



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 06/19/2007
DATE OF INCIDENT: 03/18/2009

FAMILY KNOWN TO:
Philadelphia Department of Human Services

DATE OF REPORT: 04/03/2009
REPORT FINALIZED: 02/05/2010

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 July 3, 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 fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Circumstances of Near Fatality

The mother was in the [REDACTED] and had been using her sister as the day care provider. The maternal aunt obtained employment and could no longer provide day care. The mother asked her paramour who resided with the maternal grandmother to watch her children while she went to the program. If she did not attend the program, she risked losing her [REDACTED]. The mother received a phone call at work from her paramour, the perpetrator, requesting that she come home immediately. The mother discovered that the boys were burned and called 911 for an ambulance. [REDACTED] presented with second degree burns to his buttocks, backs of his legs, back of calf, but not on the back of his knees, and bruising to his chest from below his nipple to below the ribs. His twin, [REDACTED], presented with bruising to the left side of his eye, his left leg, right foot and right ankle. He had first degree burns to his groin area and a little burn to his buttocks. His burns looked more like splash burns than [REDACTED] did. The doctor provided a likely explanation of the injuries. She conjectured that one child was put in the tub. As the second child was put in the tub, the first child was screaming. Both children were then removed. [REDACTED] was hospitalized from 03/18/2009 to 04/17/2009. [REDACTED] was hospitalized a few days less. Both children were placed in medical foster care. The mother's paramour was [REDACTED]. He has turned himself into the Philadelphia police and is currently incarcerated, pending trial.

Summary of Review.

1. Family Constellation.

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED] ***	Victim Child	06/19/2007
[REDACTED] ***	Mother	[REDACTED] 1984
[REDACTED] ***	Brother	[REDACTED] 2007
[REDACTED] *	Brother	[REDACTED] 2005
[REDACTED] *	Brother	[REDACTED] 2003
[REDACTED] **	Brother	[REDACTED] 2000
[REDACTED]	Father of [REDACTED]	[REDACTED] 1987
[REDACTED]	Father of [REDACTED]	[REDACTED] 1983
[REDACTED]	Father of [REDACTED]	[REDACTED] 1986
[REDACTED]	Maternal grandmother	[REDACTED] 1961
[REDACTED]	Father of [REDACTED] (Deceased)	

*placed together in Tabor foster home

**Resides with his paternal grandmother

***Placed in medical foster home with Children's Choice

2. Documents Reviewed and Individuals Interviewed.

For this review, the Southeast Regional Office (SERO) reviewed the family's files from Tabor Children's Services, and the complete six-year Philadelphia Department of Human Services (DHS) case file provided by the county. The DHS case file included the Integrated Intake Assessment and Mid-Point Meeting for Tabor's Family Preservation Services.

SERO interviewed the family's social worker from Tabor Children's Services, and the doctor from St. Christopher's Hospital. Representatives from SERO attended DHS's Act 33 Review on 04/17/2009.

Case Chronology.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Allegations were that [REDACTED] have severe [REDACTED]. Three of the children have [REDACTED] and some have hair loss because of the [REDACTED]. [REDACTED] has [REDACTED]. All of the children were dirty. Mother stated the children have had [REDACTED] for several months. All victim children are five years of age and under. The mother reported having little support in the home. The maternal grandmother is disabled. The fathers of children are not involved. The mother had come to the ER with her paramour who she states does not live with her. Mother reported that that she needs DHS assistance; she reported being overwhelmed with the care of four children under five years of age. The mother was given several prescriptions for [REDACTED].

The family was referred and accepted for Family Preservation on 01/23/2009. The family's goals were to stabilize housing, locate appropriate day care, monitor children's wellbeing, address [REDACTED] truancy, and evaluate mother's [REDACTED]. The mother had an intake on 02/09/2009, but did not keep the follow up appointment on 04/01/2009 at Community Council. The mother missed the follow up appointment due to her enrollment in the [REDACTED]. At the mid-point meeting on 03/17/2009, [REDACTED] was reported to be a satisfactory student in kindergarten, but had 12 unexcused absences and 11 lateness's (the school district considers 5 lateness's as truant).

03/18/2009

The reporting source states that [REDACTED] were severely burned. The reporting source states that [REDACTED] has bruising to his face, chest and back. [REDACTED] also has 2nd and 3rd degree burns from the waist down to the bottom of his feet, front and back. [REDACTED] has 2nd and 3rd degree burns to lower extremities and bruising to his face. The reporting source states that [REDACTED] is burned the worst, and that they both may be transferred to St. Christopher Burn Center within the next two hours.

