



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 11/25/2011

Date of Death or Date of Incident: 5/28/12

Date of Oral Report: 5/28/12

**FAMILY KNOWN TO:
The Department of Human Services**

REPORT FINALIZED ON: 02/13/14

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.

(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. The County has convened a review team in accordance with Act 33 of 2008 related to this report June 15, 2012.

Family Constellation:

HOUSEHOLD MEMBERS:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	[REDACTED]/2011
[REDACTED]	Mother	[REDACTED]/1975
[REDACTED]	Maternal Grandmother	[REDACTED]/1954
[REDACTED]	Maternal Aunt	[REDACTED]/1976
[REDACTED]	Maternal Cousin	Adult

Notification of Child Near Fatality:

On 5/28/12 the Department of Human Services received a Child Protective Services (CPS) report that the victim child (VC) was admitted to the Children's Hospital of Philadelphia (CHOP.). The VC was severely underweight and was [REDACTED]. The victim child began to have [REDACTED] of CHOP, was not responsive and had [REDACTED]. The VC had low blood pressure and was very dehydrated. The VC was placed [REDACTED] and determined to be in serious condition based on suspected abuse or neglect.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office reviewed the medical records/case notes of the victim child, the DHS investigation records, structured case notes, Act 33 records and safety plans. The Southeast Regional Office interviewed the initial DHS SW, who previously worked on the case as well as the present social worker, the CHOP nurse, the medical examiner, the police officer assigned to the case, the attorney for DHS and attended the County's Internal Fatality Review Team Meeting held on 6/15/2012.

Summary of Services to Family:

Previous Children and Youth Involvement:

Mother has had 4 older children removed from her care and placed for adoption. The family first became known to DHS in May 2001 as a result of a [REDACTED] report. The family was referred numerous times through 2006 for [REDACTED] reports. The family was offered assistance with [REDACTED], referred to [REDACTED]. The parents had a history of homelessness and living in shelters. Numerous providers were involved with the family over the years.

[REDACTED]

Circumstances of Child Near Fatality On 5/28/12 DHS received a Child Protective Services (CPS) report that the VC was admitted to CHOP. The VC is a six month old child who presented at the ER as severely underweight and with life threatening [REDACTED]. He was diagnosed as [REDACTED]. He began to [REDACTED], became less responsive and had [REDACTED]. The VC was [REDACTED] and determined to be in serious condition.

The VC was born at the Hospital of the University of Pennsylvania (HUP) on 11/25/2011 at 36 weeks gestation. [REDACTED], although [REDACTED] reported that she was seen by OB-GYN throughout her pregnancy. A drug screen was negative. The baby showed signs of [REDACTED]. The VC remained in the hospital for five days. [REDACTED] was to follow up with [REDACTED] appointment after child's discharge. The hospital report did not show that they had any concerns with mother's ability to care for her child.

[REDACTED] reported that the child was his usual active playful self until 5/29/12 when he started slowing down, drinking milk more slowly, flopping around slowly and running out of breath. After child started making weird noises, maternal grandmother advised mother to call 911 and child was taken to CHOP [REDACTED] started [REDACTED] while he was in the [REDACTED] which was corrected [REDACTED]. The child had a [REDACTED]. The examination of the baby did not reveal that the child had any physical injuries and there was no evidence that this was intentional. A review of the medical records documented that there was lack of well child visits, mother's inability to articulate child's feeding regiment and concerns about child's overall care. Child was reported to be severely neglected.

██████████ reported that the child has seen 5 or 6 ██████████ but only one visit is recorded on 12/5/11. ██████████ was unable to articulate who she saw and cannot recall last set of immunizations. ██████████ did make one ██████████ appointment which was documented.

██████████ was a no show for a ██████████ appointment on 12/15/11. She stated that she missed the appointment because she does not have ██████████ Mother also stated that she was not aware that her child had ██████████ although this was discussed with her before ██████████ was discharged and ██████████ was given the appointment date.

The DHS social worker went to the home of ██████████ who resides with her mother, ██████████ (MG), her sister, ██████████, and her daughter, ██████████. The home was a one room efficiency apartment. There was no food in the refrigerators and there were empty cans of milk. There was no milk in the home. The DHS social worker notes revealed that the maternal grandmother and aunt were interviewed; they informed the worker that the victim child appeared ill the day before ██████████ took the child to the hospital. MG stated that she told ██████████ to take the child to the hospital but her daughter refused to go and said nothing was wrong with the victim child. The aunt reported that the child had ██████████ the day before, but did nothing to get the child to the hospital. The aunt and grandmother were concerned and told the mother to take the child to the hospital but the mother would not listen to them stating that the child was fine.

Current Case Status:

- The VC ██████████ on 7/11/2012 and was placed in foster care through ██████████ in general foster care.
- The VC is receiving ██████████. He will continue to be closely observed and get the required well baby visits and ██████████.
- The mother continues to have supervised visits at ██████████.
- The District Attorney's office had initially issued a bench warrant for ██████████ arrest however she was not residing in the home of record. The detective arrested ██████████ when she came to a visit at the agency. The district attorney's office withdrew the warrant and dropped the charges once they received documentation of mother's ██████████ and lack of understanding on how to care for her child. The detective stated that the injuries were not intentional.
- ██████████ does not have any other children under her care. The four older children ██████████. She has been attending ██████████ at ██████████ but that is not consistent.
- The child's goal is ██████████. On 6/20/2012 The Department ██████████ The medical evidence reviewed determined that the child's physical condition was placed at risk by the mother's lack of proper care. The maternal Aunt ██████████ and Maternal grandmother ██████████ were household members present in the home, and saw that the child was not properly cared for. They are identified as ██████████.

- The 5 year old child, [REDACTED], who is the cousin of the victim child, was also residing in the home. She was interviewed by the DHS intake worker [REDACTED] and had a physical examination. She is well cared for by her mother. However, due to the conditions of the home, the child was placed with her biological father until [REDACTED] could locate housing.

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

Strengths:

The CPS investigation was completed in a thorough manner.

The Department of Human Services collaborated with the medical staff at CHOP, the medical examiner's office and the Police Department to assist in determining the facts of the case and to indicate this report. The Department also made outreach to [REDACTED]

[REDACTED] provided services to the household members for [REDACTED]. The Department interviewed the other child in the home, reviewed medical records of the child and had the child seen by her physician. A safety plan was made and that child was placed with her father due to the conditions of the home.

Recommendations for Change at the Local Level:

The Act 33 review team had no concerns in this area. The family was not open prior to this report.

Recommendations for Change at the State Level:

The Act 33 review team had no concerns in this area.

Department Review of County Internal Report:

The Department has received and reviewed the county report. The report was detailed and documented the efforts of social work.

Department of Public Welfare Findings:

- **County Strengths:**
There was a thorough investigation completed by the county social worker.
- **County Weaknesses:**
There were none identified.
- **Statutory and Regulatory Areas of Non-Compliance:**
There were no areas of Non-Compliance.

Department of Public Welfare Recommendations:

The county would like to recommend that all hospitals that come in contact with mothers who don't have pre-natal care should contact the county agency for an assessment of the mother and determine if they are in need of services. DHS knew of mother's history and could have intervened by assessing the mother and baby's needs and provided services to the family.