



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF**



**BORN: 03/01/2010**

**DATE OF NEAR-FATALITY: 07/31/2010**

**FAMILY KNOWN TO:**

**The Family was not known to Philadelphia Department of Human Services or any other County agency**

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. 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.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	03/01/2010
[REDACTED]	Biological sister	[REDACTED] 2007
[REDACTED]	Biological mother	[REDACTED] 1982
[REDACTED]	Biological father	[REDACTED] 1982

<u>Non Household Members</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Maternal grandmother	[REDACTED] 1959
[REDACTED]	Maternal [REDACTED]	[REDACTED] 1956

**Notification of Child Near Fatality:**

On July 31, 2010 the victim child, age five months, was transported to St. Christopher's Hospital for Children. She had sustained significant [REDACTED] and significant [REDACTED] as a result of [REDACTED]. Upon arrival to the hospital, the victim child was unresponsive. The victim child was [REDACTED] in [REDACTED] at St. Christopher's Hospital. [REDACTED] certified the victim child as a near-fatality.

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records that included police and [REDACTED] pertaining to the family. Follow up interviews were conducted with the Philadelphia Department of Human Services Intake social worker [REDACTED] Intake supervisor, [REDACTED] and on-going social worker, [REDACTED]. The regional office also participated in the County Internal Act 33 Review Team meeting on August 20, 2010.

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

The family has not had any involvement with children and youth prior to this incident.

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

On August 1, 2010, the Philadelphia Department of Human Services (DHS) received a referral from [REDACTED] regarding the victim child. It was reported that the father brought the victim child to St. Christopher's Hospital, unresponsive; she was [REDACTED] and placed in the [REDACTED]. It was determined that the victim child sustained [REDACTED].

The father reported that the victim child was in a high chair and her older sibling [REDACTED] (at the time of the incident) was swinging a toy golf club, made of solid plastic, and toy wand near her. Father reported that he told the sister to stop swinging the toys near the victim child. The father left the room to prepare a bottle. When he returned, he noticed the victim child was having trouble breathing. He called the mother. Mother told him to call her sibling who is an [REDACTED] for advice. Father reported that he tried reviving the victim child with water, and rushed the victim child to the hospital. The victim child's mother was at work at the time of the incident.

According to Dr. [REDACTED] from St. Christopher's Hospital for Children, a significant amount of force would have been applied to the victim child to cause the injuries. It was reported that father's explanation was not consistent with the victim child's injuries. She had sustained significant [REDACTED] and significant [REDACTED] as a result of [REDACTED].

On August 2, 2010, the victim child received an [REDACTED] exam; the exam revealed no [REDACTED].

On August 17, 2010, the [REDACTED] was interviewed through Philadelphia Children's Alliance. During this forensic interview, the [REDACTED] whined and would not talk. The [REDACTED] made no disclosure. DHS had interviewed the [REDACTED] previously. She reported, [REDACTED]. She reported the victim child had a boo-boo and daddy picked her up. The safety plan for the sister was to be placed with her maternal grandparents. The grandparents and the victim child's parents agreed to the safety plan. The safety plan stated that both parents would have supervised visits with the sister.

On August 20, 2010 the victim child received [REDACTED] to relieve the [REDACTED].

On August 20, 2010 the Act 33 meeting was held at the Medical Examiner's Office. There was a great deal of discussion regarding the possibility of the [REDACTED] being able to inflict this type of injury to the victim child. It was determined by Dr. [REDACTED] the [REDACTED] of DHS, after the review of the medical evidence that she could not rule out the father's description of how the injuries occurred, that the [REDACTED] could have inflicted the injuries to the victim child.

**Current Case Status:**

On August 26, 2010 after discharge from St. Christopher's Hospital, The victim child was placed at the [REDACTED], requiring [REDACTED]

On August 25, 2010, Philadelphia Department of Human Services made a determination [REDACTED] for lack of supervision resulting in a serious physical injury for father. The [REDACTED] investigation revealed through interviews with [REDACTED] and parents that the [REDACTED] has hit the victim child prior to this incident. The [REDACTED] investigation revealed that the victim child was not in a high chair during the incident as previously reported. She was in a seat that was directly on the floor.

