



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Sahara Rivers

DATED 3/25/2010

BORN: November 24, 2007

Date of death: August 17, 2009

THE FAMILY WAS NOT KNOWN TO CCYA

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. 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 Constellation:

HOUSEHOLD MEMBERS:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Sahara Rivers	victim child	11/24/2007
[REDACTED]	mother	[REDACTED] 1986
[REDACTED]	father	[REDACTED] 1984
[REDACTED]	sister	[REDACTED] 2004
[REDACTED]	sister	[REDACTED] 2007
[REDACTED]	brother	[REDACTED] /2008
[REDACTED]	sister	[REDACTED] /2006

Notification of Fatality:

On 08/05/09 at 3:47 pm, The Department of Human Services (DHS) received a [REDACTED] report alleging that 21 month old Sahara Rivers was brought by ambulance to St. Christopher's emergency room. DHS SW received this case report from DHS SWS, [REDACTED] at 4:55 pm. The report was documented as a [REDACTED]

According to the reporter, the child was found by the father with no pulse and not breathing. The VC remained in the hospital in critical condition. Upon admission to the hospital, there were no signs of physical abuse to the child. According to the report, both parents were in the home at the time the VC was discovered by the father. The Doctor reported that the VC had extremely high levels of both sodium and chloride. According to the report, the doctor believed that the child may have ingested high doses of salt. The VC is on life support with no brain activities.

On 08/05/09 at 9:02 pm, a second [REDACTED] report [REDACTED] was called into DHS Hotline by the hospital alleging that the 4 other children were also tested and 2 of the 4 also had high levels of sodium.

The victim child remained unresponsive and on life support and all 4 of the other children were also admitted into the hospital. Dr. [REDACTED] stated that the victim child had been hospitalized several times, the victim child was under weight, and Mr. and Mrs. [REDACTED] had failed to attend scheduled appointments for the VC at the hospital growth clinic [REDACTED]

[REDACTED] from [REDACTED] is [REDACTED] with [REDACTED]; she was prescribed [REDACTED], but it is unknown if she is taking it. It has been noted that the mother has used [REDACTED] in the past along with her prescribed [REDACTED]. The family also has a history of [REDACTED].

On 8/06/2009 an Order of Protection was obtained and the 4 siblings were placed into foster care upon discharge from the Hospital.

On 8/07/2009 DHS interviewed the physician and SW at the Hospital and felt that the investigation met the criteria for a [REDACTED] report. A [REDACTED] report was generated and SVU was also contacted due to the unusual amounts of salt levels in 3 of the 5 children.

On 8/17/2009 the victim child was taken off life support and she died as a result of complications.

SVU is investigating.

Documents Reviewed and Individuals Interviewed:

For this review the Southeast Regional Office (SERO) reviewed the hospital report for the victim child and her siblings, the DHS investigation/assessment, structured case notes /progress notes, the DHS safety assessment and risk assessment in home tool, interviewed the Medical Examiner, DHS Administrator, DHS Social Worker Supervisor and DHS Nurse and attended the County's Internal Fatality Review Meeting regarding this case on November 20, 2009.

Case Chronology:

8/05/2009 [REDACTED] 8/21/2009

[REDACTED] felt that the salt poisoning was not accidental or natural. As per Dr. [REDACTED] the salt levels in three of the children were abnormally high, all were failure to thrive, parents missed several medical appointments, and all are developmentally delayed. [REDACTED] are considered to be [REDACTED] in the case due to them admitting to be the only persons supervising the children at the time of the incident.

8/06/2009 DHS obtained an Order of Protection for all of the children As per court order, the parents are to have no contact with any of the children due to the nature and extent of the [REDACTED]

8/07/2009 [REDACTED] 8/21/2009

The child, Sahara Rivers, was brought into the hospital unresponsive and not breathing. The child was placed on life support and died thirteen days later. The investigation revealed that the child suffered sodium poisoning which caused her death. [REDACTED]

8/07/2009 [REDACTED] 8/21/2009

The child, [REDACTED], is under 5th percentile for height and weight and she has missed several medical appointments.
[REDACTED]

8/07/2009 [REDACTED] 8/21/2009

The child, [REDACTED], had above normal amounts of salt in her system and is [REDACTED] for her height and weight. She has also missed several medical appointments.

8/07/2009 [REDACTED] 8/21/2009
The child, [REDACTED] is [REDACTED] for his height and weight, is developmentally delayed and has missed several medical appointments.

8/07/2009 [REDACTED] 8/21/2009
The child, [REDACTED] had above normal levels of salt in her system. She is under 5th percentile in her height and weight. She has missed several medical appointments.

8/07/2009 The family was accepted for services due to the unusual and unexplainable amounts of salt levels in three of five siblings. All of the surviving siblings were placed into [REDACTED] foster care through Children's Choice.

On 8/17/09 DHS received a notice that the VC had passed away from the injuries caused by the high levels of sodium and chloride.

Previous CY involvement

The family has no prior history with DHS.

