



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 10/31/09

NEAR FATALITY: 1/29/10

**The family was not known to The Department of Human Services or other
child welfare services.**

Report Dated: 7/29/10

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 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>
██████████	victim child	10/31/09
██████████	mother	██████████89
██████████	father	██████████87
██████████	paternal grandmother	adult

Notification of Fatality / Near Fatality:

According to the ██████████ received by The Department of Human Services on 01/29/10, the alleged injuries were failure to thrive and multiple limb and rib fractures. On 01/22/10, the mother reported she transported the child to her wellness visit. The mother reported she told the doctor that ██████████ was not eating like usual and she was fussy and crying more than usual. The child was examined and weighed 8.12 pounds. The pediatrician determined the parents were mixing the formula incorrectly. The pediatrician scheduled a follow-up visit on 01/29/10. On 01/29/10, the parents returned to the pediatrician and ██████████ weight dropped to 8 pounds and the parents were instructed to take her to ER. The parents escorted ██████████ to St. Christopher's Hospital on the same day (01/29/10). She was examined and diagnosed with ██████████, ██████████ ██████████ and ██████████ to the body. The parents were unable to explain the injuries sustained by ██████████ She was ██████████ at St. Christopher's Hospital and she was expected to live.

Documents Reviewed and Individuals Interviewed:

For this review the Southeast Regional Office (SERO) reviewed and discussed the case with the Department of Human Services (DHS) Social Worker (SW). DHS submitted the case record to the Regional Office. The Regional Office interviewed ██████████ DHS SW, ██████████, DHS SW, ██████████ DHS SW and ██████████ Children's Choice SW. The Regional Office attended the County's Internal Fatality Review Meeting held on 02/19/10.

Previous CY Involvement:

This family was not known to DHS prior to the near fatality.

Circumstances of Child's Fatality or Near Fatality:

On 01/29/10 DHS received a ██████████ report that the child was admitted to St. Christopher's Hospital and diagnosed with ██████████ ██████████ and bruising on the body. DHS made an immediate safety visit to the

hospital to assess the child's safety and medical needs. It was determined that the child was safe in the hospital with a comprehensive safety plan. The parents signed the plan with the understanding they are not allowed to have unsupervised visits with their child during the [REDACTED] of the case. The hospital staff refused to sign the safety plan. The hospital staff stated they are unable to be responsible for the supervision of the parents. The hospital did agree not to [REDACTED] the child to the parents. According to the interviews and documentation, DHS interviewed the child's parents at the hospital. The parents denied causing physical harm to the child and were unable to give an explanation of the injuries inflicted by the child.

The mother reported to the DHS SW that there was one occasion that she allowed the neighbor to babysit for the child. The mother insisted that the child was only with the babysitter for ten minutes and there was "no way she could have done it". The mother reported the father is the primary caregiver of the child. The parents reported the child wasn't feeling well since she received her immunization shot on 01/22/10. The parents stated their child would usually drink 6 bottles a day, 5 ounces per bottle. The parents reported they were concerned because the child began to only drink 2 ounces out of each bottle. The parents stated the child was weighing 8.12 pounds. During the wellness visit, the doctor was able to identify that the parents were mixing the formula incorrectly. The parents were given a follow up visit on 01/29/10. The child returned 01/29/10; the doctor found the child's weight had dropped to 8 pounds. The doctor advised the parents to escort the child to the emergency room. The child was [REDACTED] to the hospital on 01/29/10 and the [REDACTED] was [REDACTED] and [REDACTED]. On 02/05/10 DHS obtained an Order of Protective Custody for the child. The medical staff reported the child needed surgery based on the injuries sustained. The medical team stated if the child didn't receive the surgery the child was in danger of paralysis.

According to the medical records from St. Christopher's Hospital for Children, the child was [REDACTED] to the hospital with noted bruises on her face and [REDACTED] as well as [REDACTED]. The child had a [REDACTED] (that had [REDACTED] with the [REDACTED] ([REDACTED]), and a [REDACTED] which [REDACTED] the [REDACTED]. There was a repeated [REDACTED] completed on 03/05/10. There were still multiple fractures including [REDACTED] that appeared older than the [REDACTED]. Her bones appeared minimally [REDACTED]. There is no obstruction narrowing the airway, which was an improvement from the previous test/images. There was marked healing of the [REDACTED]. The child was noted to have [REDACTED] which was likely related to the child's [REDACTED] and lack of adequate nutrition. The level of [REDACTED] related to fractures would not lead to [REDACTED], [REDACTED]. [REDACTED] The medical staff findings were the child suffered from multiple inflicted injuries and physical abuse, neglect and a lack of adequate nutrition.

Current / most recent status of case:

- The child was [REDACTED] from the hospital on 03/26/10. She was [REDACTED] foster care agency, Children's Choice.
- The SW reported the parents have weekly supervised visits that are held at Children's Choice.
- The paternal grandmother has bi weekly supervised visits at Children's Choice.
- The [REDACTED] revealed that the child suffered severe pain as a result of child abuse. The case was [REDACTED] on 02/24/10. Both parents were identified as the [REDACTED]
- The Special Victims Unit is still investigating this case.
- The father presently has an open bench warrant for his arrest from a prior criminal case. The father has a prior disposition: endangering the welfare of children, sexual assault, indecent exposure, and the corruption of a minor. The allegations are that father sexually assaulted a foster child that lived with his grandmother.

Services to children and families:

- The child was [REDACTED] from the hospital on 03/26/10. The child will receive [REDACTED] from St. Christopher's Hospital. She was referred to [REDACTED]. The first medical appointment was on 03/29/10. The child was placed on medications, [REDACTED]. The child is scheduled for the medical specialists: [REDACTED]. The child receives [REDACTED] twice a week. [REDACTED] The parents are required to attend [REDACTED] classes, parenting and [REDACTED] and family school. According to the court order the father will participate in [REDACTED] and follow through with all recommendations. This was ordered due to father reporting that he has a [REDACTED] and has received [REDACTED] money all of his life.

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

Strengths- The Department of Human Services was responsive with providing adequate correspondence. The DHS SW made the appropriate contacts and follow-up interviews to complete a timely investigation. DHS and Children's Choice are meeting and discussing a permanency plan for the child. The paternal grandmother agreed to kinship certification.

Deficiencies- The child was to the hospital on 01/29/10. The e- report was [REDACTED] and bruising. The

structured case notes did not thoroughly address circumstances surrounding the child's failure to thrive.

**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.

- The Department of Human Services will develop and implement training for the medical personnel to understand safety assessments. The medical personnel do not understand that their cooperation is a vital key in making good safety decisions for children. St. Christopher's Medical staff refused to sign the safety plan while the child was in the hospital.

Statutory and Regulatory Compliance issues:

- There were no compliance issues identified.