



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE Near Fatality OF:**



**BORN: 1/31/2011**  
**Date of Near Fatality: 5/24/2011**

**FAMILY KNOWN TO:**  
*Philadelphia Department of Human Services*

**REPORT FINALIZED ON:**

03/29/2012

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 by Governor Edward G. Rendell. 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 has convened a review team in accordance with Act 33 of 2008 on 6/17/2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	victim child	1/31/2011
██████████	mother	██████ 1973

**Other family members**

██████████*	sibling	██████ 1996
██████████*	sibling	██████ 1993

\*reside with paternal aunt in NJ

**Notification of Child Near Fatality:**

On 5/24/2011, Philadelphia DHS received a report from ChildLine concerning four-month-old ██████████. ██████ was admitted to the ██████ at Children's Hospital of Philadelphia (CHOP) on 05/25/2011 after being diagnosed with a ██████████; ██████ was experiencing ██████. ██████ mother had noted some changes in his behavior on 05/24/2011. She had taken ██████ to his primary physician for a possible earache on 05/25/2011. The PCP believed that ██████ suffered from a urinary tract infection, not an ear infection. The mother gave the child Tylenol about 8 a.m. and when his condition did not improve later that day, his mother and staff from ██████████ (a ██████████ for mothers and their children) brought him to the ██████ at CHOP on 05/25/2011 where he was admitted to the ██████ and placed on a ██████████

Whenever the mother would leave the residence for brief periods of time, another resident who has been named as the ██████████ would watch ██████. She specifically watched him on the dates of 05/23/2011 and 05/24/2011.

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to this family from the county and the provider agency. Follow up interviews were conducted with the county caseworker and the director from [REDACTED]. The regional office also participated in the County Internal Fatality Review Team meeting on 05/24/2011.

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

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

02/09/2011 [REDACTED] report [REDACTED] 3/19/2011

The mother had been arrested two weeks prior to [REDACTED] delivery. She experienced withdrawal symptoms while incarcerated. She was admitted to a [REDACTED], and then transferred to [REDACTED]. The mother admitted to heroin use throughout the [REDACTED].

Initial allegations were that the mother and [REDACTED] tested positive for methadone when he was delivered 01/03/2011. [REDACTED] was experiencing symptoms of [REDACTED] his condition required that he might remain hospitalized for one to two months. His mother was [REDACTED] on 02/01/2011, and returned to [REDACTED].

A safety assessment was completed 02/23/2011 when [REDACTED] was ready for [REDACTED]. The determination was that [REDACTED] would be safe with a comprehensive plan. The plan included that [REDACTED] would reside with his mother at [REDACTED]. Staff at [REDACTED] signed the safety plan and agreed that the mother would not be allowed to leave the program with [REDACTED] unless accompanied by staff. The mother was fully informed of all of [REDACTED] medications by hospital staff prior to discharge.

DHS notes dated 03/03/2011 indicate that the mother was having some problems with how the night staff were treating her. [REDACTED] had been found co-sleeping with [REDACTED]. Staff provided the mother with a pamphlet, Sleeping Safely. Night staff were making hourly checks to ensure that mothers were not sleeping with their babies.

This case was accepted for service on 03/07/2011. The date of the Family Service Plan was 03/29/2011. Part of the plan was the implementation of [REDACTED] with Presbyterian Children's Village (PCV) to ensure the mother's compliance with the [REDACTED] program.

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

On 05/24/2011, [REDACTED] received a report concerning [REDACTED]. He was admitted to CHOP [REDACTED]. No other injuries were noted. [REDACTED] was unknown. The mother was primary caretaker, but had used other residents from [REDACTED].

██████ to "care sit". The facility described care sitting as the practice of residents using one another as resources to watch their children whenever they took smoke breaks or had appointments.

DHS completed an interview with the director of ██████████. She reported that on 3/5/2011, the mother was reported as dropping ████████ off her lap. ████████ and his mother were taken to CHOP ████████ and were medically cleared. The director indicated that residents are allowed to watch each other's children, called "care sitting". Interviews with staff report that this could be up to two hours; residents report that it can be for 4-5 hours. Care sitting could occur in the mothers' rooms. The mother utilized another resident, ██████████, to care sit on 05/23/2011 and 05/24/2011; this mother has been identified as an ██████████ ██████████

