



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Suehallah Minor

Date of Birth: 05/02/2012

Date of Death: 01/31/2015

Date of Report to ChildLine: 01/29/2015

FAMILY KNOWN:

Philadelphia Department of Human Services (DHS)

REPORT FINALIZED ON:

08/10/2015

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. Section 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on March 20, 2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Suehalla Minor	Victim Child	05/02/2012
[REDACTED]	Biological mother	[REDACTED]/1981
* [REDACTED]	Biological Father	[REDACTED]/1982
[REDACTED]	Biological Sibling	[REDACTED]/2009
[REDACTED]	Biological Sibling	[REDACTED]/2009
[REDACTED]	Paternal Aunt	Adult
* [REDACTED]	Biological Sibling	[REDACTED]/2004
* [REDACTED]	was adopted on August 23, 2011.	
* [REDACTED]	is incarcerated.	

Summary of OCYF 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. SERO reviewed the historical case record of the family. SERO staff conducted interviews with the following Philadelphia County staff: Performance Management Project Manager, the Investigative Social Worker. SERO staff also conducted interviews with the [REDACTED] Social Workers. SERO staff participated in the Act 33 meeting that occurred on March 20, 2015 in which medical professionals and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

April 3, 2007, [REDACTED] report [REDACTED]
The family became known to the Philadelphia Department of Human Services (DHS). A [REDACTED] report was received regarding [REDACTED]. The report was for medical neglect. It was reported that the mother had failed to seek medical care as the child was born with a [REDACTED] on her [REDACTED]. The investigation determined that the child had no history of well-child examinations and she had not received any immunizations. The child was examined by [REDACTED] and it was determined that she is [REDACTED]

May 5, 2009, [REDACTED] report [REDACTED].
The Philadelphia Department of Human Services (DHS) received a [REDACTED] report regarding [REDACTED]. The report alleged that [REDACTED] was hit as a form of discipline by her maternal grandmother. The investigation determined that [REDACTED] did not have any bruises or injuries.

January 13, 2010, [REDACTED] report [REDACTED].
The family was opened for services. The children were placed in foster care. The Philadelphia Department of Human Services (DHS) received a [REDACTED] report regarding [REDACTED]. [REDACTED] brought the children to DHS due to lack of housing. [REDACTED] was unable to provide adequate care for the children due to lack of housing and shelter. The findings were determined invalid as [REDACTED] sought help for her children by taking them to DHS. On November 30, 2010, [REDACTED] were reunified with their mother, [REDACTED]. The family was provided [REDACTED] services through [REDACTED].

August 13, 2010, [REDACTED] report [REDACTED].
The Philadelphia Department of Human Services (DHS) received a report regarding [REDACTED]. The report alleged that [REDACTED] was hit four times by kinship caregiver two weeks previously. It was reported that [REDACTED] had gotten a razor and shaved her eyebrows. [REDACTED] was reported to have laughed when her caregiver hit her. It was reported that this was the first time in which physical discipline had been used in the home. The investigation determined that [REDACTED] had no injuries.

March 18, 2011
[REDACTED] informed the Philadelphia Department of Human Services (DHS) that she did not feel that [REDACTED] were safe due to [REDACTED] behavior. [REDACTED] reported that she could not protect the children from [REDACTED]. It was reported that [REDACTED] broke down the door and threatened her and the children with a gun and knife. [REDACTED] requested that the children be placed with DHS. [REDACTED] on March 18, 2011 and [REDACTED] entered into DHS placement. [REDACTED] was arrested and incarcerated, he remains incarcerated. On May 13, 2011 the children were returned to [REDACTED]. The case was closed and services were discharged on May 24, 2011.

December 12, 2011 [REDACTED] report [REDACTED].
The Philadelphia Department of Human Services (DHS) received a report that [REDACTED] was not receiving proper medical care. There were concerns that she was not receiving follow up care for her [REDACTED]. It was reported that she suffered from [REDACTED] which is the cause of the [REDACTED].

December 17, 2011 Supplemental to December 12, 2011 report. [REDACTED].
The Philadelphia Department of Human Services received a supplemental report that [REDACTED] was currently hospitalized. It was reported that she had suffered a seizure and she was taken to Thomas Jefferson Hospital and transferred to Children's Hospital of Philadelphia (CHOP). The reports were [REDACTED] as [REDACTED] had been unaware of the scheduled follow-up appointment with a [REDACTED]. It was determined that [REDACTED] had been taking [REDACTED] to

her primary care physician. It was determined that the primary care physician had neglected to inform [REDACTED] of the appointment with [REDACTED]. It was further determined that [REDACTED] were receiving appropriate care and that they were not at risk of abuse or neglect.

May 4, 2012, the Philadelphia Department of Human Services closed the case for [REDACTED] as she was adopted.

Circumstances of Child Fatality and Related Case Activity:

On January 29, 2015, the Philadelphia Department of Human Services received a [REDACTED] report regarding Suehallah. It was reported that [REDACTED] found Suehallah unresponsive. The child was administered CPR and 911 was called. Suehallah was transported via ambulance to CHOP unresponsive. It was reported that she was in critical condition and that she might not survive. It was further reported that Suehallah tested positive for [REDACTED]. It was reported that [REDACTED] did not know how the child ingested the [REDACTED]. [REDACTED] brings her [REDACTED] home and takes her [REDACTED]. She would return the materials [REDACTED] on Wednesdays. She returns the [REDACTED] in a paper bag and transports them in her purse. [REDACTED]

[REDACTED] reported that she keeps the [REDACTED] in a locked box out of the way of the children. She reported that on January 28, 2015, she and the children went to the [REDACTED]. The children attended the on-site daycare while she [REDACTED], which included the [REDACTED] and she attended a life skills class and [REDACTED] and her children returned home at approximately 2:30pm. They remained at home throughout the day. [REDACTED] reported that Suehallah went to bed around 9:00pm and she woke up once crying because she had a bad dream. Then at approximately 11:30pm she touched Suehallah. [REDACTED] reported that Suehallah felt cool and she was not breathing. She took her to the paternal aunt's bedroom for assistance. The paternal aunt called 911 and administered CPR until the ambulance arrived.