The mother stated when she arrived and went upstairs she found the boys (twins) wrapped up in covers. The mother noticed that the boys were burnt. The mother asked [REDACTED] what happened; he stated that he was giving the boys a bath and the phone rang so he went to answer it. He stated that when he went back upstairs the 3 year old must have turned the hot water on the other boys. The mother stated that the 3 year old and the 5 year old are with her mother, [REDACTED] where [REDACTED] lives. [REDACTED]. The incident happen at the mother's home on [REDACTED].

[REDACTED] When the paramedic reached the [REDACTED] home on 03/18/2009, [REDACTED] was not at the home. He arrived shortly afterward. Initially, mother could not answer any questions. She later stated that the 3 year old sibling turned the water on and burned the twins. Mother said she was at work at the time. Mother finally stated that the knob was broken and no hot water could get out. Reporting source stated that it looked like the twins were dipped in hot water. Mother told reporting source that [REDACTED] was supposed to be watching the children. [REDACTED] wanted to transport the twins in the car (to the hospital), but mother refused. Mother did not appear upset. The children were being comforted by maternal grandmother and maternal aunt.

[REDACTED] with additional information regarding the injuries to both children from mother. Allegedly mother informed [REDACTED] that [REDACTED] gave victim children a bath while caring for them in her absence. [REDACTED] allegedly left children in the tub while he went to get something out of the microwave. When [REDACTED] returned the children were screaming. The police were called. Police allegedly informed mother that the hot water thermostat was broken. According to mother both children received 1st and 2nd degree burns. [REDACTED] is burned from the waist down. [REDACTED] has burns on his legs as well as a bruise to his head. Reporter suspects that the bruise on [REDACTED] head was a result of him trying to get out of the tub. [REDACTED] also suffered a [REDACTED] while at the hospital. It is unknown if the [REDACTED] was a result of the injury to his head. Reporter believes the children received [REDACTED] but is not certain. [REDACTED] remain at St. Christopher's Hospital. Their condition is unknown. Reporter is concerned that the thermostat has not been repaired and fears that the other children are currently residing with a family friend named [REDACTED]. Address and first name of [REDACTED] was unknown. [REDACTED]

The mother remained at the hospital with the twins. The two other children were initially left in the home of the maternal grandmother. This home was determined to be unsafe due to exposed wiring, no heat, pest infestation, and debris. The mother's

paramour [REDACTED] was also living in that home. The paternal grandmother of the oldest child agreed to temporarily care for [REDACTED], but could not commit to caring for both of them permanently. The three older children were taken to St. Christopher's Hospital for medical evaluation. All three children were again diagnosed with [REDACTED]. [REDACTED] were given oral medications for the [REDACTED]. [REDACTED] had [REDACTED] on his upper chest above the nipple; he was given a cream medication. [REDACTED] also had a burn on his left arm. The mother and [REDACTED] reported that the burn was caused by a lamp; he was seen at Children's Hospital of Philadelphia for this. [REDACTED] and [REDACTED] were placed in foster care in order to keep them together.

In-Home Services

At the time of the November 2008 referral, DHS made a home visit to the mother's home. The conditions were not acceptable. The home was overcrowded, lacked gas service, was infested with roaches, and was littered with pet feces. Safety Assessment completed 11/25/2008 determined that the children were Safe with a Plan. The Plan stated that the maternal grandmother and homeowner would provide supervision and care of the children until the heating system was repaired in the mother's home, and would notify DHS if the mother left the home. The children were not to be removed from the home and moved back to the maternal grandmother's home until the heating system was repaired.

On 12/02/2008, DHS received a phone call from [REDACTED] that [REDACTED] had made an allegation that the mother's paramour, [REDACTED]. The Safety Assessment completed 12/09/2009 determined that the Safety Plan of 11/25/2008 should continue as the mother had left [REDACTED] with an inappropriate caregiver. The family was referred for Family Preservation 12/15/2008. The family was accepted for services 12/22/2008.

Family Preservation Services through Tabor Services began 01/23/2009. The Family Service Plan completed 01/22/2009 with the mother and DHS worker identified the following objectives: children left only with responsible caretakers, mother participate in [REDACTED], suitable housing, regular nutritious meals, children clean and properly clothed, [REDACTED] attend school, mother cooperate with school evaluations, and children receive appropriate medical care. The mother was offered day care services for the children on several occasions, but declined these services even though she was eligible.

