



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

(215) 560-2249/2823
Fax: (215) 560-6893

801 Market Street, Suite 6112
Philadelphia, Pennsylvania 19107

REPORT ON THE NEAR DEATH OF



BORN: 11/19/2008
DATE OF INCIDENT: 4/26/2009

FAMILY KNOWN TO:
PHILADELPHIA DEPARTMENT OF HUMAN SERVICES
TABOR CHILDREN'S SERVICES
SUPPORTIVE CHILD/ADULT NETWORK

10/16/2009

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality that was suspected to have occurred during to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

1. Household Composition.

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	11/17/2008
[REDACTED]	Mother	[REDACTED] 1985
[REDACTED]	Father	[REDACTED] 1983
[REDACTED]	Sister	[REDACTED] 2005
[REDACTED]	Brother	[REDACTED] 2004
[REDACTED]	Brother	[REDACTED] 2007

2. Extended Family

[REDACTED]	Brother**	[REDACTED] 2001
[REDACTED]	Maternal aunt	
[REDACTED]	Maternal aunt	
[REDACTED]	Paternal grandmother	
[REDACTED]	Paternal grandfather	

** Lives with maternal aunt, [REDACTED]

Notification of Fatality / Near Fatality:

Five month old [REDACTED] was brought to the Emergency Room on 4/26/2009. His mother reported that he was lethargic and not responding. No obvious injuries were noted. The CT scan revealed [REDACTED]. He went into respiratory failure while in the CT scan and had to be intubated. He was admitted to [REDACTED] in a coma. Child came out of the coma 5/15/2009. Plans were made to discharge him to a rehab facility. Preliminary medical evidence indicates shaken baby syndrome.

2. Documents Reviewed and Individuals Interviewed.

For this review the SERO reviewed the complete DHS case file provided by the county. The DHS file included the reports from both provider agencies involved: Tabor Children's Services and Supportive Child/Adult Network (SCAN). SERO reviewed the entire SCAN file.

SERO interviewed [REDACTED], the DHS [REDACTED] investigator. The regional office attended the DHS Act 33 Review regarding this case on 05/15/2009.

Case Chronology:History of reports

9/18/08

Reporting source stated that [REDACTED], age four years old, and [REDACTED], age three years old, are both developmentally delayed and that [REDACTED], 19 months old, is [REDACTED] when examined 09/18/08 by Dr. [REDACTED] with mom. Reporting source provided mom a referral to Childlink for the victim child. Reporting source stated that victim child, [REDACTED], is not eating a proper nutritious diet. Reporting source provided mother with a good example of a nutritious eating plan for victim child, [REDACTED], to begin eating solid foods and to consume more liquids and less juice. [REDACTED]

[REDACTED] Reporting source stated that mother is seven months pregnant. The mother recently moved to Philadelphia from Virginia and has a child placed in the Virginia foster care system. DHS made contact with Lunenburg County Department of Human Services to verify this information. [REDACTED]

[REDACTED]; the agency worker reported that a maternal aunt, [REDACTED], had sought custody of [REDACTED]. The agency supported this arrangement. [REDACTED] behavior showed marked improvement after he moved. The mother's home was frequently filthy, [REDACTED]

[REDACTED] the mother is [REDACTED], has [REDACTED], and may not be capable of providing care of her children. Reporting source stated that [REDACTED], Philadelphia, Pennsylvania [REDACTED]. Reporting source stated that the mother believes her children are developing nicely. The [REDACTED] investigation determined that [REDACTED] condition was not due to neglect by [REDACTED]

[REDACTED] was admitted to the hospital 9/22/2008 and continued to exhibit eating difficulties even in the controlled atmosphere of a hospital. The case was opened for services 10/10/2008 and referred to the Family Preservation Unit. Family Service Plan meeting was held 10/20/2008. Tabor Services began on 10/28/2008.

4/26/2009

This family was open for services at the time of this report and receiving in-home services through SCAN. Reporter stated that the mother brought five month old [REDACTED] to the Emergency Room at St. Christopher's Hospital on 4/26/2009 and reported that child was lethargic and non-responsive. [REDACTED]

[REDACTED]. There was no outward visible sign of trauma. A CT scan was done and it revealed [REDACTED]

[REDACTED]. Reporter suspects that [REDACTED] is a victim of shaken baby syndrome. Child went into respiratory failure during the CT scan. Child had to be intubated. Child was placed in the [REDACTED] in critical condition. [REDACTED]

Reporter stated mother offered minimal background information and she appeared not to be unnerved by the victim child's condition (not concerned).

4/28/2009

When DHS became aware of ER visit, they developed a Safety Plan that required the other three children to be examined at St. Christopher's Hospital. Seventeen month old was examined by a physician who determined that . The parents are the primary caretakers for the child. , maternal aunt, agreed to be kinship caregiver for the three siblings. DHS made an appropriate home evaluation, and secured clearances.

