



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

*Raheemah Shamsid-Deen Hampton*  
*Managing Director*  
*Southeast Region*

801 Market St., 6<sup>th</sup> floor  
Suite 6112  
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823  
Fax: (215) 560-6893

**REPORT ON THE NEAR FATALITY OF**



**BORN: 6/16/2009**  
**DATE OF NEAR DEATH INCIDENT: 12/18/2009**

**FAMILY NOT KNOWN TO ANY COUNTY OR  
PRIVATE CHILD WELFARE AGENCY**

FINALIZED DATE 06/07/2010

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 [REDACTED] on July 3, 2008, and went into effect 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:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	6/16/2009
[REDACTED]	Sibling	[REDACTED]/2008
[REDACTED]	Mother	[REDACTED]1989
[REDACTED]	Father	[REDACTED]/1988

**Other family members**

[REDACTED]	Caregiver for [REDACTED]	[REDACTED]1964
[REDACTED]	Caregiver for [REDACTED]	[REDACTED]1963
[REDACTED]	Maternal grandfather	[REDACTED]1957
[REDACTED]	Maternal grandmother	[REDACTED]1958
[REDACTED]	Paternal grandfather	

**Notification of Fatality / Near Fatality:**

On 12/18/2009, DHS received a call concerning six month old [REDACTED]. [REDACTED] was admitted to the [REDACTED] of Children’s Hospital of Philadelphia (CHOP) with a [REDACTED] and a lot of [REDACTED]. At this time, the report was numbered for [REDACTED]. The parents could not provide an explanation for the injuries. A supplemental report came in to ChildLine on 2/1/2010. This report stated that Dr. [REDACTED] of CHOP certified this case as a Near Fatality on 1/29/2010.

**Documents Reviewed and Individuals Interviewed:**

For this review, the SERO reviewed the family’s DHS case file, the special victim’s unit interviews and the medical records.

SERO attended the County’s Act 33 Review Meeting regarding this case on 2/19/2010. Follow up questions were asked of county caseworker and supervisor during the Act 33 review.

**Previous CY involvement:**

No previous CY involvement.

### Circumstances of Child's Fatality or Near Fatality:

Review of the medical files from CHOP indicates three visits to the ER after her birth. On 6/19/2009, when [REDACTED] was only three days old, her parents brought her to the ER at the direction of their primary care physician (PCP) after blood work came back with [REDACTED] levels. At that time, medical records documented that [REDACTED] appeared alert and awake, with no acute distress, but her skin was [REDACTED]. Blood was drawn during this visit. She was [REDACTED]. She was discharged on the same day.

On 9/27/2009, [REDACTED] was seen at the ER because of vomiting for more than 12 hours. [REDACTED] was diagnosed with reflux. The parents were given instructions on feeding, and advised of symptoms to look for which should necessitate another ER visit or contact with their PCP. These symptoms included: unable to keep down formula or Pedialyte, half the number of wet diapers, fever of 101.5, diarrhea, projectile vomiting, more sleepy or lethargic than usual. [REDACTED] was discharged on the same day.

On 10/7/2009, [REDACTED] was brought to the ER at CHOP with her left ear leaking blood. The resident observed a rash on her face and body. She was diagnosed with dermatitis, [REDACTED] A [REDACTED] was collected at this time.

The parents reported that when they took their daughter for her 4-month well baby check in October 2009 to their PCP, Dr. [REDACTED], they voiced their concerns about the baby's head being large. (DHS did not have copies of records from the PCP, so exact date is unknown. This information comes from the medical records at Children's Hospital of Philadelphia.) An ultrasound was completed by the pediatrician. The pediatrician ordered a CT Scan in October. Because [REDACTED] has a heart murmur, the cardiologist had to clear her medically before the CT Scan could take place. [REDACTED] also became sick with a cold, which further delayed the scan.

[REDACTED] was medically cleared on 12/18/2009, and had the CT Scan on that date. The CT Scan showed [REDACTED] was immediately admitted to the ICU. X-rays determined that [REDACTED] also had [REDACTED] had [REDACTED] and remained hospitalized. The mother's explanation for the injuries was that the 20 month old brother frequently throws his toys; the mother remembers an object hitting the baby, but does not remember a date and did not mention whether the child cried at that time. The mother also described an instance when she woke up one night to find the victim child crying, and found her head was hanging half way off the mattress. The mother works full time; the father works part time. The children are primarily left in the care of the maternal grandmother, but the paternal grandfather has occasionally cared for [REDACTED]

On 12/22/2009 [REDACTED] was discharged from the hospital. Because the parents could not explain the injuries [REDACTED] sustained, DHS obtained an Order of Protective Custody (OPC) [REDACTED]; she was placed in a [REDACTED] through Bethanna.

On 12/22/2009, DHS instructed the parents to have [REDACTED] evaluated medically. The father brought [REDACTED] to the [REDACTED] at CHOP on that date. No medical concerns were identified. DHS informed the parents that [REDACTED] needed to reside outside their home during the investigation. DHS requested the name of a family member. After obtaining clearances and assessing the home, [REDACTED] was placed on 12/23/2009 through a family agreement with a family member.

On 12/23/2009, the DHS social worker interviewed the maternal grandmother through a language interpreter. The maternal grandmother said that she babysits the children during the day. She could not recall the date when she noticed a big lump on [REDACTED]'s head. She did identify several other children/adults who are in her home when she is babysitting: daughter, [REDACTED] (24 years old), daughter, [REDACTED] (27 years old), daughter, [REDACTED] (16 years old), son, [REDACTED] (22 years old), and son, [REDACTED] (28 years old). Social worker interviewed [REDACTED], the only one of her children who was home during the meeting. He said that he did not know any of the details of [REDACTED] being hurt.

