



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



BORN: 04/23/2010
Date of Near Fatality Incident: 07/07/2010

FAMILY KNOWN TO:
Family not known to any county or public or private agency

REPORT FINALIZED ON: 06/04/2012

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 convened a review team on 8/6/2010 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim child	04/23/2010
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Father	[REDACTED] 1990
[REDACTED]	Sister	[REDACTED] 2009

Notification of Child (Near) Fatality:

On July 07, 2010 County received a call from [REDACTED] stating that victim child was brought to the [REDACTED] at St. Christopher's not responsive. Victim child had the following injuries which were verified by x-rays and cat scans: [REDACTED]

[REDACTED] There is a concern that the child had decreased oxygen flow to the brain possibly causing brain injury. Parents reported that on the morning of 07/07/2010 the child fell from the bed that is two feet off the floor, onto a carpeted area. Parents reported that there was no crying and there was a questionable loss of consciousness.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to this family. The regional office participated in the County Internal Fatality Review Team meetings on 10/22/2010. SERO conducted interviews with DHS Social Worker, CW from Bethanna, and SVU detectives.

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

No prior children and youth involvement.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/07/2010, child came to the [REDACTED] with multiple injuries. Child had [REDACTED]. There is a concern that the child had a decrease in oxygen flow to the brain, possibly causing brain injury. Parents reported that the morning of the incident the child fell off of the bed onto the carpeted floor which was approximately 2 feet high. Parents report that there was no crying and there was a questionable loss of consciousness. Child did survive.

On 07/07/2010, the county worker interviewed mother, father, maternal uncle, maternal grandmother, and maternal uncle's paramour. All gave their account of what they believed contributed to the circumstances of near fatality situation. On 07/09/2010 [REDACTED] was [REDACTED] the hospital and placed in medical foster care.

On 07/20/2010 [REDACTED] report was [REDACTED] due to medical information from St. Christopher's Hospital confirming that the injuries the child received were consistent with inflicted trauma [REDACTED]. The account of injuries given by mother and father were not consistent with the child's injuries since they stated the child fell off of the bed.

Current Case Status:

- [REDACTED] is doing better; he is seeing now; however, he is scheduled to see a specialist in February to verify how well he is seeing. He was [REDACTED] by the [REDACTED] team in Hershey 11/2010. He is sitting up and is not as stiff as he was in the past. He is currently receiving [REDACTED] according to DHS SW on 1/28/2011.
- [REDACTED] sister, [REDACTED] resides in the same foster home as [REDACTED]
- Father was arrested on 11/9/2010 for Aggravated Assault, Simple Assault, and Reckless Endangerment of a Child and remains incarcerated. The SVU felt as though the father, not the mother, was the primary caregiver during the time of the incident when the child obtained his injuries.
- Mother is offered weekly supervised visits twice a week: an hour at her residence and an hour at the agency. Mother is [REDACTED] again and the father is [REDACTED]. Father's visits are suspended as he is incarcerated but has a scheduled hearing on February 4, 2011.

- On 1/28/2011 SERO spoke with DHS SW and she reported that there is speculation that there was domestic violence in the home; however, mother has not admitted to it.

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 on 08/06/2010 in accordance with Act 33 of 2008 related to this report.

- **Strengths:**
 - It was believed that the DHS Social Work Manager followed protocol in securing a medical examination for sibling [REDACTED]
 - DHS acted properly by obtaining an Order of Protective Custody and placing both children out of the home in light of the near fatality of [REDACTED]
- **Deficiencies:**
None identified.
- **Recommendations for Change at the Local Level:**
None identified.
- **Recommendations for Change at the State Level:**
None identified.

Department Review of County Internal Report:

- No comment at this time

Department of Public Welfare Findings:

- **County Strengths:**
 - Timely and thorough [REDACTED]
 - Use of kinship resources and other resource as deemed necessary
 - Collaboration with police departments
- **County Weaknesses:**
None noted
- **Statutory and Regulatory Areas of Non-Compliance:**
No regulatory non-compliances noted.

Department of Public Welfare Recommendations:

None identified.