[REDACTED] was unable to provide an explanation as to how Suehallah ingested the [REDACTED]. She stated that maybe Suehallah could have gotten one of her [REDACTED] and licked it or maybe she could have found a [REDACTED] pill on the floor [REDACTED] stated that she has seen pills on the floor at [REDACTED]. It was determined that the child could not have ingested the [REDACTED]. The day care is housed in the [REDACTED] however; the day care is not in the same vicinity as the [REDACTED].

The siblings of Suehallah, [REDACTED], were medically evaluated on January 29, 2015. [REDACTED] were medically cleared with no areas of concern. The safety assessment determined that the children were not safe in the home. On January 29, 2015 [REDACTED] and they were placed together in a foster home through [REDACTED]. The children were interviewed individually regarding the

incident. Both of the children reported that they know that their mother takes medication. Both of the children reported that they do not know where their mother keeps the medication.

The paternal Aunt, [REDACTED] was explored as a possible resource for the children. It was determined that she is not an available resource. [REDACTED] and her children were residing in the home of the paternal aunt at the time of the incident. [REDACTED] was interviewed regarding the incident. She reported that on January 28, 2015, [REDACTED] brought Suehallah into her bedroom and she was unresponsive. [REDACTED] reported that she performed CPR on Suehallah and called 911 and Suehallah was transported to the hospital via ambulance. She denied any substance abuse and she denied that she uses [REDACTED]. She reported that [REDACTED] keeps the [REDACTED] in a locked box out of reach of the children.

[REDACTED] reported that on January 24, 2015 [REDACTED] was given a three day supply of the [REDACTED]. The mother had been attending [REDACTED] on a consistent basis [REDACTED]. In addition, the doctors at CHOP reported that if Suehallah would have ingested the medication [REDACTED], she would have presented with symptoms earlier that day. The toxicologist reported based on the timeline of the events, it was likely that Suehallah ingested the [REDACTED] at home and not [REDACTED]. She would have been symptomatic within two to four hours of having ingested the [REDACTED].

[REDACTED] continue to remain in foster care through [REDACTED] which is why she has [REDACTED]. She receives medical treatment through Children's Hospital of Philadelphia. The children are scheduled to visit with their mother weekly at the agency. It was reported that [REDACTED] does not attend all of the visits. Currently mother is transient and she is living in a shelter. [REDACTED]

[REDACTED] the children's biological father remains incarcerated. He is currently incarcerated [REDACTED]. The [REDACTED] facilitates the visitation for [REDACTED] with their father. He is aware of the death of his daughter Suehallah. He reported that [REDACTED] is responsible for securing her [REDACTED].

On January 31, 2015, Suehallah died while at Children's Hospital for Children as a result of the [REDACTED] ingestion.

[REDACTED]

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

Strengths and Deficiencies:

1. Compliance with statutes and regulation.

- The Team felt that the Intake Social Worker did a great job investigating the case and conferencing with his chain of command. The Intake Social Worker Supervisor consulted with a behavioral health professional as to how to inform the other children of Suehallah's death.
- The Team was very concerned that Philadelphia DHS did not immediately notify the police when the [REDACTED] report was received. The police did not become aware of the case until the next day when the Medical Examiner's Office provided notification of the incident. Philadelphia DHS acknowledged the concern and provided information about measures already in place to address this issue. Philadelphia DHS will continue to examine the timeliness of police notification and provide additional employee training and changes to the information technology system as necessary. The Team was pleased that the Intake Social Work Supervisor had been in contact with the police on January 30, 2015, even though she was unaware that the police were not notified of the incident the day prior.

2. Services to Suehallah and the extended family:

- At the time of the report the family did not have an open case with DHS and was therefore not receiving any services.
- On February 3, 2015, [REDACTED] assumed case management services for the family.
- [REDACTED] remain in foster care. The mother's visitation is supervised, however she has not maintained consistent visitation. There are concerns that she may [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Recommendations for changes at the State and Local Levels

1. Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.
 - There were no recommendations
2. Monitoring and inspection of county agencies.
 - There were no recommendations

Department Review of County Internal Report:

SERO received the Philadelphia Department of Human Services Child Fatality Team Draft Report. SERO finds the county's internal reports as an accurate reflection of the Act 33 meeting.

The report content and findings is representative of what was discussed during the meeting on March 20, 2015.

Department of Human Services Findings:

- County Strengths: The County did a thorough investigation and interviewed the children using appropriate interview child friendly techniques. The County was sensitive to the needs of the children in response to the fatality of their sibling.
- County Weaknesses: The County did not submit a CY104 in a timely manner to contact the police regarding the incident.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency
There were no statutory or regulatory areas of non-compliance by the county agency.

Department of Human Services Recommendations:

- As children ingesting medication [REDACTED] has been a common theme for near fatality and fatality, there should be statewide public service announcements that discuss child safety regarding medication storage.
- The [REDACTED] should have safety checks for those clients who have children in their home.