



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: August 8, 2009
Near- Death Incident: September 19, 2009

FAMILY KNOWN TO:
THE DEPARTMENT OF HUMAN SERVICES

REPORT DATED 2/16/10

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 [REDACTED] 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 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>
[REDACTED]	victim child	08/08/2009
[REDACTED]	mother	[REDACTED] 1989
[REDACTED]	father	[REDACTED] 1988
[REDACTED]	sister	[REDACTED] 2008

NON-HOUSEHOLD MEMBERS:

[REDACTED]	paternal grandfather	[REDACTED]
[REDACTED]	paternal great grandmother	[REDACTED]
[REDACTED]	paternal great grandfather	[REDACTED]
[REDACTED]	paternal great aunt	[REDACTED]
[REDACTED]	paternal great uncle	[REDACTED]

Notification of Fatality / Near Fatality:

On 9/18/09 the Department of Human Services received a [REDACTED] report alleging that [REDACTED] sustained several injuries. Five-week-old [REDACTED] had bruises covering his face, [REDACTED] and a [REDACTED], [REDACTED] was transported to St. Christopher's Hospital for Children by ambulance. Upon [REDACTED] arrival to the hospital, he coded several times and was revived through CPR. When the parents [REDACTED] and [REDACTED] arrived to the hospital they refused to give an explanation for the injuries. [REDACTED] suffered from fractures to the [REDACTED]. [REDACTED] was [REDACTED] and considered to be in critical condition. [REDACTED] was in [REDACTED] and determined to be near fatality.

Documents Reviewed and Individuals Interviewed:

For this review the Southeast Regional Office reviewed the record for the victim child [REDACTED] and his sibling [REDACTED]. DHS included the investigation/ assessment structured case /progress from 4/18/2008 through 10/01/09. DHS included the following documentation; criminal court decisions, medical records, family service plans, safety assessments, Tabor Services, risk assessments, legal documents, photographs, [REDACTED].

The Southeast Regional Office interviewed DHS SW, who has previously worked with the family and is still employed by the agency. The regional office also interviewed DHS Operations Director, Senior Attorney, Multi Disciplinary Team Social Worker, Medical Examiner, DHS Administrator, DHS Social Worker Supervisor and DHS Nurse and attended the County's Internal Fatality Review Meeting regarding this case on October 16, 2009.

Case Chronology:

Previous CY involvement

The family became known to DHS on April 8, 2008 as a result of a [REDACTED] report alleging that the mother, [REDACTED] and the father, [REDACTED] transported their child [REDACTED] (5 weeks old, the victim child's sister) to Holy Redeemer because [REDACTED] legs were swollen and tender. The bone scan reported [REDACTED] had suffered from numerous injuries. The hospital was unable to determine how old the injuries were. [REDACTED] had suffered from a [REDACTED], a [REDACTED], a [REDACTED] was examined for further injury and transported to St Christopher's Hospital for Children. It was also reported that the parents, [REDACTED] did not have an explanation of the injuries. The parents reported their daughter [REDACTED] had been very fussy. The parents thought she was suffering from gas, they attempted to lay her on her stomach and her back and realized her leg did not look right. The parents reported there were no other children in the home and there were no other persons responsible for [REDACTED]. The father asked the doctor if the injuries could have occurred as a result of dressing their daughter. The mother was responsible for [REDACTED] during the day. The mother reported she had no idea had the injuries occurred. The father worked from 9am until 5pm every day. The doctor at St. Christopher's Hospital asked the father if the mother was [REDACTED] since she had the baby and the father replied she was at first, but now she feels better. The doctor asked the mother if there could have been an accident and that's how the injuries occurred. The mother replied with a negative. The doctor closely observed the parents interaction at the hospital. The doctor reported when [REDACTED] was lying in her crib at the hospital and began to cry, the mother shoved the pacifier in her mouth. When the father went over to the crib the child stopped crying.

