



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: 09/14/2010

Date of Near Fatality Incident: 11/19/2010

**FAMILY KNOWN TO:
THE PHILADELPHIA DEPARTMENT OF HUMAN SERVICES**

REPORT SUBMITTED: 12/5/2011

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 has convened a review team in accordance with Act 33 of 2008. The Act 33 meeting was held December 17, 2011.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	09/14/2010
[REDACTED]	Mother	[REDACTED] 2009
[REDACTED]	Father	[REDACTED] 1983

Non- Household Members

[REDACTED]	Paternal Grandmother to [REDACTED]	Adult
[REDACTED]	Brother	[REDACTED] 1998
[REDACTED]	Father to [REDACTED]	[REDACTED] 1972
[REDACTED]	Paternal Grandmother to, [REDACTED]	[REDACTED] 1951
[REDACTED]	Paternal Grandfather to, [REDACTED]	[REDACTED] 1951

The mother's son, [REDACTED], lives with his father, [REDACTED]. The father has legal custody of [REDACTED].

Notification of Child (Near) Fatality:

On 11/19/2010 the Department of Human Services received a call from ChildLine concerning the victim child, [REDACTED]. ChildLine stated the [REDACTED] was registered for [REDACTED] and was certified as a Near Fatality. The victim child was [REDACTED] to Children's Hospital of Philadelphia (CHOP) due to severe injuries to her head. The victim child had [REDACTED]. According to the [REDACTED] and the [REDACTED], the victim child was fed and fell asleep. The [REDACTED] she went to the store. The [REDACTED] when the child woke up she was laying in her vomit, limp but

responsive. According to the doctor, the injuries were inconsistent with the father's account.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office received and reviewed the case file for the near fatality [REDACTED]. The documents reviewed: structured case /progress notes, present danger assessments, risk assessments, safety assessments, safety plans, medical records and [REDACTED] from CHOP. The initial interview with DHS was conducted on 11/19/10 with the Child Fatality Program Administrator, [REDACTED]. Follow-up interviews were conducted with [REDACTED], DHS Social Worker, [REDACTED], DHS Social Worker, and [REDACTED], Episcopal SW. On 12/17/2010 the Regional Office participated in the Act 33 Review.

Summary of Services to Family:

Children and Youth Involvement Prior to Incident:

07/25/2000 – 8/12/2001

This family became known to DHS on 07/25/00 by a [REDACTED] report alleging that the mother left her two year old son, [REDACTED] in the home alone without supervision. The neighbors heard the child screaming and called 911. When the police arrived, the front door was unlocked. While the police were in the home, [REDACTED] father arrived intoxicated. The father reported when he left for work, the mother was with [REDACTED]. The police escorted the father and [REDACTED] to the paternal grandparents' home. The police thought it would be best, since the father was intoxicated. DHS provided a plan for services to the family. The mother and [REDACTED] father received [REDACTED], counseling, monitoring, daycare and parent education. The family case was closed 8/12/2001.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 11/19/10 DHS received a [REDACTED] report that the victim child [REDACTED] was [REDACTED] to the Children's Hospital of Philadelphia (CHOP) due to [REDACTED] to the [REDACTED]. The victim child had a [REDACTED] and [REDACTED]. The victim child was placed in [REDACTED]. The [REDACTED] stated that the child [REDACTED] and it was unlikely that the injuries were the result of a fall. The mother and the father were unable to explain the injuries of the victim child.

On 11/19/10 DHS completed safety assessment and safety plan for the victim child at the hospital. The safety plan dated 11/19/10 identified a safety threat in that the mother and father were unable to explain the victim child's injuries. The mother's protective capacities are diminished as the mother did not demonstrate

adequate skills to protect her child. The hospital staff agreed not to [REDACTED] the victim child to the parents. The hospital agreed to contact DHS prior to the child's [REDACTED].

The mother has another child that resides with his father. The sibling child was not in the home at the time of the incident, and has not been in any contact with the mother. The father has had custody of the sibling child since he was three years old. The sibling child and the father live at another address.

