



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF



BORN: 12/09/2009
DATE OF NEAR DEATH INCIDENT: 3/22/2010

**FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE
AGENCY**

Report Finalized On: 06/10/2010

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 by [REDACTED] on December 30, 2008 and went into effect 180 days from that date. 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	12/09/2009
[REDACTED]	mother	[REDACTED]
[REDACTED]	maternal great aunt	[REDACTED]
[REDACTED]	maternal cousin	[REDACTED]
[REDACTED]	maternal great aunt's paramour	[REDACTED]
[REDACTED]	maternal great uncle/perpetrator	[REDACTED]

Other family (not in household)

[REDACTED] father [REDACTED]

Notification of Fatality / Near Fatality:

On 3/22/2010, the child was brought into the ER at Thomas Jefferson University Hospital by the mother due to a seizure. The CAT Scan showed a [REDACTED]. The mother reported that the child was not acting right. Dr [REDACTED] ER Physician, stated that he was suspicious of abuse since there was no history given that would explain the injury. The child was certified to be in serious condition. The child was transferred to CHOP and later admitted. The child was born at Jefferson. The child had no history of physical ailments or disease. No perpetrator had been identified at this time.

2. Documents Reviewed and Individuals Interviewed:

For this review, the SERO:

- reviewed the county case file
- reviewed the Special Victim's Unit interviews.
- interviewed the DHS [REDACTED] investigator
- attended the County's Internal Fatality Review Meeting regarding this case on 4/16/2010.

Previous CY involvement:

This family had no previous involvement with any private or public child welfare agency.

Circumstances of Child's Fatality or Near Fatality:

3/22/2010

On 3/22/2010, [REDACTED] was brought to the Emergency Room at Thomas Jefferson University Hospital after experiencing a seizure. The mother reported

that the child was not acting right. The [REDACTED] indicated the child had a [REDACTED] and a [REDACTED]. The physician was suspicious of abuse, as there was no explanation for the child's injuries.

DHS began its investigation on the same day, interviewing both mother and father. The identified caregiver was the uncle. All other household members worked full time; he was responsible for the care of the child while the mother worked. DHS completed a Safety Assessment; the mother was determined to have strong parenting capacities. The mother seemed appropriately bonded with her child, and appropriately alarmed at the injuries to her child.

[REDACTED] had been diagnosed with [REDACTED], and had been [REDACTED] this was over the counter [REDACTED]. Both parents reported some improvement in [REDACTED] after he began the [REDACTED]. However, [REDACTED] would occasionally spit up, even after taking the [REDACTED].

On Thursday, March 18th, [REDACTED] father had a day visit with him. The uncle had transported him to the father's home. The father reported to the mother that [REDACTED] had spit up a little and had been a little fussy. Over the next two days, the mother and maternal grandmother reported no issues with [REDACTED]. On Sunday, March 21st, the mother noticed some changes in his behavior. She reported that [REDACTED] was spitting up, biting down on his pacifier and bottle, and was pulling his legs up to his stomach. She contacted the primary care physician (PCP) and explained his symptoms. The PCP thought it might be teething and told her to use ice. The mother reported that the doctors had been looking into a condition in which part of his stomach is too small. [REDACTED] drank about an ounce of his formula, spit some up and did the same with another ounce of formula. He was fussy and crying. The uncle told her that he would take care of [REDACTED] so the mother could get some rest. The mother went upstairs to sleep, but after hearing [REDACTED] constantly cry, she got up. She heard him stop crying as she went downstairs, but noticed he was upset. She reported that he was not crying, but was moaning. She reported he had a dead stare. He was not very responsive and weak.

The mother and maternal cousin brought him to the ER at Thomas Jefferson. He was later transferred to CHOP. The mother did not believe that either the father or uncle could have caused the injury. The DHS worker asked the mother about her uncle's statement that he had dropped [REDACTED] about a month ago in February 2010. The uncle had told her that he had been trying not to step on the dog or cat while holding [REDACTED] and had fallen back with him. He had not told her that he had dropped [REDACTED]. Mother reported that [REDACTED] had seen his PCP on February 22nd for another matter. The physician had not noted any concerns during that appointment. The mother said that other than his spitting up, [REDACTED] had not displayed any problems until Sunday, March 21st.

The DHS investigator met with the father and provided written notification of the allegations. The father works full time and reported that he did not see [REDACTED] as much as he would like. The father reported that [REDACTED] was basically fine during his visit; nothing stood out as unusual. He reported that the uncle usually transports [REDACTED] to and from the visits.

On March 21st, the DHS worker went to the mother's home to interview the uncle. She was informed that when the family members returned from the hospital, the uncle had left. They found the windows open, the fan and TV on, and some of his clothing was gone. Family members reported receiving text messages from the uncle. He suggested

several locations that he might be staying with friends or family; he also mentioned that he might hang himself because he could not live with the idea of hurting [REDACTED]. The DHS worker attempted to call the uncle's cell phone and left a message.

Current / most recent status of case:

- This case was not be [REDACTED] and was closed at the conclusion of the investigation.
- [REDACTED] was discharged to his mother's care. The mother has applied for [REDACTED]. The mother is applying for a [REDACTED] order against the uncle.
- [REDACTED] will require follow up [REDACTED]. He has a [REDACTED] in his head, and will have follow up for [REDACTED]. His [REDACTED] were negative for other injuries.
- SVU has filed [REDACTED] against the uncle.

Services to children and families:

- The family did not have an open case with DHS prior to this investigation; therefore, no services were being provided at the time of the report.
- DHS implemented [REDACTED] is a temporary service- for up to 60 days during the investigation and prior to an Accept for Service decision.

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

Report:

Strengths-

- The Team felt that the DHS social workers did a thorough job investigating this case.
- The Team felt that the safety plans were completed thoroughly.
- The Team felt the DHS social worker made good use of technology by requesting that family members forward the incriminating text messages from [REDACTED] to her own telephone to be transcribed for the record.

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

1. **Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.**
 - The Team had no recommendation in this area
2. **Monitoring and inspection of county agencies.**
 - The Team recommended that the Department of Public Welfare and medical professionals around the state meet to explore what is considered a "near-fatality." This will hopefully establish some consistency on the types of injuries/cases that are being reported as near fatalities.
 - The Team recommended that ChildLine cease the practice of certifying cases as near fatalities without certification of a medical doctor as required by law.

- The Team recommended that DPW simplify the process by which cases can be “de-certified” as near fatalities, particularly when they have been incorrectly certified as such by ChildLine.

SERO Findings:

County Strengths-

- Investigation was thorough and comprehensive. The social worker should be commended for her ability to utilize technology in her attempts to locate the perpetrator.

Deficiencies-

- None identified

Statutory and Regulatory Compliance issues:

- None identified