The parents denied causing [REDACTED] injuries. The mother suggested that [REDACTED] suffered from brittle bone disease and she needed to be tested. The medical staff and the social worker met and discussed medical plan for the child. After intensive testing the doctor reported that [REDACTED] had [REDACTED], a [REDACTED], a [REDACTED] in the [REDACTED] and in the same [REDACTED], and [REDACTED] but, possibly [REDACTED]. The hospital decided to perform another skeletal scan and were waiting for the [REDACTED] and the [REDACTED] to follow up with [REDACTED].

DHS conducted a safety assessment visit to the home. The parents could or would not explain the injuries of [REDACTED]. Therefore it was determined by DHS that [REDACTED] and [REDACTED] were unable to be care givers for [REDACTED]. She was unsafe living in the home with her parents. DHS had to petition the court for custody of [REDACTED].

Safety plan for [REDACTED] dated April 11, 2008. When discharged from the hospital she would reside with her grandfather and great grandparents. [REDACTED] was not to be left alone with her parents, [REDACTED] at anytime. On April 11, 2008 [REDACTED] was discharged to the care of grandfather, [REDACTED]. DHS Social Worker made the appropriate home evaluation and safety visits.

April 23, 2008 Special Victims Unit waiting results from test. Charges still pending.

April 28, 2008 DHS SW obtained an Order of Protective Custody for [REDACTED]. The case was [REDACTED] based on medical evidence and [REDACTED] suffered from severe pain and impairment. According to DHS, the detective from SVU notified the Office of District Attorney and additional information was needed prior to obtaining warrants for the parents. Subsequently, according to DHS only the mother was charged for the injuries involving with [REDACTED]. It was noted in the case record that the father was not at home at the time of the incident.

April 29, 2008 The Court lifted the OPC and the court ordered that [REDACTED] would remain with her grandparents and the parents [REDACTED] were allowed supervised visits with [REDACTED].

May 6, 2008 DHS implemented kinship care services through A Second Chance Inc

May 7, 2008 the court ordered the parents [REDACTED] and [REDACTED] to continue supervised visits with [REDACTED]. The Court ordered the parents to attend parenting skills classes. It was reported that [REDACTED] were married on May 6, 2008. The family reported to the Court [REDACTED] was scheduled for a full bone evaluation at Children's Hospital of Pennsylvania (CHOP). The family was paying \$3, 2000.00 for a [REDACTED].

On May 26, 2008 DHS discharged kinship services through A Second Chance, Inc. DHS implemented kinship care services through Tabor Children's Services Inc. A Second Chance, Inc. social worker and a Tabor Children's Services social worker met at the grandfather's home to conduct a safety assessment and transitional meeting. It was reported that the home was inspected and in compliance with Tabor Children's Services.

On June 3, 2008, a FSP meeting was held. DHS met with Ms. [REDACTED] and [REDACTED] to discuss and sign the FSP. The objectives were to: 1) not leave [REDACTED] alone at any time; 2) ensure that [REDACTED] was left only in the care of responsible caretakers; 3) provide [REDACTED] with regular nutritious meals; 4) Ensure that [REDACTED] was clean and properly clothed; 5) allow the Children Youth Division authorization to obtain copies of progress reports; 6) make sure that [REDACTED].

received appropriate medical examinations; and 7) comply with all recommended treatment. In addition, Ms. [REDACTED] and [REDACTED] were to: 1) were to meet with the provider social worker to understand how [REDACTED] was injured on a monthly basis; 2) refrain from any physical discipline; 3) learn non-physical methods discipline for [REDACTED] and 4) maintain a relationship with [REDACTED] through participation in placement activities and regular visitation. The grandfather will supervise the visits with the parents.

On July 1, 2008 the social worker from Tabor services made a home visit. According to the Social Worker's structured case notes [REDACTED] appeared safe and happy.

