



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**BORN: 03/01/2009**  
**DATE OF NEAR FATALITY: 10/20/2011**

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

**REPORT FINALIZED ON: 05/17/2012**

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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on 11/18/11.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	03/01/09
[REDACTED]	Mother	[REDACTED] 79
[REDACTED]	Mother's Paramour	[REDACTED] 88

**Non-Household Members:**

[REDACTED]	Father	[REDACTED] /65
[REDACTED]	Sibling	[REDACTED] 01
[REDACTED]	Maternal Grandmother, Legal Custodian of	[REDACTED] 1948
[REDACTED]	Maternal Aunt/Uncle	Adult
[REDACTED]	Maternal Aunt/Uncle	Adult
[REDACTED]	Paternal Aunt of VC	Adult

**Notification of Child Near Fatality:**

On 10/20/11, Philadelphia Department of Human Services (DHS) at approximately 1:47 pm received a near fatality [REDACTED] concerning [REDACTED], age 2. The report was made [REDACTED] that the victim child was [REDACTED] as the result of [REDACTED] and certified as a near fatality by Dr. [REDACTED]. The biological mother [REDACTED], was named as the [REDACTED]. The Reporting Source stated that the mother carried the

child into the ER at 11:20 am, saying the child fell down the steps at 6:00 am this morning and has not spoken or moved his neck since that time. Reporter said the mother did not bring the child to the ER immediately, because she was afraid DHS would take the child away from her. The attending physician, Dr. [REDACTED] stated that the child had multiple bruises everywhere, was unresponsive, not following commands, not speaking, and had [REDACTED]. The child's [REDACTED]. The child had to be [REDACTED] and the child had air in his belly and chest as well as a [REDACTED]. Once the child was [REDACTED] he was immediately transferred to St. Christopher hospital for continued treatment.

On 10/30/12, a supplemental report was filed with [REDACTED] by Philadelphia DHS naming [REDACTED] biological mother's paramour, as a second [REDACTED] of the original [REDACTED] report. It was determined during the initial part of the [REDACTED] through interviews with the mother, that he was the primary caretaker/babysitter at the time of the alleged incident.

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

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family through the course of its review of this Near Fatality [REDACTED] case; which included the review of the medical records from both Frankford and St. Christopher Hospitals, the Weisman Children's Rehabilitation Hospital, the DHS assessment and [REDACTED] records and their ongoing structured case notes and progress notes along with the safety and risk assessments completed until the case was closed on 03/12/12. SERO initiated and maintained contact with the intake social worker, [REDACTED] and his supervisor, [REDACTED] throughout the completion of the [REDACTED]; and continued to monitor the victim child's progress after his case was transferred to the Ongoing Services Unit with social worker, [REDACTED] and her supervisor, [REDACTED].

Several follow up interviews were conducted starting on 11/08/11, with the DHS social worker and the Director of Social Work, [REDACTED], at Weisman Children's Rehabilitation Hospital once the victim child was [REDACTED] St. Christopher's Hospital in order to monitor and track the child's progress until he was [REDACTED] to the care and supervision of his biological father, [REDACTED], on 12/30/11.

The regional office also participated in the DHS Act 33 Review Team meeting at the Medical Examiner's Office on 11/18/11.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

08/22/02 [REDACTED]

DHS [REDACTED] allegation of environmental neglect which was [REDACTED] and closed the case on 09/16/02 with no recommendation for follow-up services.

02/28/2004 [REDACTED]

A [REDACTED] on 03/26/04 that resulted from a [REDACTED] initiated on 02/28/2004 naming [REDACTED], the biological father of the victim child (VC) [REDACTED], (DOB: [REDACTED]/01) as the [REDACTED] is the biological mother who was living with her son at the residence of her mother, [REDACTED], the grandmother of the VC. The parents of the VC did not live together and the father had liberal visitation arrangements with his estranged wife. According to the findings, the father was found guilty of involuntary deviate sexual intercourse and has been incarcerated since his arrest. A [REDACTED] was put in place on 03/26/04 and the family was referred for [REDACTED] with Wordsworth Academy from 04/13/04 and discharged on 11/30/04. The case was closed by DHS with follow-up [REDACTED] treatment arranged for the VC.