On 12/30/2009, the foster parent provided an update to the DHS worker on [REDACTED]'s medical condition. [REDACTED] has two different shunts that drain into her abdomen. She feeds normally, but is displaying some rigidity. She is to be evaluated through Early Intervention. [REDACTED] appears to be very fussy, crying and screaming. Aftercare appointments for the shunts will be in January 2010. Foster mother had concerns that [REDACTED] left eye seemed off center and the left cheek muscles do not seem to be forming like the right side of her face. Biweekly visitation with the parents was discussed, alternating between Lancaster (location of foster home) and Philadelphia.

On 12/31/2009, the DHS worker spoke with a nurse at the ER about [REDACTED] x-rays; no broken bones were identified. On 1/4/2010, the social worker made an unannounced visit to the relatives where [REDACTED] was staying. The caregiver reported that [REDACTED] appeared to be healthy. The social worker observed that there were no safety concerns in the home.

At court on 1/19/2010, it was ordered that [REDACTED] should be placed with his sister. The placement with family friends had only been a temporary arrangement for the course of the [REDACTED] investigation. The court made a finding of child abuse and aggravated circumstances based on testimony of the DHS. DHS was ordered to continue to make reasonable efforts towards reunification. [REDACTED] was able to place [REDACTED] in the same foster home as his sister. [REDACTED] did not cry or appear sad to leave the kinship home. When [REDACTED] was brought to the foster home, [REDACTED] had been re-hospitalized at CHOP with [REDACTED] issues.

On 1/26/2010, the DHS social worker spoke with a DHS nurse about the possibility of this case being a Near Fatality. Contact was made with CHOP: Dr. [REDACTED] believed that this was a Near Fatality. DHS contacted ChildLine 2/1/2010 about the Near Fatality status.

**Current / most recent status of case:**

- DHS determined this report as [REDACTED] for both parents on 1/28/2010.
- [REDACTED] is receiving services through [REDACTED], and medical services through CHOP. [REDACTED] are being discharged August 2010. [REDACTED] will be discharged in September 2010.
- At the court hearing on 6/17/2010, the judge [REDACTED]. The judge further determined that aggravated circumstances exist and ordered DHS to work towards Reunification. During this court hearing, it was further ordered that the parents complete a parenting capacity. They have completed Part 1, and are waiting for Part II to be scheduled.
- The permanency goal is reunification, with the concurrent goal of Adoption. [REDACTED] The parents have not missed any visits. Visits occur every two weeks, alternating between the Lancaster office and the Philadelphia office. They have met all other goals. The mother is very active in [REDACTED] medical care, and attends all medical appointments. She advocates for her needs with the doctors. [REDACTED] is progressing well. She has had three brain surgeries related to her [REDACTED] and a [REDACTED]. For the [REDACTED], she had part of her [REDACTED] removed to lessen the [REDACTED]; this [REDACTED].

**Services to children and families:**

- Both children are in the same foster care placement through Bethanna.
- Parents have been referred to ARC (Achieving Reunification Center).

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

**Strengths-**

- Act 33 Review team believed that the social workers did a thorough investigation. The Safety Plan was completed comprehensively.
- Act 33 team believed that DHS did a good job in developing a safety plan for [REDACTED] and her sibling. DHS conducted unannounced visits to the kinship caretaker to assess safety.
- [REDACTED] Interpreter services were effectively used to communicate with the family who speaks [REDACTED].
- As outlined in previous Act 33 Reviews, the social worker conferenced the case with one of the DHS nurses.
- The Act 33 team noted good collaboration between the social worker and the chain of command, which resulted in effective planning for the case.

- A delay was noted in certifying this case as a near fatality. The delay was partially caused by the physician's uncertainty of the severity of [REDACTED] injuries. DHS also contributed to the delay by not following up with the doctor.

#### Deficiencies-

- DHS did not obtain medical records from the child's PCP; they also did not address the ER visits made by this family prior to the Near Fatality. This little girl had multiple medical problems that could have contributed to caretakers' frustrations with her daily care.

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

- Act 33 team recommended that DHS staff be formally trained on near-fatalities. This training should include how and when to discuss near-fatalities with hospital physicians.
- Act 33 team recommended that child abuse physicians from CHOP and St. Christopher's meet to develop a consensus of what is being certified as a near fatality.

#### SERO Findings:

##### County Strengths-

- Use of interpreter services to communicate with family members who speaks only Cantonese.
- DHS was in compliance with the Risk and Safety Assessment policies.
- The [REDACTED] investigation was thorough and comprehensive.

##### Deficiencies-

- In their strengths section, DHS noted a delay in certifying this case as a near fatality. The delay was partially caused by the physician's uncertainty of the severity of [REDACTED]'s injuries. DHS also acknowledged their contribution to the delay by not following up with the doctor.

#### Recommendations for Changes:

- During the county reviews, there is frequent dialogue about the discrepancy between the medical definition of near fatality and the Act 33 definition. The Act describes a near fatality as a child being in serious or critical condition, but physicians do not necessarily consider this as a near fatality. While DHS is to be commended for addressing this with their two primary hospitals, OCYF should also address this issue on a state-wide basis with review of training opportunities through the American Academy of Pediatrics and at the local levels with physicians and other medical professionals.