July 3, 2008 DHS reported [REDACTED] appeared healthy and well and that there did not appear to be any signs of abuse. The grandfather appeared to be meeting [REDACTED] needs. The parents were referred to the Achieving Reunification Center (ARC).

July 23, 2008 the [REDACTED] reported to DHS SW the test for [REDACTED] having brittle bone disease was negative. In addition, the [REDACTED] reported the mother was verbally aggressive to [REDACTED] while she was crying. The mother told [REDACTED], if you do not stop crying, I will kill you.

July 24, 2008, an adjudicatory hearing was held for [REDACTED]. The parents were ordered to attend ARC and the supervised visits were modified to one hour weekly. Safety visit conducted, the parents' protective capacities were still diminished. The parents could not explain [REDACTED] injuries. The Court ordered [REDACTED] to remain with the grandparents.

On August 13, 2008, DHS reported the Detective with Special Victims Unit stated the criminal charges were still pending and the plan was to charge the parents. The preparation of affidavits and warrants was imminent.

According to DHS documentation there was an Individual Service Plan /Quarterly Report from September 28, 2008 to December 2008, it reported that [REDACTED] and [REDACTED] consistently attended all of the family visits and their interaction with [REDACTED] was appropriate. It was noted that during this time period, [REDACTED] needed to complete Family School. The parents were referred to Family School and required to complete [REDACTED] and [REDACTED] classes at ARC.

On October 18, 2008, [REDACTED] was arrested and charged with intentional possession of a controlled substance by persons regulated. On May 15, 2009, the charges were withdrawn and the criminal case was closed.

November 17, 2008 Adjudicatory hearing held for [REDACTED]. The Court made a [REDACTED] [REDACTED] while in the care and control of her parents. [REDACTED] was committed to the care of DHS and to remain under the care and custody of her kinship grandfather.

It must be noted that on September 3, 2009, the Court discharged the commitment to DHS, terminated placement and ordered DHS to supervise. It was reported to the Court that the parents Ms. [REDACTED] and [REDACTED] attended Family School and that Ms. [REDACTED] attended [REDACTED]. The Court ordered that the mother was to continue to attend Family School, and the father was excused from further attendance at Family School, and the mother was to continue to attend [REDACTED]. The Judge ordered that [REDACTED] was to return to the care of the mother on that day. The child advocate objected. The Judge ordered that DHS was to implement [REDACTED]. The Court confirmed custody of [REDACTED] to her mother, [REDACTED].

DHS discharged kinship care services and implemented aftercare services through Tabor Children Services Inc.

Circumstances of Child's Fatality or Near Fatality

The Victim Child [REDACTED] was born on August 08, 2009. [REDACTED] was reunified with their parents, [REDACTED] and [REDACTED] on September 3, 2009.

On September 18, 2009 DHS received a [REDACTED] report alleging that [REDACTED] sustained several injuries. It was reported that [REDACTED] had bruises covering her face, [REDACTED] and a [REDACTED]. [REDACTED] was transported to Saint Christopher's Hospital for Children by ambulance. Upon [REDACTED] arrival to the hospital he coded several times and was revived through CPR. When the parents, [REDACTED] and [REDACTED] arrived to the hospital they refused to give an explanation for [REDACTED] injuries. It was reported that the parents had sought legal representation and they were instructed not to talk to DHS. The attending physician at St. Christopher's Hospital reported they were unable to give a prognosis at the time of the incident. Testing would be performed on [REDACTED] when he becomes more stabilized. The parents told medical staff that the dog fell on [REDACTED] leg approximately three weeks ago and the parents did not seek medical attention for [REDACTED]. The attending physician stated the parents told him before the ambulance arrived they attempted to shake [REDACTED] to make him breathe. [REDACTED] was in critical condition and in the [REDACTED] case was determined a near fatality.

A supplemental report dated September 18, 2009 was generated to DHS. It was reported that the sibling [REDACTED] lives in the home and she could still be in danger.