05/24/2007 [REDACTED]

[REDACTED] report of general neglect and supervision concerns involving the biological mother for leaving her son with the maternal grandmother home for extended periods of time was investigated by DHS. VC was reported having behavior problems in school as a result of not receiving [REDACTED] after the incident of being sexually abused by his father in 2004. DHS facilitated the cooperation of the maternal aunt and uncle and maternal grandmother who filed an action in civil court to obtain custody of [REDACTED]. The resulting Court Agreement gave primary physical and legal custody to the maternal aunt and uncle with visitation and partial custody to the maternal aunt and uncle and mother as the parties agreed upon and arranged for by the maternal aunt and uncle. A Safety Plan was implemented in line with this Court Agreement for the VC to reside with the maternal aunt and uncle and arrangements were made for a referral to [REDACTED] for the VC.

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

DHS received a [REDACTED] allegation on 10/20/11 from [REDACTED] stating that the attending physician, Dr. [REDACTED]

██████████ is certifying that a recently admitted patient, ██████████, age 2, is in serious condition as a result of suspected abuse and is being certified as a near fatality, with mother, ██████████ suspected as the ██████████. The reporting source (RS) stated that the mother carried the child into the ER at 11:20 am indicating that her son fell down the steps at 6 am this morning; and has not spoken or moved his neck since that time. The mother further pointed out when questioned about her delay in seeking medical intervention that she was fearful that DHS would take her son away from her if they became aware of her son falling down the steps. The initial medical assessment and examination described severe physical injuries which included but not limited to the following:

██████████ Dr. ██████████ further stated that the child was unresponsive and not following commands at the onset of her examination; and observed ██████████ areas everywhere at different stages of healing as well as the child's ██████████. The VC, ██████████, was medically stabilized at Frankford Hospital and immediately ██████████ to St. Christopher's Hospital for further medical assessment, care and follow-up treatment at 1:45 pm. Dr. ██████████ Child Protection Director, provided a more specific interpretation of the child's injuries and medical conditions once their trauma team was able to complete the initial medical examination and treatment of the VC, with the following notations: the child had bruises to his forehead which were patterned on ██████████ purple to pink bruise to the ██████████ and the ██████████ and injuries were linear in composition; bruises to both ears, purple, yellow and brown in color; abrasions to the inside of his lip and observable bruises to the front of his neck in a ██████████; observable oval ██████████ to his chest about 4 cm. in diameter which could possibly be bite marks, but later determined to have occurred from some oval object such as the bottom of a beer can; ██████████ with suspicion of possible toilet training and abusing of child for his inability to use the potty appropriately; bruising to the inside of the buttocks and bruising around the anus ██████████; bruises to both legs; ██████████; suspected air in his chest suggesting ██████████ resulting from possible trauma to his chest. The child was scheduled for a skeletal examination, ██████████

DHS S/W completed a Safety Assessment and Safety Plan as the result of the unexplained injuries to the VC's requiring ██████████ at St. Christopher Hospital. The Safety Plan provided for visitation by only the biological father, ██████████, only during normal visiting hours with no contact by the mother until the completion of the ██████████

██████████ biological mother of VC, was interviewed by DHS S/W at the Philadelphia Special Victims Unit at 9:30am on 10/20/11 following her interrogation by Police Officer ██████████ and Lieutenant ██████████ who had detained her and were in the process of filing criminal charges.

The mother stated that her son's biological father ██████████ resided at ██████████ ██████████. and has partial custody of ██████████ and picks him up at daycare every Friday afternoon after work and returns him to daycare on Monday mornings after their weekend visit. The mother stated that she picks him up from the day care on Mondays after the weekend visits. On the prior weekend, the mother indicated that the father asked her to pick ██████████ up on Sunday, 10/16/11, because he had a high fever. The mother stated that her older son, ██████████ ██████████, age 11, who lives with his maternal grandmother, stays with her on weekends and that he and ██████████ ended up playing and eating dinner in their bedrooms until she returned him to his grandmother's later that evening. The mother stated that she returned home and bathed ██████████ and prepared him for bed. She indicated that she did not observe any injuries on her child before going to bed Sunday evening.

The next morning, 10/17/11, she stated that she took her son to work at ██████████ ██████████ ██████████, with her due to his continued fever and felt that his condition was related to his teething; and she called to alert her son's daycare program, Pumpkin Patch Day Care located on ██████████. The mother also pointed out that she observed her son bruising himself on his neck from struggling to pull his shirt off. Although she said he began whining, the bruise did not appear to require any medical attention. She went on to point out that she observed no suspicious bruises after readying him for bed that evening except for the earlier noted one on his neck.

