



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF**

**EGYPT THOMAS**

**Date of Birth: 08/21/2008**

**Date of Death: 01/04/10**

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

**REPORT DATED September 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 into law 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:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Thomas, Egypt	Victim Child	08/21/08
[REDACTED]	sibling	[REDACTED] 2006
[REDACTED]	mother	[REDACTED] /1987
[REDACTED]	maternal grandmother	[REDACTED] /1971
[REDACTED]	maternal great-grandmother	

\*For clarity and identification purposes when referring to Egypt's mother [REDACTED] grandmother, [REDACTED] and great-grandmother [REDACTED], they will be referenced as mother, maternal grandmother and maternal great-grandmother in parenthesis before their name.

**Notification of Fatality:**

On January 4, 2010 at 4:15pm Egypt was brought into the Children's Hospital of Philadelphia (CHOP) and pronounced dead at 4:15 pm. Her mother, [REDACTED], arrived at CHOP and passed out and was transported to Presbyterian Hospital. She was admitted into Presbyterian Hospital from a [REDACTED]; she was unresponsive due to the [REDACTED]. The initial report stated that Egypt had bruises all over her body. The bruises were found by the hospital, however the medical examiner stated Egypt had some bruising, but not all over her body as stated in the original report. According to the medical examiner, Egypt had a severe case of diaper rash.

**Documents Reviewed and Individuals Interviewed:**

For this review the SEOCYF reviewed the complete Philadelphia Department of Human Services case file. The file included [REDACTED] investigations and reports; the reports were dated 02/13/2007 and 11/22/2007 regarding [REDACTED]. SEOCYF interviewed county investigation caseworker, as well as the on-going family caseworker. SEOCYF attended the Act 33 review held on January 22, 2010. During the Act 33 review the medical examiner reported Egypt's cause of death was Unexplained Sudden Infant Death.

**Previous CY involvement:**

Delinquent History of (mother [REDACTED]):

On March 14, 2002, [REDACTED] was arrested and charged with aggravated assault, simple assault, recklessly endangering another person and possessing instruments of crime. [REDACTED] received delinquent services through JJC from March 15, 2002 to April 10, 2002 and through the Youth Advocate Program from November 18, 2002 to July 1, 2003. This delinquent matter was discharged from Court on July 1, 2003.

On March 24, 2004, [REDACTED] was arrested and charged with marijuana for personal use in violation of the Controlled Substance Act and knowingly and intentionally possessing a controlled substance in violation of the Controlled Substance Act. This delinquent matter was discharged from Court on August 6, 2004

Prior DHS History:

On 2/13/2007, An [REDACTED] was received. The report was [REDACTED]. The report alleged that (mother), [REDACTED], had left her child, [REDACTED], in a Health Center #5 Medical Clinic. The mother and child were at the clinic for a well baby physical examination. It was stated that (mother) [REDACTED] had a history of acting very strange when she comes into the clinic. The DHS investigation discovered that the child was left in the clinic briefly with a responsible staff member. The staff member had willingly accepted responsibility for the care of the child while the mother went outside to make a phone call. Mother was gone for about fifteen to twenty minutes.

The investigation revealed that [REDACTED], a security guard at the medical center did accept the responsibility of caring for (mother) [REDACTED] daughter [REDACTED] while she went outside to make a phone call. [REDACTED] was in a stroller and [REDACTED] had taken her out of the stroller and put [REDACTED] behind the desk with him. According to the investigation, he did not think she was going to be gone for that long. She ended up being outside of the clinic for about fifteen to twenty minutes. [REDACTED] stated that (mother) [REDACTED] tried to leave her daughter with another staff member the same day to go outside and make a phone call. The doctor reported it because he believes the mother was exhibiting some bizarre behavior and he believed the mother was not going to return.

The investigation revealed the (maternal great grandmother [REDACTED], lives directly across the street from the clinic and would have been willing to accept responsibility of the child if necessary. A home visit was conducted in both the homes of maternal great grandmother and the home of [REDACTED]. At that time (mother) [REDACTED] was living in the home of her mother ([REDACTED]) there was no safety plan as the investigation determined that the child was safe. The case was [REDACTED] because the security guard confirmed that (mother) [REDACTED] did not leave her daughter in the clinic without supervision. The case was closed and referred

to Community Based Prevention Services for additional support. It was determined that (mother), [REDACTED], needed housing assistance, educational assistance, [REDACTED] and parenting skills. It should be noted that there is no documentation that the services were provided. The case was closed on 1/4/08 with the understanding the grandmother filed for custody of [REDACTED] and that mother would only have supervised visits with [REDACTED] and grandmother would ensure this. The grandmother refused kinship care services at this time.

