



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF



BORN: July 24, 2009

DATE OF NEAR FATALITY INCIDENT: 11/221/2009

FAMILY KNOWN TO:

Family was not known to agency prior to this report.

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 [REDACTED] on December 30, 2008 and went into effect 180 days from that date. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected 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. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	07/24/2009
[REDACTED]	Mother	[REDACTED] 1993
[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Maternal Grandmother	[REDACTED] 1975
[REDACTED]	Paternal Aunt	[REDACTED] 1989
[REDACTED]	Paternal Uncle	[REDACTED] 1965
[REDACTED]	Paternal Grandmother	[REDACTED] 1961

Other Family:

[REDACTED]	Father's foster mother	[REDACTED]
[REDACTED]	Father's foster father	[REDACTED]
[REDACTED]	Father's foster sister	[REDACTED]
[REDACTED]	Father's foster brother	[REDACTED]
[REDACTED]	Father's foster brother	[REDACTED] 1994

[REDACTED] was removed from the home on 11/24/2009 in anticipation of [REDACTED] returning to the home.

At the time of the oral report, 11/22/2009, the living arrangement of the family members listed above was as follows:

- [REDACTED] and [REDACTED] resided at [REDACTED]
- [REDACTED] resided at; [REDACTED] resided at; [REDACTED] resided at;
- [REDACTED] resided at; [REDACTED] Street, Philadelphia, PA-Licensed with Tabor Children's Services

Notification of Fatality / Near Fatality:

12/09/2009- Received [REDACTED] Oral Report date 11/22/2009 stating that the parents of 3 month old [REDACTED] took child via ambulance to Temple hospital, because they thought child had a seizure. Child has an old [REDACTED]. Child is in stable condition at St. Christopher's Hospital.

2. Documents Reviewed and Individuals Interviewed:

For this review, the SERO reviewed the county's Investigation data, spoke with assigned DHS worker, [REDACTED] DHS worker [REDACTED] DHS Ongoing Supervisor, [REDACTED] Philadelphia Police Special Victims' Unit, Lt. [REDACTED] Children's Choice Foster Care Agency and reviewed medical records from Temple University Hospital and medical records from St. Christopher's Hospital

Case Chronology:

- 10/03/2008- [REDACTED] failed to show up for Truancy Court
- 07/24/2009- [REDACTED] was born to [REDACTED]
- 12/09/2009- [REDACTED] received naming 3 month old [REDACTED] as the Victim Child presenting 11/21/2009 to St. Christopher's Hospital for Children with an [REDACTED].
- 12/11/2009- [REDACTED] was [REDACTED] to Weisman Children's Rehabilitation Hospital in Marlton, NJ.
- 01/07/2010- [REDACTED] placed in [REDACTED] Foster Care through *Children's Choice* after leaving Weisman Children's [REDACTED] Hospital; [REDACTED] never returned to the care of her parents after being admitted to St. Christopher's Hospital for Children as a result of injuries that were the subject of the [REDACTED] report on 11/22/2009.

Previous CY involvement:

This case became known to DHS on 10/03/2008 when [REDACTED] had a truancy court date for which she was not present because of her runaway status. The judge ordered DHS to hire a private investigator to assist in locating [REDACTED] the private investigator was hired but did not have any success locating [REDACTED]. At the last court hearing, [REDACTED] mother [REDACTED] revealed, that [REDACTED] was pregnant; due to this information, the judge kept the case open. Ms. [REDACTED] stated that she desired to have the case closed as she felt [REDACTED] would not resurface because she does not want to go into placement. On 04/18/2009 Ms. [REDACTED] stated that she had spoken to [REDACTED] who stated that she was 'fine' but would not reveal where she was getting prenatal care or her whereabouts. [REDACTED] resurfaced in July prior to having her baby. On 07/24/2009, [REDACTED] delivered her baby, [REDACTED]; DHS was informed of the birth by [REDACTED] mother, [REDACTED] 07/27/2009. [REDACTED] was enrolled on 09/14/2009 in a program at Temple University to receive her GED and to be placed in a nursing program once her GED is acquired. Next court date is scheduled for 12/18/2009.

