4year old sibling dumped salt in the room, the victim child was at the home of her bio-father, the mother was at work and the other children were being take care of by their maternal uncle. It was not known if any salt got into the baby's formula or into water used for the formula.

A Safety Assessment was completed on 5/7/2012; it was determined that the Victim Child and two of her siblings were determined safe. The 4 year-old sibling of the Victim Child was determined to be safe with a Plan. The Safety Plan provided that (1) the mother will keep formula and spring water in a secure place, (2) Caregivers will keep all follow up appointments for Victim Child, (3) Caregivers will ensure that [REDACTED] is supervised at all times by an adult, and (3) Caregivers will provide proper care and supervision for household children. The maternal grandmother, [REDACTED], was named the responsible party on the Safety Plan.

On 5/8/2012, the doctors at CHOP determined that Victim Child was doing much better. The decision was made to release child from hospital care to her mother. Follow-up appointments were necessary and scheduled.

On 5/15/2012, the Victim Child was again determined to be safe in this assessment. Two siblings were determined to be safe with a plan. The 4 year-old sibling was again determined to be safe with a plan and a 9 year-old sibling as well. It was realized that the 9 year-old sibling had [REDACTED] that were not being addressed by keeping appointments that were made. Within the safety plan it was determined that (1) [REDACTED] will ensure that the mother will keep all medical and mental health appointments and (2) Mother will establish a consistent alternate caregiver for the children when she is working. The responsible person is designated as Tabor Children Services, [REDACTED], who is also providing [REDACTED] services.

The report initiated on 5/4/2012 was [REDACTED]. Services indicated [REDACTED] describe continued DHS involvement for child, parent, and perpetrators.

Current Case Status:

Child is doing well and is back home with her mother. IHPS services are currently being implemented to ensure the health and safety of the children in the household. During the course of investigation, the mother has cooperated with DHS and continues to do so.

County Strengths and Deficiencies as identified by the County's 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 related to this report.

- Strengths:

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 as it was not required [REDACTED]. The oral report was made on May 4, 2012 and the report disposition of it [REDACTED]. The County did not prepare a Near Fatality Report for this case.

Deficiencies:

No deficiencies noted.

• Recommendations for Change at the Local Level:

No recommendations at this time

• Recommendations for Change at the State Level:

No recommendations at this time

Department Review of County Internal Report:

A report was not completed by the County.

Department of Public Welfare Findings:

• County Strengths:

DHS representative went out immediately to check on the safety of the child. Interviews were held with medical professionals providing service to child and home visit where children reside were conducted the same day. Both a Risk and Safety Assessment were conducted shortly after the interviews and prior to the child returning home. [REDACTED]

[REDACTED] DHS is also providing continuing services through IHPS.

• County Weaknesses:

There were no weaknesses noted.

• Statutory and Regulatory Areas of Non-Compliance:

There were no areas of Regulatory non-compliance.

Department of Public Welfare Recommendations:

• County Strengths:

DHS representative went out immediately to check on the safety of the child. Interviews were held with medical professionals providing service to child and home visit where children reside were conducted the same day. Both a Risk and Safety Assessment were conducted shortly after the interviews and prior to the child returning home. The determination and completion of the CY 48 was made prior to 30 days. DHS is also providing continuing services through IHPS.

• County Weaknesses:

There were no weaknesses noted in the review of this near-fatality case.

• Statutory and Regulatory Areas of Non-Compliance:

There were no areas of Regulatory concern to initiate Regulatory citations for areas of non-compliance.