

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823
Fax: (215) 560- 6893

REPORT ON THE Near Fatality OF:



BORN: 03/13/2011
NEAR FATALITY: 07/26/2011

FAMILY KNOWN TO:
Delaware County

REPORT FINALIZED ON:

09/19/13

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 on September 7, 2011 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	03/11/2011
[REDACTED]	Brother	[REDACTED]/2008
[REDACTED]	Brother	[REDACTED]/2010
[REDACTED]	Biological mother	[REDACTED]/1989
[REDACTED]	Biological Father	[REDACTED]/1979

Non-Household Members:

* [REDACTED] Biological father of [REDACTED]/1980

Notification of Child Near Fatality:

Delaware County Children and Youth received a referral on July 20, 2011 that [REDACTED] was brought to Chester Crozer Medical Center emergency room that morning by her mother, [REDACTED] with multiple injuries. The child had [REDACTED] Mother, who provided the information to the hospital, was very un-nerved and anxious during the interviews. Mother stated that a few days prior to this hospitalization, [REDACTED] was not breathing, non-responsive and blue. [REDACTED] began to perform CPR. The baby revived after this episode. However, mother did not seek medical attention until 48 hours later when [REDACTED] entered the ER with injuries. The mother later reported that she had shaken [REDACTED] during this incident.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted with the investigating caseworker, [REDACTED], Supervisor, [REDACTED], ongoing social worker, [REDACTED], CHOP social worker, [REDACTED] and Officer [REDACTED]. Hospital reports and medical records were reviewed as well as Risk assessment dated 9/16/2011, Safety assessments,

7/20/2011- 9/19/2011 and structured case notes. The Act 33 team review and MDT meeting recommendations are included in this report. Regional office staff attended the Act 33 Review on 9/7/2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family was known to the children and youth agency. The mother, [REDACTED], was involved with CYS as a child. The family was open and closed in intake in 1992. The family received SCOH services from 1993 to 1995.

On 5/11/2011 a [REDACTED] reported that mother was upset that the baby was not being discharged and refused to feed the baby. Mother caused a disturbance in the hospital. The physician was concerned about the mother's ability to care for the premature child and two small children with no support. Mother had limited prenatal care. [REDACTED]. The mother had been told several times that the baby was being discharged, but was not. On that particular day, the mother expressed having trouble getting someone to care for the other children. This had created stress for the mother trying to get to the hospital on a daily basis.

The county received a call the following day from [REDACTED] stating that they wanted to withdraw the report. The mother came [REDACTED] and apologized for her behavior, saying that she was upset that the child was not being discharged. The county closed the report and the family was not seen. The county determined there was no need for further assessment for services.

Circumstances of Child Near Fatality and Related Case Activity:

On July 20, 2011 Delaware County Children and Youth received a telephone call [REDACTED] concerning 4 month old [REDACTED]. On 7/20/11, [REDACTED] was taken to Chester Crozer Medical Center where she was found to have sustained numerous injuries including

[REDACTED]

[REDACTED] was transferred to CHOP [REDACTED] in serious but stable condition as a result of suspected abuse. The mother reported her son dropped the child a few times and that may have caused the injuries. The Delaware County social worker consulted with CHOP physicians, hospital social worker and nursing staff. The child's injuries are not consistent with the explanation of the child falling a few times. Mother is the primary caretaker [REDACTED] father, [REDACTED], is incarcerated. The [REDACTED]

[REDACTED], and spent almost two months in the hospital after birth. She was [REDACTED] in May 2011 with [REDACTED]. Mother was inconsistent with

follow up medical care. [REDACTED]

Mother denied this and said she was not trained [REDACTED]. The hospital confirmed that mother was trained. The investigation also revealed that mother was not visiting [REDACTED] during the initial hospitalization and there seemed to be some bonding issues. Mother was inconsistent in her information to the hospital and to the police about how the child received the injuries. The mother reported that a few days prior to the injuries, [REDACTED] had stopped breathing and the mother reported shaking her. The mother also reported that her sister had been visiting the home to care for the children. The mother suggested that [REDACTED] could have received injuries while the aunt was caring for the children, as one of the aunt's children was observed biting [REDACTED] face two to three weeks prior to this incident. The mother also stated that her three year old sibling, [REDACTED], had picked up [REDACTED] and dropped her couple of times.