Family Support Services (FSS) referral was made 09/14/2009 and was implemented 10/23/2009 at which time [REDACTED] was allegedly still living in her mother's home; however, after receiving the [REDACTED] (11/22/2009) regarding [REDACTED] it was discovered that [REDACTED] had left her mother's home; the [REDACTED] investigation revealed that [REDACTED] had left her mother's home on or about October 1, 2009. During the course of the investigation, DHS identified the following safety threats: 3, *Caregiver(s) cannot or will not explain the injuries to a child*; 6, *Caregiver(s) cannot or will not control their behavior*; 9, *Caregiver(s) in home are not performing duties and responsibilities that assure child safety*, regarding [REDACTED] and [REDACTED]

referral was made on 12/24/2009. NET accepted the [REDACTED] referral and prepared to open on [REDACTED]. [REDACTED] could not be implemented due to [REDACTED] being placed on 12/18/2010 from the 'bar of the court' as the judge was concerned that she would "run" again due to her runaway history.

As ordered by the court, [REDACTED] was sent to a [REDACTED] CBDS-The Net for Girls, Henry House. SW was working on locating a placement for [REDACTED] as she is about [REDACTED] with her second child. [REDACTED] had a [REDACTED] assessment completed which recommended mother-baby placement. DHS is not in agreement with mother-baby placement with [REDACTED], but the judge ordered DHS to consider mother-baby with the impending child.

Circumstances of Child's Fatality or Near Fatality:

Per DHS Structured Case/Progress Notes 11/23/2009, the following is Mother, [REDACTED] account of the events leading to [REDACTED] injuries: Ms. [REDACTED] reports that on Friday, morning 11/20/2009, she was at the home of [REDACTED] foster parents located at [REDACTED]. Ms. [REDACTED] said that she was staying at this address because it was closer for her to go to school. Ms. [REDACTED] said that she left to go to school and when she came home from school, Mr. [REDACTED] said that the baby [REDACTED] could not open her left eye. Ms. [REDACTED] said that she picked the baby up and called her by her name and [REDACTED] opened her eye; Ms. [REDACTED] said that she then put [REDACTED] back in the car seat. Ms. [REDACTED] said at 5:00PM, she, Mr. [REDACTED] and [REDACTED] went to Mr. [REDACTED] biological parent's house located at [REDACTED] Philadelphia, PA; while there, [REDACTED] woke up, Ms. [REDACTED] fed her a bottle, changed her pampers and [REDACTED] went back to sleep. Ms. [REDACTED] said that they (Mr. [REDACTED] herself and [REDACTED]) stayed the night on [REDACTED]. Ms. [REDACTED] said that when she woke up Saturday morning 11/21/2009, she noticed that [REDACTED] began to shake a little bit, and then she stopped and smiled. Ms. [REDACTED] said that about 7:00PM Saturday night 11/21/2009, [REDACTED] began to shake, her eyes were distant and she was drooling down the side of her face. Ms. [REDACTED] said that she called the ambulance and the ambulance first took them to Temple University Hospital. Ms. [REDACTED] said that on the way to the hospital, [REDACTED] had [REDACTED]. Ms. [REDACTED] said that when they arrived at Temple Hospital, [REDACTED] was given a CAT scan. [REDACTED] said that during this process she noticed Mr. [REDACTED] was "not acting himself", he jumped up and began getting nervous and impatient. Ms. [REDACTED] said that all of a sudden Mr. [REDACTED] began saying that he didn't know what happened to [REDACTED] and that he did not do anything to her. Ms. [REDACTED] said that [REDACTED] was in the care of Mr. [REDACTED] all day Friday 11/20/2009, from 9:00AM until 4:00PM when Ms. [REDACTED] came home from school. Ms. [REDACTED] said that on Friday, 11/20/2009, Mr. [REDACTED] sent a text message to her cell phone asking her "when times get rough are you going to stay with me?" Ms. [REDACTED] said she responded by asking Mr. [REDACTED] what was wrong and he said "nothing", but he just wanted to know. (SW asked Ms. [REDACTED] to see message on her cell phone, but she said that she erased the message.) Ms. [REDACTED] said that she thinks Mr. [REDACTED] did something to the baby. Ms. [REDACTED] said that when Mr. [REDACTED] drinks, he tells [REDACTED] to 'shut up' when she is crying and also says that [REDACTED] is 'getting on his nerves.' Ms. [REDACTED] says that Mr. [REDACTED] gets agitated with [REDACTED] and complains that she cries a lot when she is with him but is quiet for Ms. [REDACTED]. Ms. [REDACTED] said that Mr. [REDACTED] drinks "Vodka", "Old English", "211"

