



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**NATHAN ARCELAY**

**DATE OF BIRTH: 03/27/1998**  
**DATE OF DEATH: 05/27/2011**

**FAMILY KNOWN TO:**  
**Family was known to Philadelphia County**

**REPORT FINALIZED ON: 06/06/12**

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 has convened a review team on June 03, 2011 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:****Name:**

Nathan Arcelay

**Relationship:**

Victim Child

mother

Father

sibling

sibling

sibling

**Date of Birth:**

03/27/1998

1977

1977

1994

2004

2005

**Notification of Child Fatality:**

On 05/17/2011, the Philadelphia Department of Human Services received a call from ChildLine concerning the victim child, Nathan Arcelay. The victim child was in critical condition at St. Christopher's Hospital. The victim child, who was 13 years old, was left unsupervised in the bathtub full of water. The victim child has Nail Patella Syndrome (NPS) and is non-verbal. The reporting source stated that the [REDACTED] was giving the victim child a bath along with his [REDACTED], [REDACTED] [REDACTED] has NPS also, along with being deaf and non-verbal. While both children were in the bathtub, the [REDACTED] went down stairs for twenty minutes. When [REDACTED] returned [REDACTED] was standing up in the tub and victim child was under water. The mother called 911 and the police and paramedics arrived on the scene. The paramedics transported the victim child to St. Christopher's Hospital and the police transported the mother to the hospital. The victim child was [REDACTED] because he was not breathing on his own. The hospital listed the victim child in extreme critical condition as per the police report.

### Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case information pertaining to the [REDACTED] family. Follow up interviews were conducted with the DHS Caseworker, [REDACTED], and DHS Child Fatality Program Administrator, [REDACTED].

### Summary of Services to Family:

#### Children and Youth Involvement prior to Incident:

There was a 3/23/2011 pending [REDACTED] for [REDACTED] [REDACTED] which was [REDACTED] and [REDACTED] were placed into the home due to mother missing medical appointments for her children who are medically needy. At times the mother does well and other times she does poorly. She needs a constant reminder of her children's medical appointments, as she often forgets them due to the children having so many appointments. The report was called in due to Nathan missing his appointment for a [REDACTED]. The mother was informed that a report would be called in due to missing the appointment. According to St Christopher's Hospital, the [REDACTED] is up and down in compliance with the medical appointments. Nathan was listed as the victim child, as he was not taken to the doctor and follow up appointment.

6/22/2006 [REDACTED] [REDACTED] for [REDACTED] lack of [REDACTED] for [REDACTED] and Nathan on both [REDACTED] and [REDACTED]

3/24/2003; [REDACTED] [REDACTED] is perpetrator; Victim child had a [REDACTED] [REDACTED]. [REDACTED] investigation was on-going and a full body scan was conducted; this was a new injury.

3/21/2003; [REDACTED] [REDACTED]: [REDACTED] is the perpetrator; Victim child had a 3 centimeter [REDACTED] on the back of his [REDACTED], two [REDACTED] [REDACTED] explanation did not fit the injuries.

3/04/2003; [REDACTED] [REDACTED] was the perpetrator; Victim child was born with a congenital condition and needed to be seen for [REDACTED]. The victim child was not receiving the level of care needed.

### Circumstances of Child Fatality and Related Case Activity:

On 5/17/2011, DHS received a call from hot line stating victim child was severely mentally challenged per law enforcement. The victim child was left alone in the bath tub on the morning of 5/17/2011 with his brother [REDACTED] while mother went downstairs. The children were placed into the bathtub due to the victim child

taking off his diaper and smearing feces on the wall, his brother, the bed, and himself. There were feces everywhere. When the mother came back upstairs the victim child was under water. Medics were called and the child was in extreme critical condition as per police. DHS was to contact St. Christopher's Hospital to determine whether or not this case would be certified by a Physician as a near fatality and if the child is expected to live. DHS was to call ChildLine back if case was determined to be a near fatality and the case would then be registered for lack of supervision (based on child's special needs he should have been supervised) resulting in a physical condition. On 5/17/2011 [REDACTED] contacted St. Christopher's Hospital and spoke with Dr. [REDACTED]. Dr. [REDACTED] informed [REDACTED] that the victim child was on life support and Dr. [REDACTED] was not certain whether child will live. On 5/27/2011 victim child was taken off of life support and pronounced dead. The determination of the investigation was [REDACTED] due to the circumstances of the investigation- not revealing adequate evidence to support the allegation. Although this was an unfortunate accident, the mother was trying to multitask. The victim child pulled off his diaper and smeared feces on himself, his brother, the bed, the wall, and the floor. The mother was in the process of trying to clean the room, sheets and the boys. It was reported that the victim child was developmentally able to sit up unattended, which makes this truly an unfortunate accident.

**Current Case Status:**

- The family is currently [REDACTED] services from [REDACTED] Center and [REDACTED]
- [REDACTED] has also been offered to the family to deal with the death of victim child, Nathan.

**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 has convened a review team in accordance with Act 33 of 2008 related to this report on 06/03/2011.

- Strengths:  
The MDT Social Work Services Manager did a good job investigating the case. The notes were detailed and safety assessments were completed according to policy.
- Deficiencies:  
None noted at this time.
- Recommendations for Change at the Local Level:

Team recommended that DHS explore additional community and in-home supports for families with special needs.

- Recommendations for Change at the State Level:  
None noted

#### **Department Review of County Internal Report:**

The Southeast Region has received and reviewed the county's Act 33 review, and is in substantial agreement with their findings.

#### **Department of Public Welfare Findings:**

- County Strengths:  
Philadelphia County was sensitive to the mother during the investigation due to the nature of the fatality of her child.  
DHS worker contacted child's school to confirm child's developmental skills and need for supervision and physical assistance.  
DHS worker educated himself about the children's specific syndrome and how it impacted the child's development.
- County Weaknesses:  
None noted
- Statutory and Regulatory Areas of Non-Compliance:  
None noted

#### **Department of Public Welfare Recommendations:**

The Department recommends that caseworkers receive specialized training to assess the levels of supervision required for different developmental needs of children.