



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 7/6/2000

FAMILY KNOWN TO:
Philadelphia Department of Human Services
DATED 01/8/2010

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, December 30, 2008. 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.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	7/6/2000
[REDACTED]	Mother	[REDACTED] 1973
[REDACTED]	Father	[REDACTED] 1974
[REDACTED]	Sister	[REDACTED] 2001
[REDACTED]	Brother	[REDACTED] 1993*
[REDACTED]	Maternal grandmother	[REDACTED] 1955**

*non household member, in a Permanent Legal Custodianship arrangement since 2005

**caretaker of children, and alleged perpetrator

Notification of Near Fatality:

On 8/7/2009, the Department of Human Services (DHS) received a report that nine year old [REDACTED] was brought to Hahnemann Hospital Emergency Room (ER), and then transported to St. Christopher's Hospital for Children. DHS had received a report on 7/10/2009 that the mother would lock up the children when she was angry. DHS had only seen the younger sibling, 8-year-old [REDACTED], at that time, who is now in foster care. DHS came back to the home on this date with the police. Police forced the door open and found the victim child inside the bedroom severely malnourished, with abrasions all over her body, [REDACTED] to her feet, and cavities in her mouth. Child was being admitted to [REDACTED].

The [REDACTED] further noted that the child had prolonged starvation and had difficulty verbalizing. Child had never been to school or to see a doctor. Reporting source alleged that grandmother would lock up the children if they had "stolen" food or if she was angry.

Documents Reviewed and Individuals Interviewed:

For this review the SERO reviewed the Philadelphia Medical Examiner's file, and the complete county case file and the Special Victim's Unit interviews.

SERO attended the County's Internal Fatality Review Meeting regarding this case on 9/24/2009.

Case Chronology:**Previous CY involvement:**

5/4/2003 [REDACTED]

Allegations were that the mother was engaging in prostitution and leaving the children home alone. DHS was unable to make a determination based on the family being transient.

6/10/2003 [REDACTED]

Allegations were that mother was abusing drugs and was not properly caring for her children. DHS was unable to make a determination based on the family being transient.

7/15/2003 [REDACTED]

Allegations were that there were three children at home alone since 4 a.m. The investigator did not find any children in the home. Mother reported that the children were at the maternal grandmother's home in Wildwood for the week. During this investigation, another [REDACTED] report came in that alleged that the children were hungry and were not allowed to play outside. Report was closed 9/26/2003.

7/29/2003 [REDACTED]

Allegations were that the children were living illegally in a home that lacked windows and water service. Report was closed 9/26/2003.

10/20/2004 [REDACTED]

On this date, eleven year old [REDACTED] was brought to DHS by his caretakers because they could no longer handle his behavior. Since the previous report, the mother had been arrested on drug charges. [REDACTED] had been sent to live with the maternal grandmother; [REDACTED] had been cared for by family friends, [REDACTED]. After obtaining a restraining order, DHS placed [REDACTED] with his maternal grandmother, [REDACTED], in kinship care with Women's Christian Alliance (WCA). WCA provided services to [REDACTED] and maternal grandmother in the home. No services were specifically identified for [REDACTED]; however, they were seen by WCA on numerous occasions. Maternal grandmother was awarded permanent legal custody of [REDACTED] by the court on 12/23/2005; services by DHS were closed at this time. [REDACTED] services were provided by Women's Christian Alliance.

11/9/2006 [REDACTED]

On this date, the maternal grandmother asked DHS to assist in managing [REDACTED] behaviors; he was exhibiting "inappropriate sexual behavior." [REDACTED] was removed from the home and placed into foster care. The girls remained with their maternal grandmother. [REDACTED] received [REDACTED] services through Joseph J. Peters Institute, but he adamantly denied that he had abused his sisters. His sisters did not receive any victims' services. DHS completed Risk Assessment 11/13/2006 of two girls, identified that girls were at risk if brother not removed from home. DHS completed home visit. At the time of this investigation, the girls were 7 and 8 years old and had not yet been enrolled in school. This investigation was a [REDACTED], and was [REDACTED]

Family Service Plan identified ongoing treatment for family to address issues of [REDACTED], but the girls never received any victims' services.

7/6/2007 [REDACTED]

Allegations were that [REDACTED] had been hit with a broom and a hammer while residing with his maternal grandmother.

2009

[REDACTED]'s foster parents received permanent legal custody of him. DHS' case was closed at this time.

7/10/2009 [REDACTED]

Allegations were that the maternal grandmother kept [REDACTED] locked in their bedroom all the time. Reporting source could hear children from inside the room on 7/7/2009, knocking to be let out. The report further alleged that there was a potty in the room and there was a lock on the outside of the bedroom door. Reporting source also stated that alleged [REDACTED] beat [REDACTED] with a fist 2-3 months ago, but the reporting source did not see any injuries. Reporting source stated that "something was going on with the alleged [REDACTED]" but would not elaborate.

