pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Naeem Rudd

Date of Birth: 08/06/2014
Date of Death: 03/20/2016
Date of Report to ChildLine: 05/17/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
11/30/2016

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Philadelphia County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/03/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Naeem Rudd	victim child	08/06/2014
[redacted]	sibling	[redacted]2008
	sibling	2011
	mother	1991
	father	1975
	maternal grandmother	1965
	maternal uncle	1992
	maternal uncle	1994

Summary of OCYF Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, siblings and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the investigative social worker as well as the social worker from the community umbrella agency. SERO attended the Act 33 Review Team meeting held on 06/03/2016.

Children and Youth Involvement prior to Incident:

On 08/11/2014, there was a report concerning the family that was not accepted for investigation since there was no specific allegation of abuse or neglect of the children. The caller alleged the mother stole $200 and allowed homeless drug addicts to live in the home.

On 10/15/2015, there was a [redacted] report that alleged the victim child had not been seen for medical care since age 5-months-old and was now 14-months-old and was behind with immunizations. The report was [redacted] All of the children were up to date on their well child visits and immunizations and were not scheduled to be seen again until 2016. The case was not accepted for services and was not open at the time of the child's death.

On 03/20/2016, there was a [redacted] report alleging the victim child was found unresponsive and transported to the hospital via ambulance where he was pronounced dead. There were no signs of trauma or abuse. The child had recently been treated [redacted] The initial cause of death was ruled due to lead poisoning. The final autopsy report was not yet determined. The report was determined [redacted] on 04/05/2016.

Circumstances of Child Fatality and Related Case Activity:

On 05/17/2016, the county received a [redacted] report after the autopsy results from the child's death on 03/20/2016 revealed the child died from drug intoxication and that the child ingested an excessive amount of morphine. It is unknown how the child ingested the morphine. [redacted] She reports she kept her medications in a drawer low to the floor in her bedroom which was easily accessible to children. Initially it was reported to the County that the parents put the child to bed at 9:00 p.m. At midnight the father went to check on the child and gave him a bottle. The father laid down on the bed next to the child and they fell asleep. At 5:00 a.m. the father got up and noticed the child was not breathing and was unresponsive. The mother called 911 and began cardiopulmonary resuscitation (CPR). The child was pronounced dead at 5:56 a.m. There were no external signs of abuse or trauma. The county found no safety threats for the siblings at that time.

However, as a result of the new information relating to the cause of death, the siblings were placed with the paternal grandfather as a safety resource. He was to ensure supervised visits with the parents and that all medications would be secured at all times. When he failed to adhere to the safety plan and permitted the father unsupervised access to the children, [redacted] the children were placed in foster care that same evening.

Interviews with all relevant parties occurred. The report was [redacted] on 07/12/2016 naming [redacted] as the perpetrators of abuse for egregious failure to supervise. The cause of death was drug intoxication and the manner of death is undetermined. There are no charges. Criminal investigation is ongoing.

[redacted] report concerning the siblings was generated due to the cause of death of the child and was determined [redacted] on 07/31/2016 for [redacted] since it was not clear how the child ingested the morphine. The case has been accepted for service and the county and community umbrella agency are providing case management, [redacted] family support services, placement services, [redacted]

[redacted] and parenting education. In addition the agency is attempting to identify potential kinship resources for the children. The parents have weekly supervised visits with the children and are in compliance with the goals of the service plan. The permanency goal is Reunification.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  The team felt the SW did a good job investigating the report. The SW from the Community Umbrella Agency continues to explore kinship resources for the children in order to place them in the same home. Both parents were referred for parenting capacity evaluations.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  The previous rejected report in August 2014 had no specific allegations, however, there were alleged risk factors and perhaps should have not been screened out. The other concern was that the family was referred for [redacted] at the time of the child's death, however, services have not begun. A re-referral will be made.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  No recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  No recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  No recommendations.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county dated 08/31/2016. We are in agreement with the county's findings.

Department of Human Services Findings:

- County Strengths:
  There was clear documentation. All parties were interviewed. Assessments resulted in relevant services for the family. Casework supervision occurred throughout the investigation.

- County Weaknesses:

Children were not placed in the same resource home, nor with the same subcontractor provider agency by the Community Umbrella Agency.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None noted.

Department of Human Services Recommendations:
The county could encourage further outreach to the medical community to provide information and education on the importance of securing all medications out of reach of children.