



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



BORN: JULY 09, 2011
DATE OF NEAR FATALITY: August 10, 2011

FAMILY NOT KNOWN TO COUNTY AGENCY

REPORT FINALIZED ON: June 8, 2012

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 not convened a review team in accordance with Act 33 of 2008 related to this report due to the case [REDACTED].

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	07/09/2011
[REDACTED]	Sibling (Half)	[REDACTED] 1993
[REDACTED]	Sibling (Half)	[REDACTED] 1997
[REDACTED]	Sibling (Half)	[REDACTED] 1996
[REDACTED]	Aunt (Paternal)	[REDACTED] 1960
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1970

Notification of Child Near Fatality:

On August 10, 2011, the Philadelphia Department of Human's Services (DHS) received a [REDACTED] report alleging that one-month-old [REDACTED] was in critical condition due to [REDACTED], thus receiving the determination of Near Fatality. The child's whereabouts and condition were unknown at the time the report was completed; because, the mother took the child from the office against medical advice (AMA). The report was made by Dr. [REDACTED], pediatrician [REDACTED]. Law enforcement is not pursuing any charges for this family.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current [REDACTED] case notes completed by DHS [REDACTED] Ms. [REDACTED]. Follow-up interviews were conducted with Ms [REDACTED]. SERO

completed an extensive review of all medical records received from St. Christopher's Hospital for Children.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

There was no involvement with DHS and this family prior to the [REDACTED] which was initiated on 08/10/2011.

Circumstances of Child Near Fatality and Related Case Activity:

On 8-10-11 a [REDACTED] report was generated alleging that a [REDACTED] child, one-month-old [REDACTED], was in critical condition. The mother, [REDACTED] brought [REDACTED] into the doctor's office on 8/10/11 for well child check-up. The doctor had a consultation with the child's mother requesting that she [REDACTED] the child into the hospital immediately, and made arrangements for child to be [REDACTED] to St. Christopher's Hospital. However the mother left the doctor's office with the child "against medical advice (AMA)." [REDACTED] (age 22) not believing anything was wrong with her child, panicked and left the hospital with the child. Dr. [REDACTED]

[REDACTED] stated that [REDACTED] was in critical condition, thus formulating a Near Fatality report. However, the child was [REDACTED] on 8/10/2011 at St. Christopher's at a weight of 5lbs. 2oz after only gaining 4 ounces since birth.

Child Medical History:

The child was born [REDACTED]. Child was initially [REDACTED] at birth. Child has [REDACTED] and is on a [REDACTED]. Dr. [REDACTED] stated that child is currently severely malnourished. Child has gained almost no weight since birth. The child's weight at birth was 4 pounds and 14 ounces. The child's weight as of 08/10/2011 was only 5 pounds. Child should have gained at least 3 lbs since birth. Child has been diagnosed as [REDACTED].

Current Case Status:

The oral date of the [REDACTED] was 8/10/2011, [REDACTED]. The child, [REDACTED] was observed on 8/10/2011 at Albert Einstein Medical Center along with, [REDACTED], child's mother [REDACTED]. The child was [REDACTED] to St. Christopher's Hospital later on that same date. The child's father encouraged her to bring the baby back to the hospital. The child weighed 5lbs. 2oz and he was diagnosed as [REDACTED] on the date he was [REDACTED] into St. Christopher's Hospital for Children. While under the hospital care, the parents were educated on proper feeding instruction.

On 08/12/2011, the baby, [REDACTED], was [REDACTED] St. Christopher's Hospital. On that same day, DHS Nurse [REDACTED] met with the family at their residence [REDACTED]. The Safety assessment was complete: Safe with Comprehensive Plan. Per the DHS [REDACTED] the safety plan calls for both aunts ([REDACTED], paternal aunt) and ([REDACTED], maternal aunt) to assist the parents with the proper caring and supervision of [REDACTED] (victim child). DHS nurse visited the family's home weekly to check on the family. The training and/or observation were completed with all caregivers identified in the Safety Plan to ensure the baby received the proper measurement and portions of formula to support a healthy weight. The child gained 2.71 kg from 8/10/11 to 08/16/11.

DHS [REDACTED] had interviewed the appropriate family household members during [REDACTED] which included [REDACTED], and [REDACTED] as well as Dr. [REDACTED], Dr. [REDACTED] as well as other appropriate hospital staff. On 08/22/2011, a [REDACTED] was completed and [REDACTED]. Per DHS [REDACTED] she did not find that the parents were negligent nor intended to harm the child. The [REDACTED] determined that the [REDACTED]. The parents were properly educated on how to prepare the baby's formula and demonstrated that they could appropriately care for and feed the child as this was witnessed by the DHS home visiting nurse prior to case closure. The case was then closed on 1/19/2012 and the safety plan lifted, as it was no longer needed. Also, a Risk Assessment was completed with the Overall Risk determined to be Moderate.

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

There was no Act 33 review Team convened due to the case being completed prior to 30 days. The [REDACTED], no services planned or provided.

Department of Public Welfare Findings:

County Strengths:

- DHS conducted a thorough [REDACTED]
- Efficient [REDACTED] methods

County Weaknesses:

- None denoted at this time.

Statutory and Regulatory Areas of Non-Compliance:

- DHS was in compliance with all Statutory and Regulatory areas within this [REDACTED]

Department of Public Welfare Recommendations:

None at this time.