On July 20, 2011, a safety assessment was completed and a safety plan was implemented. It was determined that the children would be safe with a comprehensive safety plan. [REDACTED] were medically examined and determined to be healthy and did not exhibit any signs of abuse. However, a review of medical records revealed that mother had not taken [REDACTED] for routine checkups, including immunizations. Since August 2010, mother cancelled and did not show up for 8 sick appointments and 2 well checkups that were scheduled because the child was sick. The safety plan dated 7/20/11 placed [REDACTED] with his father, and [REDACTED] was placed in foster care. Mother has bi-weekly supervised visits, and the siblings visit one another.

The investigation by [REDACTED] was referred for [REDACTED] as she appears [REDACTED] has unstable housing and was residing with a god sister. Mother admits to using marijuana and she is currently unable to provide a minimal level of care for her children. Mother was tested for drugs and tested positive for marijuana. Based on the risks and strengths of this family, the overall level of risk is high.

Current Case Status:

- The Chester Police interviewed [REDACTED] several times and her statements were inconsistent. The police were waiting for the District Attorney's office to make a determination if mother will be charged. Contact with the officer was made on 1/29/2012. The officer stated that the DA reviews three cases at a time. The DA was waiting for a third case before a review could be held and a determination of arrest would be made. As of this date, no criminal charges have been filed against the mother.
- Mother has supervised visits with [REDACTED] Mother has been referred for [REDACTED], parent education and job training.
- [REDACTED] is currently incarcerated at [REDACTED] State Correctional Institute.
- [REDACTED] 1/12/12 to a medical foster home. She still has a [REDACTED] [REDACTED] Due to her medical needs, [REDACTED] could not be placed in the foster home with her brother. The foster parents have another medically fragile child and could not take her sibling. There was

one family member explored for a placement resource. This family resource did not have adequate space.

- The Family Service Plan permanency goal is return to parents. The county will continue to explore other family members for placement and permanency goals.
- [REDACTED] plan includes follow up appointments to the following [REDACTED]:

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

Strengths:

- The county took appropriate action of developing a safety plan and removing the children.
- The agency collaborated well with medical providers and law enforcement professionals.

Deficiencies:

- None identified

Recommendations for Change at the Local Level:

- None identified

Recommendations for Change at the State Level:

- None identified

Department Review of County Internal Report:

The Department has received and reviewed the county report. The baby was born prematurely to a mother who had two young children and the hospital reported that she could not visit the baby on a regular basis due to the needs of the other two young children.

Department of Public Welfare Findings:

County Strengths:

- Collaboration with the medical team and child abuse team at Children's Hospital.
- Timely and quality safety and risk assessments and safety plan.

County Weaknesses:

- The county received a report on this mother in May 2011, but did not follow up with the family as the reporting source [REDACTED] called back and wanted to withdraw their initial report. The basic information provided (that the single mother of three children under the age of five was very stressed) warranted further assessment.

Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendations:

- [REDACTED] was born prematurely to a young mother with two other children under the age of five. When mother missed medical appointments, children and youth services should have been alerted by the medical professionals. More training should be done to help medical providers identify vulnerable children.
- In May 2011, [REDACTED] alerted the county agency that the mother was unstable and not capable of caring for [REDACTED] and her two young siblings. The mother did not have supports and during one visit at the hospital, the mother's behavior was not appropriate and she refused to feed [REDACTED]. Later the social worker called and wanted to rescind the report. The children and youth agency never saw the children. When the agency receives a report about a parent with very young vulnerable children, particularly from [REDACTED], the county agency should gather more information before screening it out. If [REDACTED] was concerned about the mother's ability to parent three young children with no supports, the county should have followed up with the mother to determine the risk and safety of the children. This practice needs to be revisited. Two months later, July 2011, the child was admitted to the hospital as a near death report.
- There should be a DA assigned at the beginning of the investigation and should be working with the team as well as the detective assigned. It is concerning that the DA has to wait for three cases to be reviewed together before a decision of arrest is made.