



**REPORT ON THE FATALITY OF:**

**BISHOP THOMAS**

**Date of Birth: 3/15/2012  
Date of Death: 7/19/2012  
Date of Oral Report: 7/19/2012**

**FAMILY KNOWN TO:**

Delaware County Children and Youth Agency

**REPORT FINALIZED ON: 04/16/2013**

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. Delaware County convened a review team in accordance with Act 33 of 2008 related to this report on August 1, 2012

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Thomas, Bishop	Victim Child	03-15-2012
[REDACTED]	Sibling	[REDACTED]-2012
[REDACTED]	Sibling	[REDACTED]-2010
[REDACTED]	Sibling	[REDACTED]-2009
[REDACTED]	Biological-mother	[REDACTED]-1989
* [REDACTED]	Biological-father [REDACTED]	[REDACTED] 1980
* [REDACTED]	Biological father [REDACTED]	[REDACTED]-1985
* [REDACTED]	Biological father [REDACTED]	Adult

\*None of the Fathers are HHMs

**Notification of Child Fatality:**

On the morning of 7-19-2012 the mother called 911 because the child was non-responsive. The mother had met the paramedics outside the home with the child swaddled in a blanket and saying "I didn't do it." She told the paramedics that the child had been cold at 5:00AM when she checked on him. Mother claims she placed a blanket on the child's legs at that time. The child was found with a temperature of 105 degrees on arrival at the Crosier Chester Hospital Emergency room at 7:45 am. Dr. [REDACTED] pronounced the child dead between 8:00 am and 9:00 am. The case was being handled by the medical examiner, [REDACTED], the pathologist, to perform the autopsy. The police determined that the mother's account was inconsistent with the medical evidence, and have labeled the death suspicious.

**Summary of DPW Child Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, [REDACTED], and the

Supervisor, [REDACTED], on 08-01-2012. The regional office also participated in the County Internal Fatality Review Team meeting on August 1, 2012. During the internal Fatality review meeting, it was revealed that a final autopsy report was pending.

**Summary of Services to Family:**

**Children and Youth Involvement prior to Incident:**

5/20/2011 [REDACTED]

The family became known to the agency with a [REDACTED] report on 5-20-2011 for neglect and homelessness issues. According to the case record, the family has had a history of unstable housing, including [REDACTED]. Ms. [REDACTED] had been in CYS [REDACTED] program, but had been terminated due to non-compliance. As a condition to [REDACTED] on 6/20/2011, [REDACTED] was required to complete a drug screen. At that time, she tested positive for cocaine. She denied using cocaine, stating she had only used marijuana. She was retested on 6/30/2011 and tested negative for all substances. The Family Service Plan of 7/7/2011 addressed the mother's need to participate in [REDACTED] at [REDACTED].

The mother has a history of not ensuring the children attend their well visits. She has also been resistant to doctor's medical advice which caused one of the twin boy's [REDACTED]. Ms. [REDACTED] had a felony charge that limited her ability to obtain employment and successfully obtain housing. Additionally, she had unaddressed [REDACTED]. She completed a [REDACTED] at Community Hospital to address her [REDACTED]. She also stated that she suffers from [REDACTED]. She demonstrated poor impulse control and poor decision making skills. The Family was accepted for on-going Services to Children in their own home (SCOH) Services effective 6-29-2011, and was still open at the time of the near fatality. The following services have been provided to the family since their involvement with Delaware County Children and Youth services on May 20<sup>th</sup>, 2011:

Services to Children in their own home (SCOH)  
 Collaboration with Medical Professionals  
 Family Support Services

[REDACTED]

Family visitation  
 Kinship Home Studies

On 1/19/2012, while Ms. [REDACTED], her older children, [REDACTED] (ages 3 and 2) were informally placed with a caregiver, pending a home study. The caregiver on 1/26/2012 reported that she could no longer care for the children and they were returned to their mother's care. On 2/5/2012, the mother

was not home when the children were dropped off by the school van. The children attend [REDACTED] Daycare Program. CYS went to the home to wait for mother. When the mother did not return by 5:30 pm, CYS took protective custody. The CYS worker went to the home later that evening to drop off letters, and found the mother at home sharing a meal with a friend. She did not disclose her whereabouts and she was informed of the action taken by the County. On 2/7/2012, the children were returned to the mother's care by the court. At this time, the mother was residing with a friend as terms of the safety plan. On 3/15/2012, the twins were born.

On 3/30/2012, CYS received a report that the family home was infested with fleas and cockroaches. Ms. [REDACTED] was living with Mrs [REDACTED]. The reporting source offered herself as a resource for the children, but would not provide information to complete the clearance process. On 4/5/2012, the mother and her four children left the home that they were sharing with Mrs. [REDACTED]. On 4/11/2012, the mother told the caseworker that CYS would never hear from her again. The mother did not send the children to day care at this time. The [REDACTED] Day Care driver contacted the CYS case worker and informed them of the situation. On 4/12/2012, CYS was granted custody of the children based on the mother's abandonment of the children's care. Only [REDACTED] was located at this time; she was placed in the care of paternal aunt. On 4/13/2012, [REDACTED] were placed in a CYS approved foster home. [REDACTED] continued in the care of paternal grandmother, pending the home study approval.

On 5/1/2012, the children were ordered moved to the home of the maternal grandmother, pending the completion of the home study, so the children could be together. On 5/3/2012, the paternal grandmother requested the removal of [REDACTED] due to the amount of work required to care for them. The twins were moved to a CYS foster home. [REDACTED] remained in her home until 5/9/2012; concerns were raised about the clearances of a household member. [REDACTED] was returned to the home of the paternal grandmother. Ms [REDACTED] can only care for her granddaughter, [REDACTED] was placed in CYS foster home (separate from his siblings). On 5/15/2012 the physical and legal custody of the children was awarded to the mother with court ordered agency supervision after the agency had determined the mother had secured stable housing. The CYS continued to provide the various SCOH services.

