



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**Milton Galarza-Rojas**

**Date of Birth: October 7, 2010**

**Date of Death: July 26, 2011**

**FAMILY KNOWN TO:**

**The family was not previously known to the agency.**

**REPORT FINALIZED ON: 01/25/2012**

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. Philadelphia County (Department of Human Services) has convened a review team in accordance with Act 33 of 2008 related to this report on 8/19/2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Milton Galarza-Rojas	victim child	10/7/10
[REDACTED]	sister	[REDACTED] 08
[REDACTED]	mother	[REDACTED] 89
[REDACTED]	MGM	[REDACTED] /62
[REDACTED]	MGF	[REDACTED] /62
[REDACTED]	MUN	[REDACTED] 97
[REDACTED]	MUN	[REDACTED] /00

***Other family members living outside the home:***

[REDACTED]	father	[REDACTED] 84
[REDACTED]	MCO/caretaker/AP	[REDACTED] /84
[REDACTED]	caretaker/AP	[REDACTED] 88
[REDACTED]	MUN	Adult
[REDACTED]	MUN	Adult

**Notification of Child Fatality:**

On 7/26/11, the Department of Human Services (DHS) received a [REDACTED] report alleging that 10 month old Milton Galarza-Rojas had died of [REDACTED]. He was pronounced dead at 3:04 am at St. Christopher's Hospital by Dr. [REDACTED]. The report was upgraded to a [REDACTED] when additional information was received that the child had multiple old and new bruises and cigarette burns on his body. He also tested [REDACTED] in his system as per Dr. [REDACTED] of the Philadelphia Medical Examiner's Office. At the time of his death, Milton was in

the care of his maternal cousin, [REDACTED], and her paramour, [REDACTED]. The child died in their home. When his body was examined at the hospital, it was discovered that there were several needle marks on his wrists, legs and feet area. However, it was noted by the medical examiner that the child did not have any physical bruises or burns on his body, as previously reported.

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

For this review the Southeast Regional Office (SERO) reviewed St. Christopher's Hospital report and medical records for the victim child, as well as the autopsy and investigation report from the Philadelphia Medical Examiner's office. SERO also reviewed the DHS [REDACTED]/assessment, structured case notes, risk and safety assessments and plans, the FSP, court orders and PCP records. Interviews were completed with the [REDACTED] DHS Social Worker and Supervisor, as well as the On-going Social Worker and Supervisor. SERO attended the DHS Act 33 Review Team meeting for this case on 8/19/11 and has included their recommendations in this report.

#### **Summary of Services to Family:**

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

The family has no prior history with the agency.

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

On 7/26/11 at 6am, the [REDACTED] report was received by Philadelphia DHS. At 10am it was upgraded to [REDACTED] due to the new information. A [REDACTED] report was then generated for the two children of the alleged [REDACTED]. The social worker from DHS contacted the reporting sources from [REDACTED].

On 7/26/11, DHS social worker visited the home at [REDACTED] to meet and assess the safety of the alleged [REDACTED] two children, [REDACTED], age 8, and [REDACTED] age 5. DHS conducted an interview with the children about the incident involving Milton's death. The children were in the home of their father [REDACTED] and his relatives. They came to stay with their father as a result of the report concerning Milton's death. The children were deemed safe in their father's care.

On 7/26/11, arrangements were made to have a Spanish speaking interpreter present for interviews with Milton's mother and the alleged perpetrators the following day.

On 7/27/11, DHS social worker visited the home at [REDACTED] to conduct a safety assessment for [REDACTED] and the other children in the home and to interview

the mother about the [REDACTED] allegations. The Spanish interpreter was present. The mother reported that Milton was only temporarily staying with her cousin and her paramour since her home was in disrepair. He was only there for the last two days. Milton's father was currently incarcerated. She reported that Milton was born with breathing problems and that she did not think her cousin would abuse Milton. She knew nothing about the other reported injuries and was only told of his death afterwards by the police. The social worker observed that there was little food in the home, no smoke detectors or fire extinguishers, the basement was flooding, the home was in deplorable conditions and there appeared to be other family members temporarily staying in the home, but otherwise the children were deemed to be safe.

