



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: 05/28/11**  
**NEAR DEATH: 07/05/11**

**FAMILY KNOWN TO:**

**The family was not known to The Philadelphia Department of Human Services or any other child welfare agencies.**

**REPORT FINALIZED ON: 1/31/12**

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. The Department of Human Services did not conduct an Act 33 Review Meeting. The County investigation was [REDACTED] within 30 days of receiving the report from [REDACTED]

**Family Constellation:**

| <u>Name:</u> | <u>Relationship:</u> | <u>Date of Birth:</u> |
|--------------|----------------------|-----------------------|
| [REDACTED]   | Victim child         | 05/28/2011            |
| [REDACTED]   | Mother               | [REDACTED] 1986       |
| [REDACTED]   | Father               | [REDACTED] 1986       |

The father does not reside in the home with the mother and victim child.

**Notification of Child Near Fatality:**

On 07/05/11 the Philadelphia Department of Human Services (DHS) received a [REDACTED] report that the victim child fell out of a stroller and landed on his face. The mother and the father took the child to St. Christopher's Hospital because he had a bad fall. The child was admitted [REDACTED] [REDACTED]. According to the attending physician, the child's injuries were not consistent with the parent's explanation. The child was expected to live.

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

For this review, the Southeast Regional Office made an initial contact with the Department of Human Services on 7/06/11. The Regional Office conducted follow up interviews with assigned social worker, [REDACTED] on 7/6/11, 7/21/11 and 7/27/11. On 8/5/11, regional office made contact with Detective [REDACTED] from the Special Victims Unit (SVU) to follow up with the status of the criminal investigation.

**Summary of Services to Family:**

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

This family was unknown to the Philadelphia Department of Human Services and the family was not active with community agencies prior to this investigation.

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

On 07/05/11, DHS received a [REDACTED] report that alleged the child fell out of a stroller and was transported to Saint Christopher's Hospital for Children. When the child arrived at the hospital, the medical doctor certified the child to be in critical condition. The child was admitted to [REDACTED] and received a [REDACTED]

The [REDACTED] revealed the child suffered from a [REDACTED]. The medical doctor at St. Christopher's Hospital reported the child's injuries were inconsistent with the parent's report. The mother reported the child was in a car seat of a Snap-n-Go baby trend stroller. The mother reported while she was taking the child out of the car, the child was still in the car seat. The mother reported when she placed the child with the car seat in the stroller she had forgotten to buckle the child in the seat securely. The mother reported, as she began to push the child in the stroller he fell out of the stroller onto the ground. It was noted that the Snap-n-Go has a dual function; the car seat fits directly in the stroller. According to the mother, she did not securely buckle the child in the seat before she began to push the child in the stroller.

On 07/05/11 DHS conducted a safety assessment at the hospital and completed a home evaluation. There were no safety threats and there were no other children in the home.

On 7/06/11, the Detective from Special Victims Unit interviewed the mother and the father at the hospital.

On 07/06/11, the attending physician with the Child Protective Program at St. Christopher's stated the injuries were not suspicious for child abuse.

On 07/06/11 the child was [REDACTED] and returned home with the parents. There were no safety threats identified as per the safety assessment completed on 7/05/11 and a safety plan was not required.

**Current Case Status:**

- On 07/06/11 the child was [REDACTED] and returned home with his parents.
- On 07/7/11, DHS referred the parents to Parents Plus. This is a 12 week community program that focuses on safety in the home. The parents were cooperative and attended the program.

[REDACTED] DHS completed the [REDACTED] on 07/21/11 and [REDACTED]. The case was [REDACTED]

- On 08/05/11 the Detective from SVU reported no charges will be filed against the mother and the case was closed. According to the Detective, the incident was an accident.

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

There were none identified.

**Recommendations for Change at the Local Level and State Level:**

There were none identified.

**Department Review of County Internal Report:**

The Department of Human Services was not required to convene for an Act 33 Review Meeting. The County investigation was [REDACTED]

**Department of Public Welfare Findings:**

County Strengths: DHS was thorough and timely with the investigation. DHS referred the family to Parents Plus; this program provides the family with additional services focused on safety in the home.

County Weaknesses: There were no areas of concern.

Statutory and Regulatory Areas of Non-Compliance: There were none.

**Department of Public Welfare Recommendations:**

The Department recommends that training be provided to doctors to help them recognize trauma-related injuries related to child abuse. Organizations such as local child advocacy centers or medical associations should be encouraged to address this in the required annual training for physicians. The surgeon certified the child as being in critical condition. The surgeon ordered the [REDACTED] which showed a [REDACTED]. The surgeon initially reported the mother's explanation was inconsistent with the child's injuries. After a thorough review of all medical evaluations and records, the attending physician with the Child Protective Program at St. Christopher's Hospital determined that the injuries were not the result of child abuse.