



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Southeast Regional Director

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

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

REPORT ON THE NEAR FATALITY OF:



Date of Birth: [REDACTED], 1999

Date of Near Fatality Incident: July 6, 2010

**The family was known to
Montgomery County Office of Children and Youth**

Date of Report: January 5, 2012

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. Montgomery County convened a review team in accordance with Act 33 of 2008, on August 12, 2010, related to this report.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED] 1999
[REDACTED]	foster mother	[REDACTED] 1949

Notification of Child Near Fatality

On July 12, 2010, Montgomery County, Children and Youth received a call that the incident that occurred on July 6, 2010 was called in as a Near Fatality. Child was being transported home from the Easter Seal Day Camp on July 6, 2010 on the school bus. Reporting source states that the air conditioner was not working on the bus and the temperature outside was 100 degrees. The child was transported to his foster home at [REDACTED], Elkins Park, Pa 19027. When the bus arrived at the home, the foster parent was not at home, but arrived approximately five minutes later. Between the time the foster parent arrived home and getting the child into the home, the child had a seizure and had to be transported to Abington Hospital with a body temperature of 107 degrees and he was having seizures. Child was transferred to Children's Hospital of Philadelphia (CHOP). Child is medically-fragile and requires a wheelchair to get around; he also has [REDACTED] and a feeding tube. [REDACTED] at CHOP diagnosed the child as in critical condition and brain dead; ventilator will be removed, if child's condition does not improve.

Summary of DPW Child Near Fatality Review Activities

The Southeast Region Office of Children, Youth and Families obtained and reviewed the [REDACTED] conducted by Montgomery County Children and Youth caseworker [REDACTED]. Follow up interviews were conducted with the caseworker, the supervisor, [REDACTED], and [REDACTED], fatality review coordinator. The regional office also participated in the County Act 33 Fatality Review Team meetings on August 12, 2010.

Summary of Services to Family

Children and Youth Involvement prior to Incident

Child was placed in the kinship foster home by Illinois Department of Children and Families through Interstate Compact, and supervised by Montgomery County.

Circumstances of Child (Near) Fatality and Related Case Activity

Child was living in kinship care in Montgomery County through Interstate Compact. Parental rights were terminated in Ohio. Child requires a wheelchair to get around. His diagnosis is [REDACTED]

[REDACTED]. Child had fallen the previous week and was being scheduled for surgery for repair of his [REDACTED]

Child was being transported home from the Easter Seal Day Camp on July 6, 2010 on the school bus. Reporting source states that the air conditioner was not working on the bus and the temperature outside was 100 degrees. The child was transported to his foster home. When the bus arrived at the home, the foster parent was not at home, but she arrived approximately five minutes later. Between the time the foster parent arrived home and getting the child into the home, the child had a seizure. The bus driver followed protocol and called the company dispatcher who called for an ambulance. The child was transported to the hospital (CHOP) by Emergency Medical Services (EMS). Child was taken to Abington Memorial Hospital by paramedics and transferred to CHOP. [REDACTED] at CHOP diagnosed the child as in critical condition and brain dead.

The Cheltenham Police were called to the incident [REDACTED] worker went to CHOP for first contact with guardian of child. Police have the video from the bus. Video that was reviewed by the police and children and youth shows the child's seizure while on the bus. The [REDACTED], employees of a bus company contracted with Cheltenham School District, were interviewed by the police, [REDACTED]. Detective determined that the bus driver and aide responded to the child's needs and followed policy for calling and reporting an emergency. The bus company initially was not communicating with children and youth; they were only willing to communicate with the police department. The driver and the aide were in contact with the dispatcher to inform the dispatcher of the medical need; according to the bus company policy, this was the proper line of communication. The Paramedics were called by the bus dispatcher.

Current Case Status

- The case was [REDACTED]. The police also did not file criminal charges on the bus driver nor the bus-aide.
- Child has a nurse that assists with his care when the kinship mother is not available or is at work. The nurse has been assigned since the date it was determined that the child needs round the clock nursing care as stated in the evaluation from [REDACTED] in July 2008.
- Child's diagnosis is [REDACTED]

- The child recovered from the heat stroke and is back to his baseline level of functioning. At the hospital, child was hydrated and had full recovery.

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

Montgomery County convened a review team in accordance with Act 33 of 2008 on August 12, 2010.

- Strengths: Montgomery County Children and Youth worked closely with the Cheltenham Police Department in the investigation. When the bus company would not communicate with children and youth, the police did share all of the information from the bus company that they had from this case.
- Deficiencies: There were no deficiencies noted in this case.
- Recommendations for Change at the Local Level
 1. Standard policy should be developed between the Department of Education and OCYF about transportation of special needs children, including climate control, availability and training of aides, medical information of children available to staff.
 2. Policy about aide's position on bus that would address the staff person's ability to view child and assess child's medical condition.
 3. Training for EMS personnel to ensure they understand their role under the Child Protective Services Law (CPSL).
 4. Manufacturer of wheelchair should be informed of child's burns from the attached metal tray.

- Recommendations for Change at the State Level

None identified.

Department Review of County Internal Report

The Regional Office participated in the Montgomery County review team on August 12, 2010. There were questions raised in this case concerning who should conduct this investigation. Was it child abuse or student abuse? Was this an extension of the child's school year? Another issue was should the foster parent be named as perpetrator since she was not home at the scheduled time, requiring the bus to wait outside her home.

Department of Public Welfare Findings

- County Strengths: The County had a very good coordinated effort with the police department in the investigation of this case.
- County Weaknesses: There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance: Montgomery County Children and Youth was in compliance with all statutory and regulatory areas in this [REDACTED].

Department of Public Welfare Recommendations

None identified.