DHS made a safety visit to the hospital to assess the children's safety. DHS SW requested that [REDACTED] be examined as a result of [REDACTED] injuries. The medical staff reported [REDACTED] suffered from [REDACTED] a [REDACTED] a [REDACTED] and blood on the brain and that the injuries were old and healing. [REDACTED] suffered from at least [REDACTED] and was without oxygen for 30 minutes. It was reported that [REDACTED] would probably suffer from [REDACTED]. It was reported that the family refused to talk to the police. The police stated they were going to search the parent's house.

The DHS Social worker discussed the family's history with the hospital social worker and the SVU detective. The DHS SW explained to the parents [REDACTED] and [REDACTED] that [REDACTED] would have to be placed to ensure her safety. The parents requested that [REDACTED] be returned to the care of her paternal grandfather. DHS SW informed the parents that [REDACTED] would need to be examined in the ER to be medically cleared. [REDACTED] had two [REDACTED] which were two centimeters in length, on the back of her neck and a [REDACTED] which was one and half centimeters round, on the back of the right mid thigh. It was reported that [REDACTED] [REDACTED]

The safety assessment was [REDACTED] was conditionally safe in the hospital. The safety plan for [REDACTED], she will be returned to the home of her grandfather, Mr. [REDACTED]. According to the documentation Ms. [REDACTED] were not cooperative with the medical staff in supplying information. In addition when the DHS SW questioned them about the injuries they responded by stating their attorney told them not to speak with DHS or the Police.

On September 18, 2009 DHS SW requested an Order of Protective Custody (OPC) was obtain for [REDACTED]. The Judge gave a verbal consent for the Order of Protective Custody (OPC). According to DHS, the grandfather allowed the parents to spend unsupervised time with [REDACTED]. This information was communicated to the Judge and he issued an order for the child to be placed in a foster home. The SW and DHS Supervisor agreed that [REDACTED] would be placed in regular foster care as a safety measure. [REDACTED] was placed in a Tabor Children's Services Inc. foster home on September 18, 2009. It was reported when it was time to escort [REDACTED] to her foster care home, the father was resistant to giving [REDACTED] to DHS and security had to restrain him

On September 21, 2009 there was a shelter care hearing held for [REDACTED]. The Judge lifted the OPC, discharged DHS supervision and recommitted [REDACTED] to the care and custody of DHS. It was reported to the Court that [REDACTED] was presently in a Tabor Children's Services, Inc foster home. The Court ordered that [REDACTED] was to be returned to her grandfather [REDACTED]. The Court ordered that the parents, Ms. [REDACTED] and [REDACTED] were not allowed to visit [REDACTED] or [REDACTED] in the hospital.

On September 24, 2009, a hearing was held for [REDACTED]. It was reported to the Court that [REDACTED] was hospitalized at St. Christopher's Hospital for Children. The Judge ordered the parents to submit [REDACTED] and participate in assessments. The Judge ordered the parents not to make contact with [REDACTED] or allowed to speak with the hospital staff. The parents were only allowed to make an end of life decision for [REDACTED] under the supervision of DHS.

On October 5, 2009 at a hearing for [REDACTED], the Judge ordered the temporary commitment to DHS to stand and the stay away order against the parents. The Court found that the parents were in criminal contempt of Court for visiting [REDACTED] at St. Christopher's Hospital for Children and were to be incarcerated for 72 hours.

Current / most recent status of the case:

On January 16, 2010, Ms. [REDACTED] and Mr. [REDACTED] was arrested and charged with two counts of aggravated assaults; two counts of endangering the welfare of children, parent /guardian commits offense two counts of simple assault-grading-victim under 12, defendant 21 or older; two counts of recklessly endangering another person and simple assault. Bail was posted for Ms. [REDACTED] on January 17, 2010. Some of the charges were changed or withdrawn. Ms. [REDACTED] criminal matter was scheduled for October 14, 2010. According to DHS the parents are presently incarcerated.

