



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 03/28/09
Near Fatality Incident occurred 6/14/2009

FAMILY WAS NOT KNOWN TO ANY COUNTY AGENCY

REPORT DATED: 12/15/09
REPORT FINALIZED: 02/16/10

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 by Governor Rendell 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.

Family/Household Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	victim child	03/28/09
[REDACTED]	sibling	[REDACTED] 2008
[REDACTED]	mother	[REDACTED] 1973
[REDACTED]	father	[REDACTED] 1975

Notification of Fatality / Near Fatality:

On 6/14/2009 two month old [REDACTED] was transported to St. Christopher's Hospital; [REDACTED] reported that injuries are unexplained. [REDACTED] was in the care of his mother. The mother reported that after feeding [REDACTED], his eyes rolled back in his head. It appeared to her as though he was having a seizure. [REDACTED] Upon arrival, this child was certified as near fatality; certifying physician was Dr. [REDACTED]. However, this information was not given to [REDACTED] and SERO until 7/21/2009.

Documents Reviewed and Individuals Interviewed:

For this review the SERO reviewed the Philadelphia's Department of Human Services (DHS) complete county case file and information from the special victim's unit interviews.

SERO interviewed the DHS intake worker, [REDACTED], and ongoing DHS social worker, [REDACTED]. The SERO also attended the County's Internal Fatality Review Meeting regarding this case on 7/02/09.

Previous CY involvement:

4/26/2009 [REDACTED] 5/29/2009 [REDACTED]
On 4/26/2009, the mother brought [REDACTED] to Albert Einstein Medical Center. She reported that while she was feeding [REDACTED], her 13 month old son had jumped on the bed and jumped on [REDACTED]. Victim child was transferred to St. Christopher's Hospital for Children. He had sustained a fracture of his right forearm, which required a cast. [REDACTED] [REDACTED] were completed. [REDACTED] did not believe that a 13-month old possessed the force to cause an infant to suffer such a fracture. Mother was [REDACTED].

Circumstances of Child's Fatality or Near Fatality:

Case Chronology:

Original [REDACTED] of 4/26/2009:

On 4/26/2009 a [REDACTED] report was called into DHS stating the child was transferred from Albert Einstein Medical Center ("AEMC") to St. Christopher's Hospital for Children. [REDACTED]

[REDACTED] had [REDACTED] completed, which were normal. [REDACTED] Mother stated that she was breast feeding [REDACTED] when the 13-month-old sibling jumped on the bed and jumped on [REDACTED]. It was reported that there were concerns that a 13-month-old did not possess the force to cause an infant to suffer such a fracture.

On 4/26/2009, the DHS worker interviewed the father at the hospital; he had been at work when the injuries occurred. There is an indication that the family speaks limited English and no interpreter was present. He reported to the social worker what the mother had reported to him. The DHS worker conducted a home visit on 4-26-2009; she met with the mother and observed 13 month old [REDACTED]. After completing the Safety Assessment, she determined that [REDACTED] was safe. There was some difficulty interviewing the mother as she spoke only Hindi and Gujarati. DHS did employ interpreter services for this interview. The mother was consistent with her report to the DHS worker that [REDACTED] had fallen on [REDACTED] while she was feeding him.

The initial Safety Plan of 5/18/09 stated that [REDACTED] was to remain in the hospital during the investigation. However, [REDACTED] was discharged without any written change to the Plan, and was subsequently [REDACTED] by the mother (the subsequent report). During the Act 33 Review, the social worker disclosed that she "gave permission for the child to go home." The exact date of [REDACTED]'s discharge from CHOP was unclear from the DHS files.

[REDACTED] sibling, [REDACTED], did not have any type of medical evaluation during this investigation. The DHS worker obtained the name of the children's pediatrician, but did not request any medical records.

[REDACTED] was taken to St. Christopher's on 5/18/09 for a follow up [REDACTED]

[REDACTED] she had never met the mother or the 1 year old sibling. She further stated that the explanation for the cause of the injury is not consistent with the actual injuries. The Act 33 Review revealed an obvious communication problem between DHS and the hospital.

The case was [REDACTED] 5/29/2009. There are no notes in the DHS case record from 4/27/09 through 5/19/09. The DHS worker conducted a home visit on 5/19/09. On this date she met with the parents to discuss follow up appointments and services to be implemented; she also observed [REDACTED] and his sibling to be safe. An interpreter was not

used during this home visit, even though the DHS worker had identified at the initial contact that there "may be a slight language barrier."