On 11/22/2007 A [REDACTED] was received. This was reported by a family member. The report was [REDACTED]. The report alleged that (mother); [REDACTED], held [REDACTED]'s head under water and no one called in a report or took [REDACTED] to the hospital. [REDACTED] was a year old at the time of this incident. It further alleged mother left a bottle of Tylenol on the bed with [REDACTED] unsupervised. The (maternal grandmother), [REDACTED] and (maternal great-grandmother), [REDACTED] called the mobile team for assistance because (mother), [REDACTED] was [REDACTED] and they were afraid she might hurt the child. At that time (mother) [REDACTED] was hospitalized at Friends Hospital. The family was concerned about mother talking to herself and stating that people were out to get her. The family called to have (mother) [REDACTED] out of concern for her. Her diagnosis was [REDACTED]. It was reported by the Friends Hospital that (mother) [REDACTED] was discharged from the hospital on December 12, 2007 because she refused to take her medication and the hospital did not want to be responsible for her when her symptoms returned.

The investigation revealed that (mother) [REDACTED] was washing [REDACTED] hair, however not trying to harm her. This was determined through interviewing the (maternal grandmother) [REDACTED]. The safety plan for [REDACTED] was to place her in the care of (maternal grandmother), [REDACTED]. The Philadelphia Department of Human Services recommended that (maternal grandmother) [REDACTED] file for legal custody of [REDACTED], obtain a restraining order to keep (mother) [REDACTED] away from the child and she was offered kinship care. At that time (mother) [REDACTED] went to live with (maternal great-grandmother).

The family's case with Philadelphia Department of Human Services was closed on March 3, 2008. It is unknown when [REDACTED] was returned to her mother.

#### **Circumstances of Child's Fatality:**

On January 4, 2010 (maternal great grandmother), [REDACTED], came to the home of (mother), [REDACTED] to take her food shopping. When she arrived, she saw that the home was in disarray. She reports that mother was incoherent, mumbling under her breath and walking around wearing only her underwear. [REDACTED] (maternal great-grandmother) reports that she called (maternal grandmother), [REDACTED] to tell her that something was wrong with mother. She reports that she saw [REDACTED] walking around but did not see Egypt. She walked to the bedroom and called for Egypt, she did not see her. She looked by the crib and saw the child lying on the floor with the crib on top of

her. She picked Egypt up and felt that she was cold. She then called (maternal grandmother) [REDACTED] and told her that Egypt was dead. Maternal grandmother [REDACTED] told her to try to resuscitate the child and that she would call 911. Within minutes (maternal grandmother) [REDACTED] was at the home and shortly after the paramedics arrived. The paramedics arrived at the address of [REDACTED]. The paramedics reported that Egypt had been dead for an hour prior to their arrival. Egypt was 1 year and 4 months old at the time of the fatality. The safety plan for [REDACTED] at this time was placement in a foster home, with supervised visits with grandmother and great-grandmother.

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

**Investigation**

The [REDACTED] reveals the fatality was not a result of abuse or neglect. The cause of Egypt's death is unknown per Act 33 review. On January 13, 2010, the [REDACTED] investigation was [REDACTED] for bruises only. The case was [REDACTED]. The child was in the mother's care at the time of her death. The child was dead on arrival to the Hospital; the mother was hospitalized from a [REDACTED]. The [REDACTED] is (mother) [REDACTED].

During the Act 33 meeting it was disclosed that Egypt did not have bruises all over her body as initially reported. However, she did have a severe diaper rash. In Structured Case Notes dated 01/10/2010, Egypt had been treated by Dr. [REDACTED] who stated Egypt had to be treated for severe diaper rash caused by [REDACTED] in July 2009. Dr. [REDACTED] stated Egypt was brought in again in August 2009 and her notes state the baby's rash was healing significantly. Dr. [REDACTED] stated in August 2009 Egypt was prescribed A&D ointment to be used every time the baby's diaper was changed. Dr. [REDACTED] said in July, the prior physician thought the baby's rash may have been severe due to Zinc deficiency, but testing revealed the results were negative. Dr. [REDACTED] described the rash in August 2009 noting [REDACTED].

Dr. [REDACTED] stated Egypt was seen in her office on 10/6/2009 and had a full physical. It was then noted the pigmentation was less in that area. Dr. [REDACTED] reported that (mother) [REDACTED] was compliant with all medical appointments and there were no concerns regarding the children's care. The county has reported the (mother) [REDACTED] has recovered from being unresponsive and from the PCP drug overdose. The county does not have the date of her hospital discharge, they have requested medical records, and they have not received the records. In speaking with the present DHS worker on January 24, 2011, the Special Victims Unit did receive the hospital records of (mother) [REDACTED] however DHS did not receive the medical records. DHS has requested the records from Special Victims but has not received the records.

It was reported through the county that (mother) [REDACTED] still does not know what happened to Egypt. She made an attempt to attend the last Philadelphia Family Court Hearing regarding [REDACTED] on June 10, 2010. However, she arrived late to the

hearing, and the hearing was already completed. She became verbally aggressive in response to missing the hearing.

██████████ was discharged from foster care on February 19, 2010 and placed with her father, ██████████. Per Philadelphia Department of Human Services caseworker, father has been granted physical custody of ██████████. There is a stay-away order on (mother), ██████████.