On 1/05/2009 [REDACTED] received an [REDACTED] at Elwyn through the [REDACTED]. She was referred by her teacher and her mother due to concerns regarding [REDACTED]. The evaluation was to determine her eligibility for three to five year olds [REDACTED]. The results of the evaluation showed that the child had at least a [REDACTED] standard deviations below the mean in one or more areas of development. The delays resulted in the need for [REDACTED] in order to participate in typical activities and routines.

The report states that there is no recommendation for [REDACTED] to the family at this time.

Circumstances of Child's Fatality

On 08/05/09 the family became known to DHS through a [REDACTED] report alleging that 21 month old Sahara Rivers was brought by ambulance to St. Christopher's emergency room. This report was elevated to a [REDACTED] report. According to the report, the child was found by the father with no pulse and not breathing. The child's sibling, [REDACTED] who was in the room with the VC at the time of the incident stated that her sister Sahara choked and that she "killed herself". The VC had a history of developmental, speech and motor skill delays and was being seen by a therapist. Upon admission to the hospital there were no findings of physical abuse to the child. The child was born at 30 weeks gestation and there were no known drug and alcohol issues for either parent. The mother suffers from [REDACTED]. The mother takes [REDACTED].

her [REDACTED] issues. At the time of the incident, both parents were in the home, but it was the father who discovered the child. According to the reporter, the child's lab work revealed high levels of sodium and chloride. The doctor felt that all of the children may have ingested high doses of sodium and chloride. The doctor felt that the children may have ingested high doses of salt.

On 08/05/09 a second [REDACTED] report was called into the hotline at 09:02 pm. This report was received as a [REDACTED]. This report was made due to the high sodium levels of the VC. The VC had extremely high levels of sodium and was currently unresponsive. The emergency room physician at ST Christopher's decided to also evaluate the other four children. The evaluation indicated that two of the four children had high sodium levels. [REDACTED]

On 08/06/09 an initial safety assessment worksheet was completed in the home of the VC with 7 out of 14 safety threats identified at that time. All five children were hospitalized. The VC remained on life support. According to the safety assessment, the hospital alleges the mother has [REDACTED]. The children are unsafe to return home. The caregiver's cognitive protective capacities are diminished. The mother has [REDACTED]. There is a history of [REDACTED] and all children are age 5 and under, born within 9 months apart. According to DHS case progress notes, during the investigation the mother stated that the children eat their meals in their rooms and that they eat by themselves. The children were in the bed room unsupervised by the parents and the oldest child is 5 yrs old. According to statements taken by the doctor, the mother gave a brief history of the family and the events that lead up the VC coming to the hospital via emergency response. The mother stated that the father did not like visits from family members, four of the five children have [REDACTED] and the baby boy does not like to get out of the crib.

According to the doctor, the baby, [REDACTED] showed signs of [REDACTED]; he seems to be on a level of a four month old rather than a nine month old. The doctor stated that the mother had a bag of [REDACTED] with her at the time of the hospital interview. The mother stated that the [REDACTED] were for her [REDACTED]. According to the interview, the mother was hospitalized a week prior to the incident for [REDACTED] reasons; the mother could not clearly state why she was [REDACTED].

The mother stated that she is [REDACTED]. While in the hospital, the mother observed another child being brought into the ER unresponsive. The mother's reaction was not normal which led the doctor to believe the mother to have [REDACTED] by [REDACTED]. (It was later determined by the [REDACTED] that the [REDACTED] has been ruled out since the endocrinologist stated that he cannot be sure about the [REDACTED].

According to medical records and the mother's statements, the VC had been admitted into the [REDACTED] before due to [REDACTED]. The mother [REDACTED].

was instructed to give the VC [REDACTED] as recommended by the PCP, but the mother stated that the VC did not like the [REDACTED] so she gave the VC [REDACTED] instead. The children were all going to St. Christopher's for well baby care but the parents missed many appointments and it is not clear as to why the missed appointments were not reported to DHS hotline at the time. All the children were at [REDACTED] for height and weight. All the children were failure to thrive with developmental delays. The mother stated that the children were premature. The children had [REDACTED] and Childlink. [REDACTED] had [REDACTED] but was not [REDACTED]. The mother stopped attending St. Christopher's and transferred to another Provider the early part of 2009. The Provider, as per hospital records, is Dr. [REDACTED], who stated she only saw one of the children once. The children were referred to [REDACTED] through St. Christopher's but the parents only brought the VC to one in March of 2009.

On 8/06/2009 DHS interviewed the mother, [REDACTED] at the hospital. [REDACTED] was informed of the allegations and why the children will remain in the hospital. [REDACTED]

[REDACTED] stated that she keeps the [REDACTED] away from the children.

[REDACTED] stated that the children eat their meals in their bedrooms and they do not eat when they are down stairs. [REDACTED] stated that the children were eating peanut butter and jelly sandwiches at the time of the incident. The youngest child was asleep in his bassinette and the girls were playing. [REDACTED] stated that she was a few minutes in the bedroom and then she went down stairs while [REDACTED] went up stairs to watch the children. [REDACTED] stated that her husband called down to her and instructed her to call 911 while he performed CPR on the VC.