On 5/20/09 a call came into the hotline alerting DHS to the fact that [REDACTED] had come in for a follow up [REDACTED] on 5/18/2009 and he was discovered to have [REDACTED]

[REDACTED] to the DHS intake worker to alert her to the findings of the [REDACTED] and to find out what "DHS was going to do with the family." The DHS intake worker let [REDACTED] know that the family would be receiving In Home Protective Services (IHPS) once the case was forwarded to ongoing services. Case was discussed with the Special Victims Unit (SVU); both DHS and SVU felt that the parents were credible and the injury was an accident. SVU was not going to pursue criminal charges. The DHS social worker was initially going to make the determination of [REDACTED] as she believed the injuries were accidental. After the Social Worker Administrator (SWA) reviewed the case file, she determined that that the case should be [REDACTED] based on the medical documentation that the mother's explanation for the injuries was not consistent with the injuries.

It should be noted, there was a delay in the implementation of In Home Protective Services, (IHPS). According to the social worker, a referral for IHPS was made on 5/19/09 however services were not implemented until 6/10/09. On 6/14/09 another report was called in to the hotline based on the [REDACTED] and the "near fatality" classification.

Subsequent [REDACTED] of 6/14/09:

On 6/14/09 the child was transported to St. Christopher's after a call to 911. [REDACTED] The injuries were unexplained. Child had been in the care of his mother who alleged that after feeding the child, his eyes rolled into the back of his head and it appeared as though child was having a seizure. At the time of the report, it was unknown if the child was certified to be in serous or critical condition. [REDACTED]

DHS interviewed the father who reported that his wife had called him at work to report that [REDACTED] had a seizure. The father immediately left work; when he returned to the home, he called 911. At the hospital, DHS interviewed the mother with the assistance of relatives translating; the mother reported that she was breastfeeding [REDACTED] and he became unconscious.

As of 6/18/09 both children have been placed in foster care through Friendship house. Detective [REDACTED] of Philadelphia's SVU is investigating the case. This [REDACTED] investigation was [REDACTED] and reviewed by the county.

On 7/14/09 SERO communicated to [REDACTED] that the [REDACTED] was certified as a "near fatality", and was advised to have the county contact [REDACTED] to confirm the certification. The SERO received notice through [REDACTED] of the "near fatality" on 7-21-09.

The case was actively involved receiving IHPS by Carson Valley Children's Aid at the time of the subsequent [REDACTED] (6-14-09) report was made.

Current / most recent status of case:

[REDACTED] of 6/15/2009 was [REDACTED] 6/17/2009 based on medical evidence. [REDACTED]

As noted above, there were two [REDACTED] investigations. During the Act 33 review, some discrepancies were noted regarding the determination of the initial (4/26/09) [REDACTED] which was originally documented as "[REDACTED]" and then changed to "[REDACTED]" by the administrator.

According to case correspondence dated 6/17/09, the case was determined to be [REDACTED] based on medical evidence and information gathered during the investigation. Unfortunately, there was a typographical error in the actual input of the determination. After further discussion with the SWA, the report was [REDACTED] DHS changed the CY48 to reflect the [REDACTED] status; however, the other information remained the same. [REDACTED], the investigating social worker, was advised to make the changes in the progress notes to reflect the [REDACTED] status. The letters were also changed to [REDACTED] in the record. DHS contacted [REDACTED], [REDACTED], [REDACTED] DHS needed to complete the appropriate data entry tasks in order to change the determination in FACTS (the DHS information management system) from [REDACTED]

[REDACTED] was receiving [REDACTED] every Thursday. Both children are receiving regular medical care, immunizations and [REDACTED]. They will be reassessed every 3 months until their 3rd birthday, according to the schedule for Academy of Pediatricians.

On 8/13/09, mother was arrested for the injuries to [REDACTED]. On 8/27/09, the children had a visit with their mother at the prison, supervised by the foster mother. The parent's attorney is requesting an early re-listing for the criminal charges related to this case.

The father had a [REDACTED] conducted at the Achieving Reunification Center (ARC) and is enrolled in parenting classes. The DHS worker has initiated the Interstate Compact for the Placement of Children (ICPC) process for a home evaluation of family in New Jersey to plan concurrently. The foster mother and DHS worker report concerns regarding the reunification of the family, specifically around the father's ability to protect the children from mother.

Services to children and families:

- In Home Protective Services referral was made 5/19/09.
- As of 6/18/09 both children have been placed in foster care through Friendship house.

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

Strengths-

- The Multi-Disciplinary Team (MDT) and the hotline social worker did an outstanding job [REDACTED] this report. They were able to assess the reported injuries and circumstances accurately and expediently secure the safety of both children.
- Recent case information demonstrates the search for kin relatives as resources.