and "Hurricane" and says that there have been times when Mr. [REDACTED] was watching [REDACTED] and Ms. [REDACTED] has come home from school and smelled alcohol on his breath.

Per DHS Structured Case/Progress Notes, the following is Father, [REDACTED] account of the events leading to [REDACTED] injuries: Mr. [REDACTED] reports, that during the day he watches [REDACTED] while her mother is at school from 9:00AM to 4:00PM Monday thru Friday. He says that when mother gets home from school, she has [REDACTED] from 4:00PM thru 1:00AM which is when he gets home from work (Mr. [REDACTED] works at Walgreens cleaning the store and travels to different Walgreen stores to clean). Mr. [REDACTED] says that Ms. [REDACTED] and [REDACTED] have been residing with him at [REDACTED] Philadelphia, PA. Mr. [REDACTED] stated that he noticed that [REDACTED] was getting sick, meaning she was having seizures, drooling, eyes going back in her head and he noticed a mark on her left side. Mr. [REDACTED] stated that Ms. [REDACTED] noticed the mark on [REDACTED]'s left side when she was changing her. Mr. [REDACTED] said that at 7:00PM on Friday, 11/20/2009, (while they were at his mom's house located at [REDACTED] both he and Ms. [REDACTED] called the ambulance that took [REDACTED] to Temple Hospital. Mr. [REDACTED] said from Temple, [REDACTED] was transported to St. Christopher's Hospital. Mr. [REDACTED] said that the day before which was Thursday, 11/19/2009, he and Ms. [REDACTED] took [REDACTED] to the hospital because she kept crying and was "fussy." Temple did a [REDACTED] on [REDACTED], diagnosed her with [REDACTED] [REDACTED] her and sent her home. *SW asked Mr. [REDACTED] to provide a timeline of events that occurred from Thursday, 11/19/2009 up until [REDACTED] was taken to the emergency room on 11/21/2009 for the seizures. Mr. [REDACTED] stated that on Thursday, 11/19/2009 when [REDACTED] was taken to Temple Hospital, all of them had just returned from his cousin's home about 6:30PM and at 7:00PM he and Ms. [REDACTED] noticed [REDACTED]'s left arm shaking. Mr. [REDACTED] said that he noticed the 'mark' on [REDACTED] at 12:15PM on Friday and when he asked Ms. [REDACTED] about the mark, she thought it was from Thursday when Temple Hospital put "brown stuff" on her and gave her the [REDACTED]. Mr. [REDACTED] said that Ms. [REDACTED] told him not to worry about the mark. Mr. [REDACTED] said that he and Ms. [REDACTED] were discussing the situation and they both think they know what happened to [REDACTED]. Mr. [REDACTED] says that where he resides is a foster home that he grew up in; he says residing in the home are his foster parents, other foster children as well as the foster parent's biological children who are [REDACTED]. Mr. [REDACTED] says residing in the home at [REDACTED] Street, is foster mother, [REDACTED], foster father, [REDACTED] their daughter, [REDACTED], who is [REDACTED] and her daughter, [REDACTED] who is also [REDACTED] and the foster parent's foster son, [REDACTED], [REDACTED]. Mr. [REDACTED] says that [REDACTED] is always picking up [REDACTED] (without permission) and he always has to tell [REDACTED] not to pick up the baby.