A DHS Hotline worker was dispatched to the home immediately to assess the safety of the children. The DHS worker was able to interview the maternal grandmother and [REDACTED]. DHS was told that [REDACTED] was at the shore with a friend. [REDACTED] denied any abuse or neglect. A lock was observed on one of the bedroom doors; maternal grandmother admitted to locking the girls in the room for short periods of time. DHS observed the maternal grandmother remove the lock; maternal grandmother assured the DHS worker that she would no longer lock the girls in their rooms. The home was noted to be neat, with operable utilities and ample food. Maternal grandmother was told that another worker would be out the next day to assess the safety of [REDACTED]. Safety Assessment completed on 7/11/2009 indicated that [REDACTED] was safe- after home visit. Grandmother had told DHS that [REDACTED] was visiting family friends.

DHS made repeated attempts to see [REDACTED] between 7/11/2009 and 7/20/2009; no one was ever available. DHS filed a Motion to Compel Cooperation with Family Court. On 8/7/2009 a breakdown order was issued for the maternal grandmother's residence. DHS, accompanied by the police, entered the residence and found [REDACTED] and maternal grandmother in the home. [REDACTED] was found emaciated; her body was covered with marks.

8/7/2009 [REDACTED]

After finding [REDACTED] emaciated, DHS arranged for her transport to Hahnemann Hospital, then to St. Christopher's Hospital. [REDACTED] was described as severely malnourished, abrasions all over her body, [REDACTED] (swelling) to her feet and cavities in her mouth. [REDACTED] was admitted to the [REDACTED]

██████ was placed in foster care on this date after DHS secured an OPC. Safety Assessment was completed on 8/7/2009. ██████ determined to be unsafe, placed in foster care. ██████ name was handwritten on this safety assessment. The plan noted that she was in foster care. Safety Assessment was completed 8/11/2009 . Plan said she was safe with a comprehensive plan; plan was for her to remain in hospital with no visitors unless approved by DHS.

Circumstances of Child's Near Fatality:

Although ██████ made the initial report to ChildLine, they did not follow up with ChildLine to report that the investigation had been certified by a physician as a Near Fatality.

Current / most recent status of case:

This case has been ██████ have been placed together in a foster home.

Services to children and families:

- The Act 33 review team expressed concern that DHS could have improved their practice. Several ██████ reports were listed as simultaneously ██████. Neither ██████ were ever opened for services. An assumption was made that they were safe since they had moved to the grandmother's home. No services were ever offered to the grandmother.
- ██████ were the victim children in a ██████ investigation. The ██████. There is no documentation that the sisters received any victims' services. ██████ was removed from the home. It is believed by the team that if court ordered visitation had occurred, that someone might have noticed the deteriorating condition of ██████.
- Family profile was completed on maternal grandmother prior to her receiving PLC of ██████. The profile included information on the girls and their planned enrollment in public school. No one in DHS followed up on this. However, DHS would have had no legal authority, as the law does not require school enrollment until age 8. The team discussed concerns that maternal grandmother's ██████ was not fully assessed during the completion of the family profile. DHS did not thoroughly assess the impact of placing a problematic teen into a household with two small children.
- DHS required a "breakdown order" to assess ██████'s safety. Three weeks time elapsed between the time that DHS was advised to secure the order and the actual hearing date.

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

Strengths-

- Hotline and Intake social workers did an excellent job investigating this report. They made daily attempts to see the girls. When they were not successful, they obtained a court order to access the home.
- Social work team consulted with the Law Department, as had been recommended in a previous Act 33 Review.
- Both girls were placed in the same foster home.

Deficiencies-

- The Risk Assessment completed during the investigation rated the family's risk as Moderate. The Act 33 team believed that the risk would more accurately be rated as High. Portions of the Safety Assessment were noted to be filled out incorrectly. The review team noted that DHS has made progress in providing social workers with training on Safety and Risk Assessments. DHS continues to provide transfer of learning and has available a Safety Assessment technical assistance hotline to assist workers in filling out this document.

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

None identified.

SERO Findings:

County Strengths-

- DHS made repeated efforts to see the second child, eventually seeking a court order to gain admission to the home.
- DHS placed the siblings in the same foster home, meeting stipulations of Fostering Connections special transmittal.

Deficiencies-

- In 2006, Family Service Plan identified ongoing treatment for family to address issues of [REDACTED], but the girls never received any [REDACTED] services. The agency failed to follow through on the identified needs of the family.
- The children did disclose that [REDACTED] had been in the closet during the home visit. While the worker requested that the lock be removed from the closet, the grandmother was not asked to open the door for the worker to look inside to either verify or negate the allegations.
- There was a three week delay between the time that DHS was advised to secure the order and the actual hearing date. During this time, [REDACTED]'s condition certainly deteriorated.
- SERO became aware of this incident when a case summary was provided on 8/31/2009 for the Act 33 Review scheduled for 9/4/2009. At that time, SERO requested the historical file and began the formal review. DHS was advised to

call ChildLine to report this as a Near Fatality. SERO received notification from ChildLine on 9/3/2009 that this was being certified as a Near Fatality.

Statutory and Regulatory Compliance issues:

- DHS needs to continue its transfer of learning for Safety Assessment. This case demonstrated that DHS workers need further assistance in use of the Safety Assessment tools.