On the following two (2) days, 10/18/2011 and 10/19/2011, she called in sick at work due to her not feeling well and held her son back from daycare who played and did normal things, showing no signs of being sick. The mother went on to explain she thought that some of the bruising on his legs was caused by her son climbing on her couch that has a metal base and again stated that she observed no suspicious bruises before putting her son down on either day.

The mother informed the social worker that on Thursday morning, 10/20/11, that she noticed a rash on her son's penis while changing his diaper and at the time didn't feel it required any medical attention; and continued to ready herself for work. She stated that around 6:00 am or 6:30 am ██████████ was following her downstairs but had stopped at the top of the stairs to play with the cat and was holding his "sippy" cup and when she beckoned him, he fell down the steps that are carpeted to the bottom. She said that she immediately picked him up and comforted him for several hours in her arms and stated that ██████████ was making noises, trying to talk and unable to hold his head up. She went on to point out that ██████████ kept pulling her hair which she thought was a sign of being in pain and started to shake at which time she decide to walk her son to the Frankford

hospital which was about six (6) blocks away. When asked if she had informed her son's father of incident, she indicated that she had not for fear that he would "flip-out" for he has threatened in the past to take custody of her son because he feels she is not able to care for her son properly. She went on to point out that her previous paramour had robbed her but that she no longer has any contact with him.

Collateral interviews, 10/21/11, occurred with the maternal grandmother [REDACTED], [REDACTED] son, at their home on [REDACTED]. Although the grandmother was very supportive of her daughter's efforts of parenting and holding a job to support herself, she pointed out that at times she has [REDACTED] them and admits that her [REDACTED] has not always been the best; saying that her daughter has a [REDACTED] as a result of this. She went on to blame the incident on her daughter's paramour, [REDACTED] who is a known [REDACTED] and cocaine user. She denied any knowledge of her daughter allowing [REDACTED] or anyone else to supervise her son, [REDACTED] alone; except for his biological father who takes him on weekends. She denied any knowledge of her daughter using drugs but again admitted that her daughter is [REDACTED]. She indicated that she has had custody of her daughter's older son, [REDACTED] since 2001 who normally stays with his mother on weekend.

The interview of [REDACTED] confirmed the mother's account of being with her on weekends and that [REDACTED] returned home early on the Sunday, 10/05/11, ill from his father's visit. He also pointed out that although [REDACTED] is usually at the home when he visits, he was not there through the time of his return home to his grandmother's. He indicated that [REDACTED] never supervised him nor did he ever see him supervise [REDACTED] alone. He reported seeing bottles of booze, beer cans and little pink bags in his mother's bedroom but has never seen her use them. He stated that his mother never physically disciplines him.

An interview of the Pumpkin Patch Day Care teacher, Ms. [REDACTED], occurred on 10/24/11 by the DHS S/W, confirmed the drop off and pick up arrangement of [REDACTED] as described by the mother. Ms. [REDACTED] pointed out that there were no attendance problems and the child always came to school and was no behavior problem. She went on to point out that she never observed any bruises on the child for she had to change his diaper at different times throughout the school day. She corroborated the mother's account of the child being out sick from Monday, 10/16/11 through Thursday, 10/20/11 and pointed out that she noticed that the child was displaying signs of not feeling well at days end on Friday, 10/13/11. On 10/24/12, DHS S/W contacted the Special Victims Unit with the information on [REDACTED] that he had obtained from the maternal grandmother, and was informed that he had been arrested on 10/22/11 on aggravated assault of [REDACTED] and was being held at [REDACTED]. The detective indicated that Mr. [REDACTED] denied causing the injuries to [REDACTED] but

admitted to being alone with the child. The SW pointed out to Detective [REDACTED] that the person was named as a [REDACTED] in another open [REDACTED] as of 09/23/11 involving VC, [REDACTED] (DOB: [REDACTED]/08) that Det. [REDACTED] was the investigating officer.

On 10/24/12, an interview of [REDACTED] employer at [REDACTED] [REDACTED] [REDACTED], Director, was conducted by the DHS SW who found that his statement did not correspond entirely with the mother's statement that she had her son at work with her on Monday, 10/16/11; nor that she had left work at 11:30am following a call regarding her son falling down the steps. Mr. [REDACTED] confirmed that the child did not accompany her to work on 10/16/11. She was off sick the following two (2) days (10/17, 18/11) to return to work on 10/20/11 at 7:30 am only to leave suddenly for an emergency at home at 9:47 am as confirmed by her time card.

