



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: 03/29/2011**  
**Date of Near Fatality Incident Report: 09/17/2011**

**FAMILY KNOWN TO:**  
The Family had no history with any  
Public or Private Children and Youth Agency

**REPORT FINALIZED ON: 06/18/2012**

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 Child Line. Philadelphia County convened a review team on October 7, 2011 in accordance with Act 33 of 2008 related to this report. The [REDACTED] on October 3, 2011, within 30 days of the report.

**Family Constellation:****Household at time of incident**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	03/29/2011
[REDACTED]	Paramour	[REDACTED] 1990
[REDACTED]	Friend	Adult

**Primary residence**

[REDACTED]	Mother	[REDACTED]/1994
[REDACTED]	Maternal grandmother	Adult

\* [REDACTED] Bio-Father 22 years old

The bio-father of the victim child is incarcerated in Pennsylvania.

**Notification of Child Near Fatality:**

On 09/17/2011 at approximately 3:36 PM, the SERO received a Near Fatality report from [REDACTED] on [REDACTED]. The reporting source was [REDACTED]. The report stated the victim child and her dad had been staying with a friend at [REDACTED]. The child's father reported that the child fell off a bed twice, once on 9/12 and again on 9/13/2011. Dad brought the child to Aria Torresdale Hospital on 09/17/2011, after she appeared to be in a limp state. The child had several medical concerns: [REDACTED] to [REDACTED], [REDACTED]

[REDACTED]. The child had an [REDACTED]. The child was certified to be in [REDACTED] prior to being transported to CHOP.

**Summary of DPW Child Near Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records from Philadelphia DHS pertaining to the family. Follow up interviews were conducted with the DHS social worker, [REDACTED]

[REDACTED] The regional contacted the New Jersey Department of Youth and Family Services (DYFS) Social Worker, [REDACTED] who gave information concerning the victim child's mother who is in kinship care through DYFS. The mother [REDACTED], 17 years old) resides in Camden with her grandmother who is ill. The regional office also participated in the County Fatality Review Team meeting which occurred on October 7, 2011.

**Summary of Services to Family:**

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

The family was not known to DHS prior to this report. The mother's paramour had prior involvement with DYFS of New Jersey. This case had been closed in 2005.

**Circumstances of Child Near Fatality and Related Case Activity:**

[REDACTED] came to the attention of DHS on September 17, 2011 as the result of a [REDACTED] report alleging that [REDACTED] arrived with her Father, [REDACTED] at Aria Hospital in respiratory distress. [REDACTED] was unconscious and had to be [REDACTED]. Child had an [REDACTED] scan. She was transported to CHOP where it was discovered that she had a [REDACTED] [REDACTED]. Mr. [REDACTED] explanation that [REDACTED] had fallen off the bed on two occasions was inconsistent with the injuries. CHOP determined the injuries were the result of inflicted trauma. [REDACTED] was [REDACTED] from CHOP and [REDACTED] to Weisman Rehabilitation Center in New Jersey. The mother, [REDACTED] (17yo), and the alleged father, Mr. [REDACTED] (21 years old), reside in New Jersey. Ms. [REDACTED] is in kinship care with her grandmother through the DYFS. Reportedly both of [REDACTED] parents are deceased. It was determined through the course of the [REDACTED] that the [REDACTED] Mr. [REDACTED] is not the victim child's bio-father. The bio-father of the victim child is a 22 year old man named [REDACTED] who is incarcerated in Pennsylvania. Mr. [REDACTED] hooked up with the mother while she was 8 months pregnant and has been acting as the father since. The [REDACTED] report was [REDACTED] Mr. [REDACTED] for [REDACTED]. The DHS social worker confirmed that DYFS planned to place [REDACTED] in foster care upon [REDACTED] the rehabilitation center. The DHS case was subsequently closed on 10/03/11. The criminal [REDACTED] is still pending.

The safety Assessment dated 9/17/11 for ██████████ determined that the child would not be safe in the home. Safety Threat #10 was identified: Caregiver's protective capacities are diminished. Mr. ██████████ did not take the child to the hospital until she became unresponsive. Although the child had reportedly fallen twice previously, the paramour did not have the parenting skills necessary to keep the child safe. A safety plan was developed to ensure the child's safety. Child will be placed in the custody of DYFS foster care upon ██████████ the rehabilitation center. The home of maternal grandmother has been described as chaotic and there are several children running all over the house. In addition the maternal grandmother has an ██████████ through DYFS.

### **Current Case Status:**

██████████ is currently in the custody of DYFS foster care. DYFS is still ██████████ the old injuries on ██████████. Medical reports indicated that ██████████ had some old bruises/ injuries. The mother had reported that while ██████████ was in her care she fell off of maternal grandmother's hospital bed, prior to the visit to the paramour's home. This was four days prior to the visit with the paramour's home. There was concern that some of ██████████ injuries could have occurred while in care with her mother. Mother is in Kinship foster care with her grandmother in New Jersey Father is residing in Philadelphia. The Philadelphia Special Victims investigation is ongoing against the paramour. No criminal charges were filed against the mother in NJ. The DHS case was ██████████ on Mr. ██████████ ██████████ on 10/03/2011.

### **County Strengths, Deficiencies, and Recommendations for Change as Identified by the County's Child Near 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 Child Line. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report. The review occurred on October 7, 2011.

#### **Strengths:**

- Collaboration with the medical team at Children's Hospital Of Philadelphia (CHOP)
- Timely and quality safety assessments and safety plan
- Collaboration with the DYFS social worker

#### **Deficiencies:**

- There are none identified

#### **Recommendations for Change at the Local Level:**

- DHS should ensure that the MDT [REDACTED] workers receive training and support to address vicarious traumatization. The Medical Examiner's Office Bereavement Support Unit will provide interim support. Training should be provided for Social Worker Services Manager about how to gather accurate medical information, including appropriate contacts at the hospitals.

Recommendations for Change at the State Level:

- There are none noted

Department Review of County Internal Report:

The Department is in receipt of the county report, and is in substantial agreement with the findings.

Department of Public Welfare Recommendations:

DHS should work with the hospitals to establish a contact person within the hospitals' child abuse team and medical staff when requesting information on the child's status.