



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: 02/13/05
DATE OF NEAR DEATH: 11/09/09

**THE FAMILY WAS NOT KNOWN TO ANY COUNTY AGENCY
THE FAMILY WAS NOT KNOWN TO ANY SOCIAL SERVICE AGENCY**

Submitted 9/13/2010

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 Governor Rendell 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.

Circumstances of Near Death.

On November 9, 2009 [REDACTED], age 4 years, was hit by a Chester Water Authority truck at the corner of 4th and Highland Avenue in Chester, PA. The accident occurred near the residence of his paternal aunt, [REDACTED]. The mother and father, [REDACTED] and [REDACTED], were visiting the aunt's home with [REDACTED], and his siblings [REDACTED] and [REDACTED]. [REDACTED] was outside playing on the corner with his brothers and other children. A neighbor saw the accident and picked [REDACTED] up out of the street and carried him to the aunt's home. The father transported [REDACTED] by car to the emergency room. [REDACTED] sustained facial fractures. Chester police are investigating the accident. The report was [REDACTED] for Lack of Supervision.

Summary of Review.

Family Constellation

| <u>Name</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|-------------|---------------------|----------------------|
| [REDACTED] | Victim Child | 02/13/2005 |
| [REDACTED] | Brother | [REDACTED] 1999 |
| [REDACTED] | Brother | [REDACTED] 2001 |
| [REDACTED] | Sister | [REDACTED] 2008 |
| [REDACTED] | Mother | [REDACTED] 1984 |
| [REDACTED] | Father | [REDACTED] 1970 |

Documents Reviewed and Individuals Interviewed.

For this review the SEOCYF reviewed the Delaware County Children and Youth case file, which included: the structured case notes, the risk assessment, the safety assessment, the [REDACTED] investigation, and the medical reports. SEOCYF staff also interviewed Delaware County Children and Youth staff that included; [REDACTED], intake unit supervisor, and [REDACTED], intake social worker. The original [REDACTED] social worker [REDACTED] is no longer with the agency.

Case Chronology.

Prior to [REDACTED] accident the family has not had involvement with any County Children and Youth Agencies, or any other social service agencies. Subsequent to the receipt of the

██████████ report Delaware County Children and Youth immediately commenced an investigation.

The investigation determined that at the time of the incident ██████████ was outside of his paternal aunt's home playing with other children, including his two older brothers, ██████████, age 10 and ██████████ age 8. The paternal aunt's home is at the corner of the street, the children were playing in front of the home.

A Safety Assessment was completed and revealed that the children were Safe with no safety threats present.

The hospital discharge plan was developed that the mother would be responsible for supervising ██████████ and meeting his medical needs as prescribed by CHOP, upon his discharge.

The investigation revealed that both parents were very attentive to ██████████ needs while he was in the hospital. The hospital reported that someone was always at ██████████ bedside during his hospital stay over a month long. Both parents were cooperative with CYS involvement and cooperated with the investigation. CYS interviewed the family members and the neighbors to complete the ██████████ investigation. The investigation determined the level of risk as LOW. The ██████████ investigation was completed within 30 days with a ██████████. The county agency determined the family was not in need of services and the case was closed.

Findings and Recommendations

South East Regional Office's (SERO) Findings:

1. The ██████████ investigation revealed that the child's injuries were not a result of child of abuse or neglect
2. The safety assessment completed revealed that all of the children were safe with no safety threats present.
3. The Office of Children, Youth and Families believes that Delaware County Children and Youth followed protocol surrounding the investigation.