



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Fatality OF:

Izell Greer

BORN: 10/09/2009

DIED: 4/9/2011

**FAMILY WAS KNOWN TO PHILADELPHIA DEPARTMENT OF
HUMAN SERVICES**

REPORT FINALIZED ON:

07/05/11:

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. 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 convened a review team in accordance with Act 33 of 2008 on 5/6/2010.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Izell Greer	Victim child	10/09/2009
[REDACTED]	Mother	[REDACTED]/1988
[REDACTED]	Father	[REDACTED]/1986
[REDACTED]	Sister	[REDACTED]/2011

Notification of Child (Near) Fatality:

On 4/09/2011, the Philadelphia Department of Human Services (DHS) received a report of [REDACTED] concerning 17 month old Izell Greer. The father was named as the [REDACTED]. Izell had been brought to Torresdale Aria Hospital. The father reported that the child's [REDACTED] had fallen out while he was sleeping. The father realized that child was in distress and tried to resuscitate him, and called 911. Izell was pronounced dead at Aria Torresdale.

Izell had multiple medical problems and received [REDACTED]. The family had cancelled the nurse for the night, reporting that they just wanted some family time. Both parents were extensively trained on the child's medical equipment. Izell should have been connected to the [REDACTED]

Summary of Department of Public Welfare (DPW) Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. The regional office also participated in the Philadelphia DHS Act 33 Review Team meeting on 5/6/2011 where the medical examiners reports and autopsies were discussed.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

11/17/2009

Izell was born with [REDACTED]

[REDACTED]. Izell continued in the [REDACTED] of St. Christopher's Hospital after birth because of his need for ongoing medical care. In November of 2009, a [REDACTED] was received alleging medical neglect. Concerns were raised that the mother was not cooperative with the use of the [REDACTED] as the mother did not fully understand the medical necessity. The mother reported to the DHS worker that she believed that the hospital was not explaining clearly to them about her son's medical needs. This referral was received while Izell was in the [REDACTED]. The allegations also included that the mother had issues of [REDACTED], and that domestic violence existed in the family.

While Izell was hospitalized, the mother had appeared intoxicated at the hospital on 11/2/2009. The parents admitted to being under a great deal of stress as a result of having a medically needy newborn. The mother acknowledged that she had been inappropriate when she went to see her son on that date, but she had just wanted to spend time with her son that night after celebrating her 21st birthday. The mother stated that she had never acted this way before and said that she would never act this way again. The [REDACTED] notes indicated that the mother reported that the hospital staff did not fully explain the need for the [REDACTED]. Hospital staff reported that the mother was visiting her child daily and hospital staff observed that she and the father were very appropriate in their interactions with their son. The DHS case notes indicated that the parents were observed to be providing appropriate care for Izell. These [REDACTED]. Additionally, Izell [REDACTED] on 12/22/2009 to [REDACTED]. He also needed to gain weight before he could be discharged from the hospital. Izell was [REDACTED] the hospital in January 2009.

Circumstances of Child Fatality and Related Case Activity:

Current Case Status:

During this [REDACTED] it was determined that the father had fed Izell then sat down in a chair while holding him. They had both fallen asleep. The initial report indicated that the father and child were co-sleeping, but subsequent [REDACTED] did not support this allegation. The initial report indicated that on the night of 4/9/2011, the parents had been sleeping on a mattress on the floor. When Mr. [REDACTED] woke up about three hours later, he discovered that Izell was not on the mattress and that his [REDACTED] was dislodged. The father was unable to replace the [REDACTED] and was unsuccessful at resuscitation; he called 911. Izell was transported to Aria Health Torresdale. Izell was to [REDACTED].

The DHS worker interviewed both parents, and obtained medical documentation. It was determined that the father had fed Izell then sat down in a chair while holding Izell. They had both fallen asleep. The father was awakened about 4:30 pm by a phone call from his wife. He observed Izell about a foot and a half away from him on the floor, and noted that he was not breathing. He called to Izell, hit Izell's feet, and then tried to [REDACTED]. He attempted to resuscitate him. A neighbor called 911 as

the father's cell phone was dead. CPR was administered until the paramedics arrived. The family had visiting nurses from two different agencies for 16 hours per day. Interviews with the visiting nurses revealed that Izell was an active child who had begun pulling out his [REDACTED]. The nurses were working with the doctors to wean Izell off [REDACTED]; he was to be on it if he was sleepy or in distress. It was determined through the [REDACTED] investigation that the father had not intended that he would fall asleep while holding Izell and the investigation was determined to be Unfounded on 5/6/2011 as the child's death was not the result of abuse or neglect.

During the investigation, on 4/16/2011, a baby girl, [REDACTED], was born to [REDACTED]. A safety assessment was completed on 4/19/2011. The Safety Assessment identified that Safety Threats were present in that, the father's behavioral and cognitive capacities were diminished in regards to Izell as the father had not used the [REDACTED], as well as the caregiver cannot or will not explain the injuries to the child, and the caregiver cannot or will not meet the child's special, physical, emotional, medical and/or behavioral needs. These threats were identified as it was initially reported that the parents were not correctly using the necessary medical equipment which may have contributed to the child's death. [REDACTED] was determined to be safe. DHS determined that the parents seemed capable of caring for a healthy newborn. DHS confirmed that the parents took [REDACTED] to her initial well baby checkup with her primary physician.

The parents received [REDACTED] from the Medical Examiner's (ME's) office. DHS also referred them to community based services for more [REDACTED] as needed.

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

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 convened a review team on 5/6/2011.

- Strengths:
- Thorough investigation
- Allowing parents time to grieve as they requested, but completing timely investigation
- Good documentation
- Safety assessment of baby born during investigation

- Deficiencies:
- The Safety Assessment noted that the baby was "Safe with a Plan", but no plan was attached. It was noted during the Act 33 Review that this notation was a typographical error.

- Recommendations for Change at the Local Level:
- No changes recommended

- Recommendations for Change at the State Level:
- No changes recommended

Department Review of County Internal Report:

- When signing the safety assessment, supervisors need to be discussing the decision with the worker and ensure that appropriate designation is noted.

Department of Public Welfare Findings:

- County Strengths:
- Respectful of family's grieving process
- Prompt safety assessment of newborn sibling

- County Weaknesses:
- In October 2009, DHS implemented the practice of using consultation with the DHS nurses in medically complex cases. This practice would have been very useful with this family's first referral and with this current investigation.

- Statutory and Regulatory Areas of Non-Compliance:
- None noted

Department of Public Welfare Recommendations:

This case points to the need for county staff to have training related to investigations of medically involved children. Not all counties have medical staff, so it is important that counties also have protocols or processes in place to assist their workers when investigating medically involved children. It was through the interviewing of the medical agencies serving this family that DHS was able to learn what the child's plan of care included, i.e., that he was [REDACTED] so the parents were not neglectful when the child was not on the equipment. County workers need to understand that when completing investigations involving medically needy children, the county worker must secure medical information and interview medical professionals to ensure that the determination is based on a clear picture of the situation.