On 8/08/09, the two [REDACTED] reports were upgraded to [REDACTED] reports due to the severity of the injuries. The reports allege that upon investigation the reporter suspected mother of having [REDACTED]. At the time of the report, the perpetrator remained unknown since the mother and father were both present at the time the VC was taken to the hospital. The reporter also alleged that the mother suffers with [REDACTED], and she did feed the children and they some times fed themselves.

On 8/11/2009, during a home visit, according to the case notes, the [REDACTED] gave the following account as to the events that lead to the VC's death. [REDACTED] denied that the children eat all their meals in their bed rooms as stated earlier in the investigation by Mrs. [REDACTED] but he did admit that the children eat snacks in their bedroom. [REDACTED] stated that the children missed their Doctor appointments only because of their mother's [REDACTED] and that she was back and forth to the hospital which made it difficult with five children at home. [REDACTED] stated that he found the VC when he came upstairs to check on the children when the mother came down stairs to get them their drinks [REDACTED] stated that the VC's lips were turning blue and her eyes started to roll in her head. [REDACTED] stated that the VC was not breathing, so he opened the VC's mouth and tilted her head back. [REDACTED] stated that he saw that the bread was stuck at the roof of her mouth along her tongue. [REDACTED] stated that he did the finger sweep and checked her

pulse. When he found that she did not have a pulse, he began CPR. [REDACTED] stated that it took the ambulance about 5 minutes to get to the house. [REDACTED] stated that when the ambulance came, they snatched the VC from him and started working on her. [REDACTED] and [REDACTED] denied giving the children salt or anything with salt. [REDACTED] stated that SVU took the food and water from the house for testing. [REDACTED] stated that there is a school being built down the street from them and that there used to be a cemetery where they are breaking ground. Both the parents stated that they also felt ill and went to the ER on 7/31/2009.

Current / most recent status of the case:

On August 7, 2009, the family was accepted for services due to the unusual and unexplainable amounts of salt levels in three of five siblings. All four of the siblings are placed in same [REDACTED] foster home. Family Group Decision Making has been ruled out due [REDACTED] reports that state that the parents will have contact with the children if they are placed with the MGM. This is an active police investigation and charges are pending on both parents. The goal, according to the Family Service Plan dated 2/19/10, is for family reunification; however this goal may change following the results of the police investigation.

Services to children and families:

- DHS maintained the sibling group by placing all the siblings in the same medically approve foster home through Children's Choice.
- The Court ordered stay away orders for the parents, [REDACTED] in order to determine the presents of [REDACTED]
- DHS psychologist is completing [REDACTED] for oldest child
- [REDACTED] through Children's Choice
- Educational services through Whitedeer Elementary School

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

Strengths:

- The Act 33 Team felt that DHS worker did a thorough job investigating the case and all relevant parties were interviewed and seen in a timely manner.
- The Act 33 Team felt that there was good collaboration between the systems making determination of findings in a timely manner.

Deficiencies:

- The Act 33 Team found that in the initial report and subsequent contact between DHS and St. Christopher's hospital, the statement was made that the mother was suspected to have [REDACTED]. After the

DHS CW read an article regarding [REDACTED] which refers to a [REDACTED] condition in a caretaker and therefore does not address what is allegedly being done to the child, in this case abuse by salt intoxication. This initial assessment of [REDACTED] led to several case management decisions by DHS which led the investigation off track and may/may not have impacted decisions made by the court. In an effort to prevent any future miscommunication between DHS and the medical provider, DHS has implemented a policy to have the DHS nurses consult on all hospital cases where abuse or neglect is suspected.

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

Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.

- The children missed several doctor's appointments and had been [REDACTED]. All of the children were at the 5th percentile for their height and weight. The parents were instructed to follow up with growth clinic, but they didn't follow through. [REDACTED] and had been admitted to the hospital several times for her condition. The family was receiving [REDACTED] services through Elwyn and ChildLink on a weekly basis and no report to DHS was made. In order to address this situation, DHS' training division should educate the hospital medical staff on the different services that DHS and its contracted agencies can provide, and on the types of medical and social concerns which are reportable.

SERO Findings:

County Strengths

- The Department of Human Services immediately provided information and documentation to the Regional Office.
- The County's Child Fatality Team has twelve individuals that have the expertise in the prevention and treatment of child abuse.
- DHS maintained the sibling group by placing all the siblings in the same foster home.
- DHS provided clear documentation of the identified safety threats in the In-Home Safety tool and case notes.
- DHS provided clear documentation of identified Risk Factors

Deficiencies:

- DHS HotLine did not identify the initial [REDACTED] even though the VC was under the age of 5 years old and unresponsive as reported. Please note that on 08/05/09 at 9:02 pm, within 24 hours a second [REDACTED] report was called into DHS Hotline by [REDACTED] alleging that the 4 other children were also tested and 2 of the 4 also had high levels of sodium. This report was identified as a [REDACTED]