On 7/27/11 the social worker visited the home at [REDACTED] to interview the alleged perpetrators regarding the allegations surrounding Milton's death. The Spanish translator was present as well. Both denied harming Milton. They reported they did not see any injuries on the child and that the bruises on his back could have come from attempting [REDACTED] when he was unresponsive. They were aware he suffered respiratory problems and reported that the mother did not give them any medicine when she brought him to her home two days prior. They put the child to bed around 10pm and when they checked on him at 1:30am he was not breathing. 911 were called. Ms. [REDACTED] denied any drug use, however, was aware that Mr [REDACTED] used marijuana. [REDACTED] admitted to marijuana use.

On 7/27/11 the ME office reports there were no physical bruises or burns on the child.

On 7/28/11 the social worker spoke with Dr [REDACTED] regarding the preliminary autopsy results which indicated the child died of [REDACTED] [REDACTED] which led to his respiratory failure. Manner of death is still to be determined.

On 8/1/11 the alleged [REDACTED] are again interviewed at 1515 Arch St. due to the new information. They continue to deny any wrongdoing.

On 8/4/11, the social worker contacted Kiddie Care day care concerning [REDACTED]. There were no concerns regarding her care.

On 8/4/11, the social worker contacted St. Christopher's Hospital regarding clarification on Milton's treatment at the hospital and his past medical experiences regarding the needle marks found on his body. It was undetermined whether he [REDACTED]

On 8/5/11 the social worker contacted Esperanza Center (PCP) to inquire about the children's medical records and care. The child was [REDACTED] several times in the last few months; however, no [REDACTED] were used in the areas where needle

marks were found on his body. Also, the mother has not been consistent with the children's routine and follow up care.

On 8/9/11 another home visit to the mother's home was conducted to assess safety of the children due to new information (drug use in the home, no food, deplorable conditions, and missed medical appointments). The safety assessment deemed the children safe with a plan. Additional family members in the home would ensure the mother appropriately cares for [REDACTED] keeps all medical appointments and would supervise the child at all times.

On 8/24/11 the [REDACTED] report was [REDACTED] was opened to assist the mother also, for the [REDACTED]

On 9/6/11 a safety assessment was conducted due to transfer to new worker. Again, the child was deemed safe with a plan.

**Current Case Status:**

On 10/24/11 another safety assessment was completed with the same determination of safe with a plan. However, mother had been non-compliant with the plan and possible placement was discussed.

On 11/1/11 the [REDACTED] was developed. The mother signed the plan and the goals on the plan were consistent with the identified safety threats and needs of the family.

On 11/2/11 a court order was obtained adjudicating [REDACTED] as dependent due to the mother's noncompliance with safety concerns. Ms. [REDACTED] failed to appear in court. The social worker went to the home with the police to place the child; however, the mother had fled with the child. Family members would not disclose her whereabouts.

On 11/3/11, Det. [REDACTED] reported that Milton died of [REDACTED]. Manner of death was ruled Homicide. Mr. [REDACTED] will be arrested for murder since the child was in his care at the time of death and is an admitted heroin user. Ms. [REDACTED] will not be charged since there is no evidence of a history of drug use. Charges are still pending against Mr. [REDACTED] since he has since fled and his whereabouts are unknown.

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

**Strengths:**

The Act 33 team felt that the DHS worker did a thorough job [REDACTED] the case and that all relevant parties were interviewed. Children were seen in a timely manner. Documentation and structured case notes were high quality.

**Deficiencies:**

The social worker used a family member as translator for the first contact with the family, against agency policy. An interpreter was used for the remainder of the investigation.

**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 report provided by the county and is in agreement with the county's findings.

**Department of Public Welfare Findings:**

**County Strengths:**

- The county provided clear documentation in the case notes and [REDACTED] report.
- The county collaborated with the local police department.
- The county referred the family to appropriate services.

**County Weaknesses:**

None identified

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

The Department of Human Services did not immediately provide information and documentation to the Regional Office. This information had to be requested several times.

Upon review of the county file it was noted that the Safety Plan dated 8/9/11 listed the mother as one of the responsible parties for the plan, however, several safety threats were noted on the safety assessment with her as the caregiver. Parents cannot be responsible parties as per the Safety Assessment and Management Process.

In addition, review of the file contained an [REDACTED] in English and safety plans in English, when it was clearly documented that the family only speaks Spanish and had the need for a translator throughout the process. This is in violation of Title VI of the Civil Rights Act of 1964. An LIS will be issued for this area of noncompliance.

**Department of Public Welfare Recommendations:**

Due to the increase in child fatality and near fatality reports due to drug overdoses, the county should collaborate with other county agencies to increase the amount of public service announcements addressing this issue.