#### **Circumstances of Child Fatality and Related Case Activity:**

On 7-19-2012 the mother reported finding the child cold at 5:00AM when she checked on him. Mother reported she placed a blanket on the child's legs at that time. 911 was called because she found the child to be non-responsive. The mother met the paramedics outside the home with the child swaddled in a blanket and saying "I didn't do it." On arrival at 7:45 am at the Crosier Chester Hospital Emergency room, the child was found to have a temperature of 105 degrees. Dr. [REDACTED] pronounced the child dead between 8:00 am and 9:00 am. The case was being handled by the medical examiner, [REDACTED], the pathologist, who will perform the autopsy. The police determined that the mother's account was inconsistent with the medical evidence, and labeled the death suspicious.

The county agency completed a safety assessment of the surviving siblings and determined that the children were not safe based on the circumstances of the child death and the children needed to be in placement. The siblings of the deceased child were placed in the same foster home through protective custody taken on 7-19-2012. Kinship resources were being explored for the children. The biological mother had weekly visits with the siblings of the deceased child at Delaware County Children and Youth Services while they were in placement.

According to the Medical Examiner, there were no obvious signs of physical abuse. Preliminary medical results confirmed there was no infection or virus present. There were no signs of influenza A or B and the medical examiner stated that he does not believe the child's death was in any way related to a hernia operation he had three weeks prior. The Medical Examiner ordered additional slides to confirm his findings which have resulted in a delay of his report.

**Current Case status:**

The autopsy is still pending; there were no signs of physical abuse or trauma. There were no fractures to the child and the skull was intact. The child had [REDACTED], which the ME notes is common in infants. Delaware County Children and Youth have implemented SCOH Services in the family home, as the siblings of the victim child were returned to their mother on 9/12/2012 by family court judge. Ms [REDACTED] is also registered in a parent education program and she has a Family Support Worker in her home. One of the siblings is recommended to attend [REDACTED].

Ms. [REDACTED] attended the four scheduled PACT classes and received positive feedback for the month of September. The following information is from the reports of PACT: She showed no indications of alcohol or drug use. She came with her children and they were clean and neat. During the seminar on lead poisoning, Ms. [REDACTED] was very cooperative with the lead poisoning officials. [REDACTED] were tested for lead poisoning; their results were negative.

On September 14<sup>th</sup> 2012, the CY [REDACTED] as there were no signs of trauma or abuse. On 11/7/2012, the Medical examiner reported to the County that the manner of death was undetermined. The cause of death was hypothermia and sepsis. There has been no arrest as there is still no manner of death determined.

The caseworker has reported that mother continues to meet with her regularly. Mother has scheduled appointments in a timely manner and has rescheduled appointments that were canceled due to hurricane Sandy. Ms. [REDACTED] continues to use the family support worker for transportation and has also arranged her own transportation to/from various appointments. Mother completed an application packet for [REDACTED] for [REDACTED] so that his behavior issues can be evaluated.

Ms. [REDACTED] attended her [REDACTED] with the [REDACTED] [REDACTED] assessor on 11/19/12 at Children and Youth Services.

Ms. [REDACTED] participated in a [REDACTED] with [REDACTED] on October 16, 2012. His recommendation is that she continue to participate in [REDACTED] at Community Hospital to improve her coping skills and reducing/managing her anger. He also recommended that she continue participating in parenting classes.

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

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. Delaware County has convened a review team in accordance with Act 33 of 2008 related to this report. The review team met on August 1<sup>st</sup> 2012.

**Strengths:**

- The agency collaborated well with the medical and child protection team at Crosier Chester Medical Team.
- The Agency complied with all statutory and regulatory requirements during their involvement with the family.

**Deficiencies:**

- None identified

**Recommendations for Change at the Local Level:**

- During the review, there were concerns raised with the Courts' understanding of the child welfare process. The County did not believe that the courts understood how the mother's mental health status impacted on her ability to be a stable parent.

**Recommendations for Change at the State Level:**

- None

**Department Review of County Internal Report:**

There were numerous services provided to the family prior to this investigation. The Department has reviewed the county report and is in agreement with their findings.

**Department of Public Welfare Findings:****County Strengths:**

- The Agency complied with all statutory and regulatory requirements during their involvement with the family.
- They conducted weekly home visits prior to the fatality.
- Safety assessments and family service plans were competently completed at the appropriate intervals.
- The agency collaborated with all treating professionals to ensure that the children were receiving an acceptable level of care.
- The biological mother was interviewed. The County consulted with the Chester Police Department and the Medical Examiner's Office.
- Kinship resources were utilized and explored throughout the case process.

**County Weaknesses:**

- The County report was sent late to the Regional office. The report was due within 90 days of the Act 33 meeting and it was received 5 months after the county meeting, 2 months late.
- The County had difficulty communicating the mother's mental health needs to the court. The courts reviewed the Family Service Plan and saw that the mother had met the Family Service Plan goals. It was not until a mental health evaluation was completed on the mother and presented to the court that the court was able to understand the agency's concern for the mother's ability to care for her children.

**Statutory and Regulatory Areas of Non-Compliance:**

- Act 33 report was submitted late to the Regional office.

**Department of Public Welfare Recommendations:**

To ensure the children's safety, the County CYs should be able to explain to the courts the children's need to be in care until the parents have successfully completed all required evaluations. The county should also include the need for mental health evaluation on their Family Service Plans which would assist the court in evaluating the parent's progress and abilities.

County agencies should ensure that the staff receive appropriate training concerning court preparation and presenting testimony, as well as preparation of Family Service Plans.