Deficiencies-

- St. Christopher's Hospital never clearly stated whether [REDACTED]'s injuries in the first report were caused by [REDACTED]. Dr. [REDACTED] insisted the injury was suspicious, but didn't state that the injuries were caused by [REDACTED]. Since it was unclear whether the injuries were caused by [REDACTED], DHS had a difficult time determining the current disposition for this case.
- There were serious discrepancies in the paperwork. Initially, the social worker and the supervisor were going to [REDACTED] the report, but later were instructed by the Administrator to [REDACTED] the report. The documentation in the file had some paperwork which stated the report was [REDACTED] while other documentation stated the report was [REDACTED]. In addition, FACTS (the DHS information management system) listed the case as [REDACTED].
- The case file was not reviewed by the assigned DHS administrator before being transferred for ongoing services as outlined in DHS policy. If this step had occurred, the administrator could have identified the above omissions and discrepancies in the case record.
- The family in this case did not speak fluent English and often needed an interpreter of some sort to translate. Although some workers used outside agencies to translate, some did not. There was no clear and consistent use of interpreter services.
- The case file was missing documentation for the time period of 4/27/09 through 5/19/09. When the issue of coverage (or lack there of) was discussed during the Act 33 review meeting—there was no justification provided. DHS administration commented on disciplinary actions resulting from the disregard. The cover letter for the Act 33 Review identified "failed performance throughout the chain of command"

Services to [REDACTED] and his family:

- The team felt that there were serious lacks in coverage and attention to the case during the first investigation by the DHS intake social worker, which resulted in the victim child returning home while the parents were still being investigated. In addition, the child went home while the safety plan was still in effect that stated that [REDACTED] was to remain in the hospital. At the Act 33 Review Team meeting, St. Christopher's Hospital Social Worker [REDACTED] stated that the intake social worker gave verbal permission for the child to go home. This was not documented in the DHS record. This lack in coverage also resulted in a complete lack of case documentation from April 27, 2009 to May 19, 2009.
- During the first reported injury, there was a lack of communication between DHS and St. Christopher's Hospital that resulted in instances of incorrect information being disseminated throughout the investigation. There were several discrepancies that could have been clarified with better communication between the two entities. There was never a documented conversation between DHS and the attending physician, only between DHS and the hospital social worker.

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

- The team made the recommendation that all fatality and near fatality cases should be reviewed by the director of the division before being transferred to another division.
- The team made the recommendation that in cases in which children are hospitalized with injuries resulting from suspected abuse, a consult should be done between the DHS nurses and the hospital medical team to assist the DHS team in understanding the medical issues in the case.

SERO Findings:

County Strengths-

- DHS made immediate contact with the child and family upon receipt of the report.

Deficiencies-

- DHS did not employ an interpreter during its contacts with the family. They noted a language barrier with the father who spoke English. The mother spoke no English and the DHS worker did not utilize the language line during each contact with the mother, relying on the father or other relatives to translate.
- There were serious lacks in coverage and attention to the case during the initial (4/26/09) [REDACTED] report which resulted in the victim child returning home while the parents were still being investigated. [REDACTED] was discharged home to his parents with no services in place, in violation of the safety plan which stated that [REDACTED] was to remain in the hospital. The lack of coverage/oversight in this case from the time period of 4/27/09 through 5/19/09 resulted in a lack of case documentation for that period. When the issue of coverage (or lack there of) was discussed

during the Act 33 review meeting---there was no justification provided. DHS administration commented on disciplinary actions resulting from the disregard.

- DHS record did not contain a Safety Plan that addressed the child's discharge from the hospital, in violation of the Safety Assessment Interval Policy.
- There was a delay in the implementation of In Home Protective Services. According to the social worker, a referral for IHPS was made on 5/19/09 however services were not implemented until 6/10/09.

Statutory and Regulatory Compliance issues:

The following LIS's will result from this case:

- Lack of supervisory review at 10 day intervals during investigation. There were progress notes in the case file dated: 4/26/09, 4/27/09, 5/19/09, 5/20/09, 5/28/09, 6/09/09, 6/10/09, 6/11/09, 6/14/09, 6/15/09, and 6/16/09.
 - **3490.61 (a) 3490.61.** Supervisory review and child contacts. (a) The county agency supervisor shall review each report of suspected child abuse which is under investigation on a regular and ongoing basis to ensure that the level of services are consistent with the level of risk to the child, to determine the safety of the child and the progress made toward reaching a status determination. The supervisor shall maintain a log of these reviews which at a minimum shall include an entry at 10-calendar day intervals during the investigation period.
- The case record did not contain a safety assessment upon discharge from the hospital--according to [REDACTED]; the child was discharged on 5/28/09. The case record contained safety plans for: 4/27/09; 4/26/09, 4/27/09, 6/14/09; according to the DHS safety policy an assessment and plan (if applicable) must be revised when circumstances change-the child being release from the hospital served as a change in circumstances.
 - **3130.31** Responsibilities of the county agency. (2) Intake to services, including the following: (ii) the direct investigation and assessment, by county agency staff, of complaints, requests and referrals for services to determine their appropriateness for the following: (A) Child protective services.