On 11/19/10, the mother reported to DHS that she and [REDACTED] father were at their home when the incident occurred. The mother reported that in the morning she fed [REDACTED], changed her diaper and placed the child in her swing. The mother reported when victim child went to sleep she moved her into the pack and play. The mother reported approximately 9 am, she went to the store and left the victim child with her father, [REDACTED]. The father reported while the mother was at the store, he went downstairs to smoke a cigarette. The father reported when he arrived upstairs he found [REDACTED] laying in vomit. The father reported he picked her up, and she was limp and unresponsive. The father reported he immediately called the neighbor. When the mother returned from the store, she found the neighbor trying to give her daughter CPR, while receiving instructions from the 911 dispatcher. When the ambulance arrived, the victim child was transported to Children's Hospital.

On 11/22/10 the mother reported to DHS, the victim child had two accidents - she fell off the bed and fell out of the car seat. The father reported she fell out of the car seat and onto the floor. The father reported the handle to the car seat was loose. The mother also reported that on 11/12/10 the victim child was not feeling well and she called and took the victim child to the doctor. According to the mother the doctor stated her child was alright and there were no concerns. The mother further stated that on 11/13/10, the victim child had a runny nose but no fever. The mother stated she had taken the victim child back to the doctor on 11/13/10; the doctor told her the victim child's head was pulsating and it felt full. The mother stated that the doctor told her not to be concerned.

On 11/22/10, the [REDACTED] reported to DHS that she cared for the victim child three weeks ago. The [REDACTED] stated she observed a lump on the left side of the victim child's head, and the child was very gassy and fussy. The [REDACTED] stated she didn't mention her concerns to the parents.

On 11/22/10 DHS interviewed the father. The father reported on 11/19/10 the mother woke up the victim child and fed her and she went back to sleep. He reported the mother left and went to the store. The father reported while the victim child was asleep, he went into the basement to smoke a cigarette. The father stated he was in the basement for 15 minutes. He stated when he went to check on the child, she was laying in a pool of vomit. The father stated he picked

her up and she was limp. He stated he called the neighbor over, because she knew CPR. The father stated when the mother arrived; the neighbor was on the phone receiving instructions from 911. The father was unable to explain the injuries.

On 12/01/10 DHS obtained an Order of Protective Custody for the victim .The child was [REDACTED] from the hospital on 12/01/10. The victim child was placed with a foster care family through Episcopal Community Services. On 12/3/10 the OPC was lifted and the temporary commit stands. The victim child was to remain as placed and DHS had to explore all family resources.

Current Case Status:

- On 12/20/10 this case was [REDACTED]. Based on the medical injuries sustained by the victim child, both [REDACTED] were identified as the [REDACTED].
- The victim child is adjusting well and living in a medical foster home through Episcopal Community Services. The foster family will follow-up with the victim child's scheduled medical appointments.
- The parents have weekly supervised visits at the agency.
- As of 3/16/11 Criminal Charges for the parents are still pending. The father has a criminal history and he is scheduled to go to court for possession with the intent to deliver controlled substances. The court date is scheduled for March 14,2011
- Both parents are required to attend parenting classes, anger management, [REDACTED] and [REDACTED].

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. The Philadelphia Department of Human Services convened a review team in accordance with Act 33 of 2008 on 12/17/10.

Strengths: The [REDACTED] was conducted in a through and timely manner.

Deficiencies: There were no deficiencies identified.

Recommendations for Change at the Local Level and State Level:

Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect: Medical personnel do not fully understand that their

cooperation is a vital key in making good safety decisions for children. The medical team at CHOP refused to sign the safety plan while the child was in the hospital.

Department Review of County Internal Report:

The Department and DHS agree that a quality review should be conducted to ensure that children with unexplained injuries and an unidentified perpetrator are not reunified with their children prematurely.

Department of Public Welfare Findings:

County Strengths: The Department of Human Services was responsive with providing adequate correspondence. The DHS SW made the appropriate contacts and follow-up interviews to complete a timely [REDACTED]. The safety assessments and safety plans were completed within required time frames.

County Weaknesses: There were no areas of concern.

Statutory and Regulatory Areas of Non-Compliance: There were no areas of non compliance.

Department of Public Welfare Recommendations

The Department recommends that DHS consult with the [REDACTED] and [REDACTED] psychologists prior to reunification.