There was a status Hearing for [REDACTED] and [REDACTED] on April 1, 2010. The next Court Hearing is schedule for May 5th 2010, the Court will rule on the contested goal change for [REDACTED]. There is a stay away order in place for both parents [REDACTED].

Services to children and families:

- The mother and father, Ms. [REDACTED] were charged with counts of aggravated assaults; two counts of endangering the welfare of children, parent /guardian commits offense two counts of simple assault-grading-victim under 12, defendant 21 or older; two counts of recklessly endangering another person and simple assault. According to DHS, both parents are presently incarcerated. [REDACTED] is adjusting well and living with a two parent foster home services are provided through Tabor Services Inc. The grandfather [REDACTED] has supervised weekly visits with [REDACTED].
- [REDACTED] is receiving residential services through Kencrest. .

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

- The [REDACTED] investigation regarding [REDACTED] injury was conducted in a thorough manner.

Deficiencies:

- The Act 33 Team found that DHS violated its safety assessment policy in this case when the DHS social worker did not conduct an in home safety assessment for this family after the birth of [REDACTED] and did not conduct an in home safety assessment when [REDACTED] was returned to her parents.

- The Act 33 team found that DHS had failed to review and revise the Family Service plans as required.
- The Act 33 team found there were no progress notes in the DHS file from 2009 except for those related to the injury to [REDACTED]
- The Act 33 team found there was no documentation of supervisory reviews.
- The Act 33 team found the referral for [REDACTED] was not made as required by DHS policy. There were no in home services for the children.

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.

- Mother had an [REDACTED] case and criminal charges still pending for the physical abuse of her first born child [REDACTED]. [REDACTED] was reunified with the parents [REDACTED]. The Act 33 team recommended a policy or quality review to ensure that parents with pending criminal charges are not reunified with their children [REDACTED].
- The Act 33 team recommends that DHS revise the Performance Based Contracting standards to require the foster care social worker to service all children that live in the home with the parents.
- The Act 33 recommends that DHS social workers should be required to consult with the Behavioral Health and Wellness Center psychologists for an addendum to a psychological evaluation prior to reunification.
- The County should conduct random case file reviews to identify the more complex cases specifically the cases with infant children.

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. The case file was missing documentation for the time period of 4/08/08 through 8/08/09. When the issue of coverage (or lack thereof) was discussed during the Act 33 review meeting—there was no justification provided. DHS administration commented on disciplinary actions resulting from the disregard. The cover letter for the Act 33 Review identified "failed performance throughout the chain of command".

Deficiencies

- Internal safety Visits were not conducted as required.
- The Court ordered DHS to refer the parents to [REDACTED]. The referral was not completed within 24 hours.
- DHS testified in Court that the parents completed all their goals, the parents were uncooperative and refused to identify how [REDACTED] sustained her injuries. The

parents may have cooperated with the request of the Court and attended Achieving Reunification Center, Family School, and received services focused on anger management, parenting, money management, [REDACTED] and [REDACTED] the parents continued to deny and refuse to identify how [REDACTED] was injured. The parents did not fully demonstrate that they were capable of ensuring the well being and safety of their children. According to the documentation and interviews, the parents refused to give an explanation on how [REDACTED] and [REDACTED] were injured. Therefore their protective capacities were diminished and both children remained at risk.

Statutory and Regulatory Compliance issues

- 3130.31(2) (ii) (b) [REDACTED] was born on August 9, 2009. DHS failed to conduct the interval home safety assessment within the required time frame.
- 3130.43. (b) (7) -Relevant documentation was not included in the case file. The record did not identify the mother's pregnancy with [REDACTED]
- 3130.31-The record did not include documentation that supervisory reviews were held as required.
- 3130.63(a)-The Family Service Plans were not revised and updated as required.