On August 25, 2010, the family was accepted for service through the Philadelphia Department of Human Services. The family received [REDACTED] through [REDACTED] Children and Family Services. On October 13, 2010 the family was reunited; services were implemented through [REDACTED] Children and Family Services. These services are continuing. The Family Service Plan was developed requiring parents to receive a [REDACTED], learn and understand age-appropriate behavior and expectations for the children and provide adequate supervision at all times.

The victim child is making progress; she continues to [REDACTED] services through [REDACTED]. The victim child continues to have the [REDACTED]. The victim child continues to receive [REDACTED] and [REDACTED] through St. Christopher's Hospital for Children and [REDACTED] St. Christopher's Hospital and [REDACTED] report that the child's [REDACTED] are more [REDACTED]. She has [REDACTED] in the areas of walking and crawling.

The sister has regressed in the area of development with toilet training, and she has started drinking from a bottle.

Mother quit her job to stay home to take care of the victim child. Both parents are actively involved in the victim child's care and treatment. Father completed all of his [REDACTED] and classes. There have been no areas [REDACTED] or incidents with the family.

The Special Victims Unit closed their case with no arrest of father.

**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 has convened a review team in accordance with Act 33 of 2008 related to this report.

**The Act 33 meeting was held on August 20, 2010, with the following results:**

- Strengths: The team felt that the DHS social work services managers responded appropriately to the Hotline report. The team felt the DHS social work services manager followed proper protocol in securing a medical examination for the sister since the injuries to the victim child were initially reported as inconsistent with the father's report on how the injuries occurred. The team felt DHS followed good social work practice by placing the sister with family members in an effort to secure her immediate safety.
- Deficiencies: The [REDACTED] that the father's reported account of the incident (i.e., that the [REDACTED] caused the injury) could not have occurred. The [REDACTED] caused DHS to conduct their investigation and make decisions based upon the assumption that the father [REDACTED] the abuse. After the Act 33 Review Team meeting, however, the DHS [REDACTED] Director reviewed the medical evidence and could not rule out father's description of how the injuries occurred. The team was concerned that DHS did not fully explore with the mother (as the non-offending parent) the option of her keeping her children in her home without the father being present in the home. The team felt the mother should have been offered the option to keep the children with her instead of placing the sister with relatives. It was also noted that mother's parenting capacities were not documented in the safety plan. The team was concerned that the police weren't notified in a timely manner by DHS and by the hospital, possibly delaying the criminal investigation. The first police notification was made on 08/03/10, two days after receiving the report. DHS notified the police department again on 08/09/10.
- Recommendations for Change at the Local Level:  
In an effort to improve communication and the transmission of information between DHS and the children's hospitals, the team recommends that there be a weekly meeting between Department of Human Service's Medical Director, DHS nurses and hospital personnel to discuss suspected child abuse cases. The team recommends DHS explore the best and most expedient ways to report suspected cases of child abuse to the Philadelphia Police Department.
- Recommendations for Change at the State Level:  
There were no county recommendations at the State Level.

**Department Review of County Internal Report:**

The Department has reviewed the county's report and is in agreement with the recommendations and findings.

**Department of Public Welfare Findings:**

County Strengths: The Philadelphia Department of Human Services provided comprehensive documentation in regard to the [REDACTED] investigation. The Structured Progress Notes were thorough and included detailed accounts of the interviews of father, mother and the [REDACTED]. The county obtained all necessary medical and hospital documentation regarding the victim child. The county continues to monitor the victim child's medical progress and has frequent communication with the in-home services providers. The county closely monitors the victim child's therapies to ensure she receives necessary medical and physical interventions. The county had the [REDACTED] interviewed forensically through the Philadelphia Children's Alliance. All of the county social workers responded in a timely and professional manner to the Department of Public Welfare.

- County Weaknesses: The investigation did not explore the possibility of mother keeping her children in the home while the father lived outside of the home during the investigation. The initial safety assessment did not address the mother's protective capacities. If this had been done, perhaps the children would not have needed to be removed. However, the county did work timely and effectively to reunite the family once the investigation was completed.
- Statutory and Regulatory Areas of Non-Compliance There are no areas of non-compliance

**Department of Public Welfare Recommendations:**

The Department agrees with the finding of the Act 33 Review team that the DHS team did not fully explore the mother's role of non-offending parent, and that the mother should have been allowed the option of keeping her children in her home without the father being present in the home. However, the initial safety assessment did not address the mother's protective capacities. The investigating worker needed to further assess the situation before being able to recommend that the victim child be returned to the mother's care.