Doctor [REDACTED], the attending physician at St. Christopher's Hospital said that this incident was a Near Fatality. Dr. [REDACTED] said that since the baby has been in the hospital, the grandparents have been at the hospital. Dr. [REDACTED] says that grandmom had a timeline as to when the baby was seen prior to going to her father's house. Dr. [REDACTED] said that mom has been visiting the baby on Saturday and Sunday. Dr. [REDACTED] said that the injuries that the baby sustained to the [REDACTED] were [REDACTED] she said that it is

questionable how [REDACTED] sustained the injury to the [REDACTED] Dr. [REDACTED] said even though the injuries are serious, [REDACTED] will not die; however, she will have some delays.

Current / most recent status of case:

[REDACTED] has [REDACTED] suffered serious injury, severe pain and impairment as a result of the injuries; mother, [REDACTED] and father, [REDACTED] were [REDACTED]

- [REDACTED] remains in Medical Foster Care, her needs are being met.
- [REDACTED] was arrested for Statutory Rape of [REDACTED] and remains in custody.
- [REDACTED] was sent to a [REDACTED] NET however, because she is pregnant and due to deliver in June 2010, she has recently been transferred to a Mother/Baby program at St. Vincent's.
- To date, neither Ms. [REDACTED] nor Mr. [REDACTED] has been charged in the [REDACTED] case concerning [REDACTED]. Law enforcement continues its investigation.

[REDACTED] delivered a male child, [REDACTED] on June 15, 2010, [REDACTED] and [REDACTED] are residents at St. Vincents/[REDACTED], a mother/baby program where [REDACTED] is being supervised and monitored with [REDACTED]

Services to children and families:

[REDACTED] is receiving medical services in her foster care setting, services she receives includes:

- [REDACTED] – weekly
- [REDACTED] - 2 times per week, at home and at St. Christopher's Hospital
- Feeding evaluation 1 time per month to evaluate her swallowing
- [REDACTED] has been recommended, although there is a shortage of [REDACTED] at this time, so she receives special instruction instead.
- [REDACTED] also receives medication for: [REDACTED] [REDACTED] also has [REDACTED], which may be [REDACTED] or a result of trauma; she receives [REDACTED] as well as [REDACTED] for this condition.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

Strengths-

- DHS worker did a through job investigating this case and provided a clear and concise sequence of events.
- As a result of the DHS investigation, [REDACTED] was arrested for [REDACTED] of [REDACTED].

Deficiencies-

- As part of the Act 33 Review of [REDACTED] case, the team reviewed the case of [REDACTED] mother, [REDACTED]. The team concluded that the social work team assigned to [REDACTED] case did not follow the protocol for coverage of

cases when the assigned social worker was on medical leave and her supervisor had transferred to another unit. The case was left uncovered for two months. During this period of time, [REDACTED] was born. Services were not implemented with the family until [REDACTED] was 3 months old.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

None Identified

SERO Findings:

County Strengths- DHS did a search and found that [REDACTED] was living in the home of the [REDACTED] [REDACTED] shared with his foster parents. DHS removed [REDACTED] from the home, to ensure his safety until they could determine the status of [REDACTED] [REDACTED] living arrangements.

It should be noted that Tabor Children's Services was already in the process of finding a new foster home for [REDACTED] as the [REDACTED]'s are up in age; however, [REDACTED] had become very close with the family and did not want to leave the home. Tabor Children's Services continued to work with [REDACTED] in an effort to help him understand that a move to another home would be in his best interest and with the incident concerning [REDACTED] Tabor moved [REDACTED] and closed the [REDACTED] foster home. [REDACTED] was placed in another foster home and is doing well.

Statutory and Regulatory Compliance issues:

- A timely Safety Assessment was completed 11/22/2009 while [REDACTED] was in the hospital, hospital staff named as caregivers; the Safety Decision was, *Safe with a Comprehensive Safety Plan-* [REDACTED] was not to be [REDACTED] without DHS approval.
- Safety Assessment completed 11/23/2009, [REDACTED] remained in the hospital, mother, [REDACTED] and father, [REDACTED] named as caregivers; the Safety Decision was, *Unsafe-* [REDACTED] was to remain in hospital pending DHS investigation, then was to be released to an appropriate caregiver approved by DHS or DHS to plan for placement; mother and father will not have any visits with the child.