



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 09/18/2009
Date of Incident: 02/07/2010

FAMILY KNOWN TO:
Not known to Department of Human Services

DATE OF NEAR FATALITY: 07/26/2010

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, on 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.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	victim child	09/18/2009
[REDACTED]	mother	[REDACTED] 1970
[REDACTED]	father	[REDACTED] 1975
[REDACTED]	maternal aunt	[REDACTED] 1968

Notification of Fatality / Near Fatality:

On 02/07/2010 child was brought to Children's Hospital of Philadelphia by EMS and parents for new onset seizure. As per father, initially there was no trauma, but after further questioning, father admitted to "playing" with the baby by throwing her in the air and admitted to dropping her from a height of approximately 5 feet. Father reported that child did not vomit. Within an hour from injury, the child began to seize. When questioned regarding her bruises, parents were unable to explain them. The mother reports that she went to the Laundromat and child was alone with dad for about 2 hours, then seizure activity was noted.

2. Documents Reviewed and Individuals Interviewed:

For this review, the SERO: reviewed the county case file, interviewed the county caseworker for the most current status of investigation, and attended the County's Internal Fatality Review Meeting regarding this case on 03/05/2010.

Previous CY involvement:

No previous history with any child welfare agency

Circumstances of Child's Fatality or Near Fatality:

On 02/08/2010 a [REDACTED] report was received by the county which stated that on 02/07/2010 [REDACTED] injuries occurred. [REDACTED] sustained a [REDACTED] a total of seven bruises [REDACTED] was brought to the Children's Hospital of Philadelphia Emergency Room by EMS and her parents. Father admitted that he dropped [REDACTED] while he was playing with her, throwing her in the air from a height of approximately 5 feet. During this time mother was at the Laundromat. Father reported that the baby did not vomit or lose consciousness. Within an hour of the injury, [REDACTED] began to seize. The parents

had no explanations for the additional bruises of [REDACTED]. Dr. [REDACTED] stated that she was concerned because the injuries are not consistent with how the father explained the injuries occurred. Dr. [REDACTED] stated that the injuries were from [REDACTED] and [REDACTED] would not have obtained injuries this severe if she fell onto carpet. Dr. [REDACTED] stated that these injuries are the result of [REDACTED] falling to the floor or being smacked against a wall or thrown into a wall.

Current / most recent status of case:

- The case was [REDACTED] 03/30/2010, due to confirmed medical evidence and [REDACTED] investigation. [REDACTED] did not have a skull fracture as stated previously but did have a [REDACTED]. [REDACTED] also had bruises on her chest and right thigh as a result of father walking into the wall while he carried her. The father did admit to having a slight learning disability but it appears that he is more impaired than he lets on. [REDACTED] sustained injury to her brain and her [REDACTED] was injured by her father and had [REDACTED].
- Doctor [REDACTED] at CHOP states that [REDACTED] had [REDACTED]. Dr. [REDACTED] stated that the [REDACTED] were new injuries and [REDACTED] did not have any old injuries. Dr. [REDACTED] states that [REDACTED] had a [REDACTED] injury and [REDACTED] and these injuries were caused by [REDACTED] and that injuries this severe were not caused by falling onto the carpet as [REDACTED] had asserted. Dr. [REDACTED] stated that these injuries are caused by falling to the floor, being smacked on a wall, or being thrown into a wall.

Services to children and families:

Family was referred to [REDACTED] and assigned to the Family Support Services.

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

Strengths-

- DHS used interpreter services to communicate effectively with the parents' of [REDACTED]
- DHS used procedures which were implemented as a result of an earlier Act 33 recommendation, by utilizing the assistance of one of DHS nurses.
- The DHS social worker counseled mother in safe sleeping practices because mother co-slept with [REDACTED].

Deficiencies-

- There was a lack of communication between DHS and CHOP. Information that the father provided to the hospital in regards to the incident was not shared with DHS.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

- None identified.

SERO Findings:County Strengths-

- Investigation was done timely.

Deficiencies-

- There is a need for the communication between DHS and the hospitals to be uninterrupted to assure that all parties are privy to the same information.

Statutory and Regulatory Compliance issues:

- None identified.