During the Mid-Point meeting for Family Preservation, the mother admitted to being overwhelmed with the care of her four children. She had been unable to keep one appointment for [REDACTED] due to her [REDACTED]; another appointment was scheduled for her. The children had physical examinations on 11/25/2008 and 12/09/2008. They were found to be [REDACTED]. [REDACTED] had Child Link evaluations on 12/17/2008. It was determined that they were currently displaying skills similar to children of their age, but they were eligible for referral for tracking services because of their [REDACTED]. [REDACTED] was evaluated by the Tabor worker using the Ages and Stages evaluation. He passed all areas, so a Child Link referral was not needed. The short term objectives that were identified to be completed before termination of Family Preservation: more structured

day care for the children, [REDACTED] for mother, and stable housing. The mother had located alternate housing; the Tabor worker had been planning to evaluate the home [REDACTED].

Findings and Recommendations.

County Recommendations:

- 1) During this investigation, two separate teams were completing Safety Assessments on this family. The Assessments were sometimes in conflict with one another. DHS recommended that an administrator at DHS have the responsibility to monitor the Safety Assessments when two work teams are completing assessments during the time period.
- 2) Supervisors should be required to look at the total number of Safety Assessments performed during a time period to determine if the level of risk has changed placing the children at jeopardy.
[REDACTED] Quality Improvement process should review a sample of cases from the Multi-Disciplinary Team (MDT) unit and compare these to those performed by the ongoing worker. [REDACTED]
- [REDACTED] DHS should develop a system of reviewing cases that have a pattern of referrals related to housing, nutrition, and lack of care by parents [REDACTED]
- 5) When completing home assessments, DHS workers should be aware to check water temperature. DHS should begin discussion with the Health Department to explore a relationship between DHS and the Healthy Homes program. DHS should also consider the possibility of the donation of water temperature safety ducks that could be distributed to families.
- 6) DHS should develop a policy that addresses the securing of background checks of household members and parents.
- 7) DHS workers need guidelines on when it is appropriate to refer a parent for a [REDACTED]. The social work staff need more information about the full array of [REDACTED] available in the community, and how to access them.

SERO Recommendations:

- 1) DHS should secure clearances on adults who are involved in significant relationships with the caretakers. In this case, [REDACTED] had an outstanding warrant and would probably not have cooperated with the request for this information. This behavior in itself would have created a red flag. DHS should develop policies and procedures to address clearances for alternate caregivers, household members, and significant adults in the parents' lives, such as paramours, friends, and family members who would be spending time around the children. When DHS was made aware of the alleged perpetrator's involvement with the family, he was invited to participate in the planning process for the children. DHS further advised both him and the mother that he should not drive the children with him when he was delivering pizza in the evenings. Furthermore, it was noted in a police record that there was [REDACTED] living

in the home. Neither DHS nor Tabor, the provider agency, knew anything about her. As it was not current DHS policy, DHS had not performed a criminal background check when they were made aware of [REDACTED] involvement nor of the other household member's existence.

- 2) DHS and provider social workers assess home safety on a regular basis. The facts of this case point to the need for the social workers to check environmental factors (i.e. temperature of water), including when families are in temporary housing arrangements. After [REDACTED] were injured, Detective [REDACTED] checked the hot water heater in the family home. The water temperature registered at 150 degrees. This is in violation of the City of Philadelphia's Property Maintenance Code (PM 405.3.2) which requires that water shall not exceed 125 degrees. There was evidence presented that the family knew that the hot water came out very hot. In fact, mother had previously stated that she would do the bathing of the children. Perhaps, DHS could collaborate with the city's department of Licensing and Inspections to create a tool for workers to assess environmental conditions in the home.
- 3) The mother had [REDACTED]; her situation probably contributed to [REDACTED]. Case notes indicate that the mother had described [REDACTED] since the birth of her first child in 2000. The representative from [REDACTED] at the ACT 33 Review indicated that the mother would have been a good candidate for [REDACTED]. Not all DHS staff were aware that these types of services were available. DHS needs to collaborate with other systems to ensure that their staff are made aware of potential community resources for their families.
- 4) This woman has four children under the age of five, and was obviously overwhelmed. While it is a very personal and private topic, perhaps the issue of family planning could have been discussed. Social workers are involved in very intimate aspects of family lives that impact on child wellbeing; this topic should not be a taboo. A sensitive social worker could at least have helped this mother get some medical information to give her some power to choose.