Dr. [REDACTED] updated the child's status on 10/24/12 and revealed the following: the child had suffered a [REDACTED] and is not doing well; his injuries were older than two or three days old; he has a [REDACTED] his injuries are not consistent with a child falling down steps; and the [REDACTED] are not consistent with human bite marks but are thought to possibly be caused by the bottom of a beer can; [REDACTED]. Dr. [REDACTED] pointed out that the prognosis on the child is [REDACTED].

During a conference call on 10/24/12 with the District Attorney's office, [REDACTED], revealed that their office had not yet charged or arrested Mr. [REDACTED] on the [REDACTED] case because they had not received the results of the [REDACTED] as of the day of the call.

10/31/11 – According to Dr. [REDACTED], the VC is being readied for [REDACTED] to Weisman Children's Rehab Hospital once he can tolerate feeding without vomiting. Most of his bruises have healed and there remains uncertainty regarding the degree of impairment to his vision.

11/02/11 – Interview of the [REDACTED], [REDACTED], revealed that he had been at the mother's home on the Wednesday evening, 10/19/11 but had departed about 4 am Thursday morning only to be called later by the mother asking him to babysit [REDACTED] for she did not want to take him to work with her. He stated that he had changed the VC diaper on Wednesday evening at about 8pm and did not notice any injuries at that time. The [REDACTED] indicated that he was getting the VC ready to take him to the playground about 9:30am and proceeded down stairs only to hear the child falling down the stairs. When questioned as to why he didn't take the child down stairs with him he stated that the VC was at the top of the stairs playing with the cat. He stated he immediately called the mother informing her that [REDACTED] fell down the steps and that he thought he broke his neck. He stated

that the mother arrived home about 10:30am. The mother was hesitant to immediately call a doctor because she feared that DHS would take [REDACTED] from her once they found out. He went on to point out that she finally agreed to walk him to Frankford Hospital but that he did not go into the hospital with her. The [REDACTED] indicated that he attempted to contact her throughout the day and finally reached her while she was at the Special Victims Unit when she described all the injuries her son sustained.

The DHS SW queried him regarding her care of the child to which he stated that the mother takes good care of him and had never seen her discipline him. He stated that he had never disciplined the child for he thought that was the mother's responsibility. When asked if the mother uses drugs, the [REDACTED] stated that she uses cocaine but was not aware if she had used any drugs during the week of the incident; and did admit using only marijuana himself.

11/14/11- DHS submitted the [REDACTED], based on the severity of the injuries to child, were considered a near fatality; and the biological mother, [REDACTED], was named a [REDACTED] due to her knowledge of how the child sustained the injuries but failed to seek appropriate medical attention to address the child's severe medical issues.

#### Current Case Status:

[REDACTED] was [REDACTED] to Weisman Children's Rehabilitation Hospital on 11/8/11 with a Safety Plan updated by the ongoing DHS SW, [REDACTED] on 12/08/11 allowing visitation to occur by the biological father; and [REDACTED] on 12/30/11 to the care and supervision of his biological father, [REDACTED] who lives at [REDACTED]. An updated Safety/Risk Assessment was completed that supported the VC moving into the residence with his father; and the Safety Plan that was implemented on 01/03/12 incorporated the action steps developed from a Family Group Decision Making Conference held on 12/17/11 allowing the father to continue working through caretaking support by various family members.

[REDACTED] current medical diagnosis at discharge is as follows:  
[REDACTED]

██████████

██████████ strength is improving on the right side and he has gained motor function with regard to his functioning mobility. He is able to sit independently and is able to ambulate. ██████████ will be seen at St. Christopher's Hospital and a private primary care physician ██████████); and will be followed by an ██████████

He has been ██████████

██████████ case is not court involved but a ██████████ was implemented with the following services while he and his father remained in the Philadelphia area:

- Turning Points for Children ██████████
- Women Organized Against Rape ██████████
- It Takes a Village (Family Group Decision Making)

██████████ St. Christopher's Hospital ██████████

A referral for ██████████ was made for ██████████ through WOAR (Woman Organized Against Rape's Children Services Department) for ██████████. WOAR was not able to conduct an intake with the family before the father and ██████████ relocated to El Paso, Texas with the paternal aunt on 3/3/12 so a referral was completed in that area.