Previous CY involvement:

The first report for this family was received 9/19/2008 due to concerns that might be failure to thrive. The family composition included the mother, father, . There were also concerns that were developmentally delayed. DHS determined that his delays were medically related, not environmentally caused. The family was accepted for services 10/10/2008; the Family Service Plan was completed 10/20/2008. The family was referred for Family Preservation services. Family Service Plan goals were for the parents to receive instruction about caring for a child with weight loss, parenting training related to child development, meeting their children's basic needs, and to provide routine medical and health care for their children. The Family Preservation provider was Tabor Children's Services; the start date was 10/24/2008. Needs identified for Tabor to address were to: ensure that children's special medical needs are met, improve parenting skills through the provision of parenting education classes, increase parents' knowledge of resources, refer parents to through the DHS, connect the mother with community resources (such as Mom Mobile), and to monitor the basic care and safety of the children in the home. In addition to Tabor Services, DHS provided a nurse beginning 10/20/2008 who made almost weekly in person contacts with the family and provided concrete parenting techniques to assist in the feeding of . The nurse also weighed during the visits. The DHS nurse instructed the parents during one home visit (10/16/2008) to take to the hospital because he was not eating. was admitted to St. Christopher's Hospital on that date. He still was exhibiting eating difficulties after his admission to the hospital. received during this hospitalization. During Family Preservation services, the mother gave birth to on 11/19/2008. Tabor assisted the family with basic baby supplies, and observed that the other children were being cared for by the father and paternal grandfather while the mother was in the hospital. The nurse continued her home visits and assessed the health and wellbeing of as well as . The nurse reviewed with the father how to mix formula; she observed that the father had been mixing it incorrectly.

At the discharge meeting with Tabor on 1/27/2009, the accomplishment of the goals was addressed. Tabor had confirmed with medical providers that the children had received medical care, including appointments with specialists. [REDACTED] was receiving [REDACTED]

[REDACTED]. Parents were observed to be administering regular feedings for [REDACTED]; his [REDACTED] was stabilized after switching medications. Tabor identified that the family should follow up with Elwyn about their recommendations, Childlink services should be monitored, and ongoing assessment of the family's housing environment should continue. DHS determined when Tabor Services were closing that further in-home services were needed from a provider which would focus their services on families with children with medical needs. A joint meeting between DHS and the two providers, Tabor and SCAN, occurred with the family on 1/27/2009 to review the family's needs. The social workers from DHS and both providers concluded that the parents had cognitive limitations, but determined that with appropriate support the parents would be able to meet their children's needs. The Family Service Description developed by SCAN on 1/27/2009 identified actions to be taken: monitor safety through home visits, support parents in following through with service providers, refer to community resources, locate parenting group appropriate for parents with special needs children, refer to Childlink, support parents in securing routine medical care, obtain medical records for children, and assist parents in enrolling children in day care and kindergarten. The SCAN worker documented the weekly visits on contact logs. Social workers were in contact with the maternal aunt who was a support to the family; she was [REDACTED] and helped with grocery shopping. During the course of SCAN's involvement, the family reported needing food on one occasion. [REDACTED]

The SCAN worker made contact with the aunt who reported that she shops biweekly for the family, and would be shopping later that night. The aunt reported that the father's family "squats" at the home, and eats up all their food, which is why the mother reported to the SCAN worker that they are in need of food.

During the evening of 4/26/2009, the parents had gotten into an argument, resulting in mother leaving the home for the evening and leaving the father with the four young children. [REDACTED] the father admitted to shaking [REDACTED] when he was frustrated that he would not stop crying.

Services to children and families:

[REDACTED] siblings, [REDACTED], are currently in kinship foster care with their maternal aunt, [REDACTED]. [REDACTED] is in a medical foster home due to his medical needs. [REDACTED] was discharged to a rehab facility. The father was arrested for the assaults on [REDACTED] and [REDACTED]. The mother remains in her home.

County-Identified Strengths and Deficiencies:

County Strengths-

- The investigation of April 2009 was conducted thoroughly and well-documented.
- Several social work teams worked on this case which resulted in this case never being uncovered.
- The family received two of DHS' most intensive services, and were recommended for Family School. Unfortunately, the connection to the Family School never occurred.
- The DHS nurse assisted the family with [REDACTED] needs after the initial [REDACTED] report.