### Current Case Status:

- ████████ was removed from the ██████████ 06/01/2011. ████████ showed ██████████ indicating lack of oxygen ████████ showed no damage to the spine ████████ was identified with weakness to his extremities.
- Upon ██████████ to foster care, ████████ has needed extensive medical follow up. He has been referred for an ██████████ He has suffered ██████████ He has become very susceptible to colds and viruses; he recently spent a week in the hospital with a ██████████.
- During ██████████, the mother experienced a ██████████ Her ██████████ goals are to ██████████, move to live with her father in California, and connect with a church. The mother is involved with a ██████████, which is spiritually based.
- The mother's ██████████ program had very positive reports on the mother's parenting skills.
- The ████████ investigator interviewed the ██████████ on several occasions. ██████████ reported that she last used heroin on 05/04/2011, and that she has a history of using cocaine and marijuana. The ██████████ has a three-year-old son, ████████ staying with her. The ██████████ reported that on 05/24/2011 she was watching ████████ in her room. She was sitting on the bed with her legs stretched out; ████████ was lying on the bed between her knees and the wall. The mother startled her when she came in to get ████████, causing her to move off the bed and ████████ fell off the bed, with a large box fan falling on top of him. The ██████████ reported that as she was standing up, she stepped on the box fan with ████████ underneath it. She reported that the mother had been on a snack and smoke break. Doctors at CHOP indicate that this account does not explain the child's injuries.
- During an interview with the mother, the ████████ investigator discovered that on 05/24/2011, the mother had gone to the store to get milk with ████████ and left her son with ██████████. The mother thinks that she saw the ██████████ drop ████████ on the bed.

- On 06/22/2011, this report [REDACTED]. Staff from [REDACTED] told the [REDACTED] investigator that the [REDACTED] had a history of hitting her three year old son, [REDACTED]. DHS completed an in-home safety assessment of [REDACTED], and her three-year-old son. The staff at [REDACTED] were very positive about Ms. [REDACTED] care of her son. The child recently had a physical, but DHS requested another one. Physical discipline is not tolerated at the treatment program; the staff report that the mothers are closely supervised. The mother reported that she might "pop" her son on the hand, but did not use physical discipline. The child reported that he either had time out or would miss a snack. The child reported he had been "popped" on the leg by his mother. He appeared very bonded with his mother.
- On 06/21/2011, [REDACTED] was [REDACTED] to medical foster care with Best Nest. His medical follow up is being done at CHOP for [REDACTED]. The permanency goal is reunification with his mother. The Family Service Plan goals include her participation and completion of [REDACTED], find appropriate housing, and complete parenting classes. DHS was ordered to find a [REDACTED] program that would accommodate mothers and children. The agency is having difficulty finding a suitable [REDACTED] program.
- Conversation with the director of [REDACTED] indicated that they have revised their "care sitting" policies and procedures. The facility has created a new contract process to be used between the mothers. During the day time, facility staff will be caring for the residents' children whenever they are at various appointments. Residents must use an approved list to select their "care sitters". Residents on this list would be senior level peers who have demonstrated responsible behaviors and are compliant with facility rules. The contract requires that a back-up peer must also be identified in the contract between residents. "Care sitting" should be of less than three hours duration.

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

Act 33 of 2008 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 convened a review team in accordance with Act 33 of 2008 on 06/17/2011.

- Strengths:
  - Investigation was timely; safety assessments were completed according to agency protocol.

- Deficiencies:
  - The care sitting program at [REDACTED] needs to be reviewed. Concerns were expressed about the mothers watching one another's children without detailed procedures in place.
  - DHS had difficulty locating a medical foster home for [REDACTED] which delayed his discharge from the hospital.
  - The foster family who had not been certified as a foster family was able to visit [REDACTED] at the hospital.
- Recommendations for Change at the Local Level:
  - Chairperson would request a meeting with [REDACTED] to address the care sitting practice at [REDACTED].
  - DHS would review the care taking practices at other mother/baby facilities.
  - [REDACTED] DHS should review the systemic issues that lead to children remaining in hospitals after they are ready for [REDACTED]
- Recommendations for Change at the State Level:
  - None identified.

#### Department Review of County Internal Report:

- County Strengths:
  - Timely investigation
  - Thorough safety assessment
- County Weaknesses:
  - Delay in child's [REDACTED] to foster care due to lack of approved resources.
- Statutory and Regulatory Areas of Non-Compliance:
  - None identified.

#### Department of Public Welfare Recommendations:

- An area to address with counties and [REDACTED] is the use of residents of mother/baby programs to be used as care takers for each other's children. The residents of this particular program have lengthy histories of drug use [REDACTED]. Their ability to parent should be closely scrutinized before they are allowed to care for any child, their own or someone else's.