██████████ has shown full compliance and cooperation with DHS and has completed his ██████████ on 02/17/12.

██████████ received training at Weisman as to ██████████ special needs. ██████████ attended and/or participated by conference call on weekly teaming meetings at Weisman in order to receive full knowledge of ██████████ special needs. ██████████ obtained full physical and legal custody of his son ██████████, through Domestic Court with no restrictions on his eventual relocation plan to El Paso, TX with his sister ██████████ which occurred on 3/3/12. A home inspection was not completed on ██████████ home in El Paso, TX because the child was not committed to DHS.

DHS also attempted to make a formal referral to the local children and youth agency in El Paso, Texas only to find that the status of the this case did not met their intake criteria of a pending threat existing since the biological father was not the perpetrator.

As part of the transfer and relocation plan, the DHS SW worked with ██████████ primary medical health care providers to network with local specialists in the El Paso area and coordinated this with ██████████ and his sister to confirm their understanding and awareness ██████████ follow-up plan.

██████ had continued to visit with his biological brother, ██████, every weekend up until his relocation to Texas. These visits were supervised by ██████ his maternal aunt.

██████ biological mother, remains incarcerated at ██████. Her preliminary hearing was on 12/29/11 and continued because counsel for ██████ requested a forthwith ██████ to determine his competence. Then on 2/2/12 it was continued again. The stay away order is still in effect. ██████ is represented by the Public Defender. The ██████ was negative. However, according to ██████, Philadelphia District Attorney's Office, the lab found a small amount of semen on the inside of the back of the shirt the VC was wearing which resulted in the District Attorney's Office ordering a DNA swab taken from ██████ in order to get a DNA comparison in support of their criminal investigation.

**County Strengths and 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 ChildLine. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report which occurred on 11/18/11.

- **Strengths:**

1. Swift and thorough action on the part of the DHS SW to reveal the inconsistencies in the mother's account of how the events unfolded leading up to the child ██████ assisted in supporting the criminal actions; and laid the ground work for an appropriate plan of safety in the event that she was released from jail.
2. The immediate action taken to alert the Special Victims Unit that the alleged perpetrator ██████, was a subject of an existing ██████ Near Fatality case resulted in the coordination of those cases at that level.
3. All relevant parties involved with this case were interviewed in a timely manner with appropriate safety plans implemented involving both the victim child and his older sibling, ██████.
4. Coordinated planning efforts to assist the biological father's efforts to establish a network of community and family supports in preparing to assume physical custody of son, ██████ once he was ██████ the rehabilitation hospital.

- Deficiencies:
  1. The Act 33 Team as voiced by the Medical Examiner presented concern over why the Philadelphia Police Department's Special Victims Unit was not able to take immediate action in arresting the [REDACTED] case filed on 09/23/11; particularly in view that there was medical evidence existing from the [REDACTED] completed at the time the other victim was hospitalized on 09/23/11.
- Recommendations for Change at the Local Level:
  1. Protocols need to be established and implemented to ensure that timely exchange of vital information amongst all members of the Act 33 Team regarding the current status and changing disposition of mutual [REDACTED] cases still under [REDACTED] occurs in order to enhance and benefit each others efforts of reaching effective outcomes that protect children at risk.
- Recommendations for Change at the State Level:  
NONE

**Department Review of County Internal Report:**

Philadelphia DHS established and maintained an open dialogue and timely exchange of reports and case file information with the Southeast Regional Office throughout the course of their [REDACTED] and into the post [REDACTED] phase of developing a [REDACTED] with the family.

**Department of Public Welfare Findings:**

- County Strengths:
  1. DHS insured that the Southeast Regional Office was kept updated with the changing disposition of this case throughout their [REDACTED] and into the period of providing services to the family.
  2. The Southeast Regional Office received timely documentation of their [REDACTED] and related case notes; and safety and risk assessment that supported their implementation of the different safety plans as the case evolved.
- County Weaknesses  
NONE

- Statutory and Regulatory Areas of Non-Compliance:  
NONE

**Department of Public Welfare Recommendations:**

A recommendation from the Act 33 Team to the City of Philadelphia that supports the identification and development of a seamless and deliberate exchange of information system that improves the timely receipt of critical changes in case disposition between the District Attorney's Office and Philadelphia Department of Human Services.