County Deficiencies-

- The Act 33 Review team concluded that both DHS and SCAN focused more on the children's medical issues than the parents' cognitive delays. Throughout the case, workers documented the parents' limitations, but it was not until March 2009 that the parents were referred for [REDACTED].
- This family was not assessed for domestic violence, and subsequently were not referred for any domestic violence services.
- During the case transfer process from one Family Preservation to another, there was no disruption of contacts with the family. However, the second worker was impeded by not having the physical case file.
- SCAN was instructed by DHS to locate parenting classes close to the family's residence, or to provide transportation to a class if that was not possible. SCAN did not locate classes that were close to their home, and did not provide any transportation for the family.
- SCAN did not thoroughly assess the parents' abilities to deal with four young children, especially in consideration of [REDACTED] [REDACTED] feeding issues.

County Recommendations for Changes at the Local Level:

- Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect
 - Family Preservation services can range from five hours a week to fifteen hours a week. This family was receiving five hours of services per week from SCAN. The team recommended that DHS establish protocols as to how many service hours a family requires and how the number can be increased.
 - DHS should consider using DHS psychologists for consultations as well as field visits to assist with securing appropriate services for cognitively delayed parents.
 - DHS should consider incorporating training on medical issues, such as failure to thrive, into the training curriculum.
- Monitoring and inspection of county agencies
 - The team recommended implementing a procedure to obtain CYD records from other counties in a more timely fashion.

SERO Findings

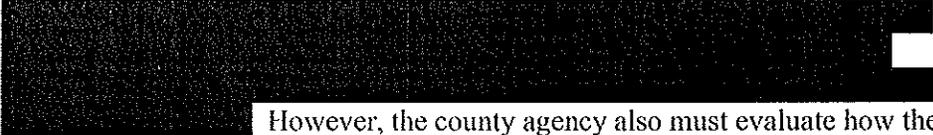
County Strengths-

- The investigation of April 2009 was well-documented, and was in regulatory compliance.
- During the case transfer process, the family did not experience a lapse of services.
- DHS appropriately used one of their nurses to accompany them on visits to complete health assessments on the children. Collateral contacts were well documented. DHS made referrals to and regularly communicated with community resources to support this family, such as Elwyn, [REDACTED], [REDACTED], Family Preservation social workers, and medical staff at St. Christopher's Hospital.

County Deficiencies-

- From the beginning of the case in September 2008, the parents were identified as being cognitively limited, but a referral for a formal assessment was not completed until March 2009.
- During the Act 33 Review, information about the father's criminal history was revealed. This revelation points to the county's existing need to develop protocols about obtaining criminal background histories on family members during the course of investigations and service provision.
- This family was not assessed for domestic violence, and subsequently was not referred for any domestic violence services. County workers would benefit from further training on domestic violence.
- The family had been attending parenting classes at Tabor until the birth of [REDACTED] and [REDACTED] increasing medical needs. When SCAN began services, they were instructed by DHS to locate parenting classes close to the family's residence, or to provide transportation to a class if that was not possible. SCAN did not locate classes that were close to their home, nor did they provide any transportation for the family. SCAN did communicate to DHS that they were only able to provide travel vouchers once per month. DHS did not follow up with this.
- DHS indicated in their Near-fatality Review Report that SCAN did not thoroughly assess the family's capacity to parent four young children, yet DHS identified on their Risk Assessment dated 12/3/2008 that the parents' cognitive limitations did not appear to impact on their ability to care for their children. So, it would seem that DHS also did not complete a comprehensive assessment of the parents' capacity. [REDACTED] reported in collateral contacts to DHS that they did not believe that the parents were capable of caring for their children. During their intake with the family, Tabor identified that the parents should be referred for [REDACTED] through DHS. Tabor repeated this theme in their Mid-Point and Discharge meetings with the family, but DHS did not follow up on this request, nor did Tabor.

SERO Recommendations

- Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect
 - When parents are identified as limited, the county agency should develop a protocol of how to obtain a formalized assessment of the parents' capacity in order to better assess Safety and Risk of the children. This could include asking the parents to sign releases of information from previous providers.
 - The county agency should develop protocols about securing criminal background clearances on family members during investigations.
 - The county agency should ensure that the initial Safety and Risk Assessments include gathering information about domestic violence. This may necessitate further training for new and experienced workers.
 - If parents need specialized services, the county must be clear with its contracted providers about expectations and outcomes. DHS wanted the parents to participate in parenting classes related to both the children's medical needs and the parents' cognitive limitations. Tabor was providing this service. But, when the family was transferred to SCAN, the SCAN worker did not connect the parent to classes because of the transportation costs.
 -  However, the county agency also must evaluate how the parents' functioning impacts on the children's safety, permanency and wellbeing. OCYF could assist the county by developing training curriculum that would help workers enhance critical thinking skills needed in these high risk cases.
- Monitoring and inspection of county agencies.
 - The county agency should not only refer children for Ages and Stages evaluations; they should have family members sign releases so they could have copies of these reports in their case files.