In speaking with the present DHS social worker on January 24, 2011; it was reported that the medical examiner changed his initial finding of Unexplained Sudden Infant Death to Homicide. It was reported that after the medical examiner reviewed the taped interview of ██████████, it filled in some questions and it was determined that Egypt's death was a result of homicide. The medical examiner re-filed the previous death certificate which stated SIDS and reported homicide. ██████████ is presently incarcerated for homicide of Egypt Thomas. ██████████ reported that mother was kicking Egypt while she was on the floor. ██████████ reported that mother kicked Egypt on her thigh on her wrist on her cheek. ██████████ reported that mother messed up the whole house and flipped the crib over. ██████████ was interviewed by DHS as well as receiving a forensic interview, through Philadelphia Children's Alliance.

#### **Services to children and families:**

██████████ and her father received after care services for one year through Juvenile Justice Center. DHS was to monitor the following services; the father received parenting and ██████████ received supportive services regarding loss and separation from Egypt and her mother and grandparents. The effective date of the case closing was June 30, 2010.

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

##### **Strengths-**

The review team felt that the DHS Social Workers did a thorough job investigating this case.

The team felt that DHS used good judgment by not initially placing ██████████ with family members due to the nature of the incident and the fact that ██████████ was the only witness able to speak about what happened. In addition maternal grandmother did not follow through with obtaining legal custody of ██████████. The team was concerned about both the location and the frequency with which ██████████ had to be interviewed regarding the allegations. DHS was instructed to bring ██████████ to the Philadelphia Police Department Headquarters to be interviewed, where she was confronted by her family members in the parking lot. This potentially impacted the subsequent interview by the police detectives. ██████████ was then interviewed two more times in the foster home. ██████████ was able to give an account of what happened during an interview with the DHS social worker on 1/7/10.

- Please note that in follow up interviews with the DHS social worker on January 24, 2011, [REDACTED] statements did determine to have an impact on the medical examiner's investigation. The medical examiner determined the fatality a homicide based on reviewing the taped interview of [REDACTED]. He revised his finding and re-submitted a new death certificate that indicates homicide. Mother is incarcerated for the homicide of Egypt.

#### Deficiencies-

The team felt DHS should have ensured that custody of [REDACTED] had been transferred to (her maternal grandmother) [REDACTED] prior to closing her case out in 2007. The mother [REDACTED] was clearly unable to care for [REDACTED] and she was [REDACTED] with Egypt at the time of the case closure.

The (maternal grandmother), [REDACTED] petitioned Domestic Relations court for custody; however, according to the team's knowledge, custody was never granted. Structured case notes dated January 4, 2010, in which (maternal grandmother) [REDACTED] self reports that she had custody of [REDACTED] when she was one year old. At some unknown time she returned [REDACTED] back to her mother, [REDACTED]. Ultimately, both of the children ended up in their mother's care.

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

The Act 33 Review took place on January 22, 2010; the team recommended that DHS social workers be instructed to consult with the City of Philadelphia Law Department when trying to determine whether a dependency petition should be filed or whether a family should be instructed to pursue a custody order through Domestic Relations Court. This requirement could be added to the memo the Law Department distributed to staff regarding when to seek a legal consult.

The team recommended that the DHS Commissioner initiate a meeting with the Police Commissioner and the District Attorney about using Philadelphia Children's Alliance (PCA) for all forensic interviews of children in cases involving a fatality. There should be further discussion on interim solutions to appropriately handle all interviews with children and possibly explore how other jurisdictions use child-friendly facilities to interview children.

#### SERO Findings:

##### County Strengths-

The county investigations were timely and thorough. The structured case notes were comprehensive and included all necessary medical documentation regarding Egypt and [REDACTED]. The family members (maternal grandmother) [REDACTED] and (maternal great-grandmother) [REDACTED] were thoroughly interviewed regarding this incident as well as the history of (mother) [REDACTED]. The county did a thorough interview with [REDACTED]. The Social Worker used child friendly techniques to engage [REDACTED]. The

county made an appropriate referral to PCA so that [REDACTED] could receive a forensic interview.

The county explored [REDACTED] father as a resource and made a determination that [REDACTED] would be safe and nurtured with her father.

Deficiencies-

Based on (mother) [REDACTED] delinquent history as a minor and mental health history, SEOCYF agrees with the Act 33 team that the Philadelphia DHS should have ensured that full legal custody of [REDACTED] had been transferred to maternal grandmother prior to closing the case out in 2007. It appears that (maternal grandmother) [REDACTED] did not obtain full legal custody, as she would not have been able to obtain a restraining order for (mother) [REDACTED]. It is also clear that she did not have legal custody as [REDACTED] would not have been in the home at the time of the fatality.

**Statutory and Regulatory Compliance issues:**

There were no areas of regulatory non-compliance.

The Risk and Safety Assessment were completed in a timely manner.

Interviews were completed with all appropriate family members and collateral contacts.