



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:



BORN: August 16, 2010
NEAR FATALITY: November 28, 2010

FAMILY WAS NOT KNOWN TO ANY AGENCY

REPORT FINALIZED ON:
03/29/2012

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 [REDACTED] [REDACTED] has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County convened a review team and met on December 17, 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	08/16/2010
[REDACTED]	Mother	[REDACTED] 1984
[REDACTED]	Father	[REDACTED] 1976
[REDACTED]	Sister 1	[REDACTED] 2004
[REDACTED]	Sister 2	[REDACTED] /2005
[REDACTED]	Brother 1	[REDACTED] /2009

Notification of Child Near Fatality:

On November 28, 2010, the Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging that 3 month three-month-old victim child was brought by his parents into Children's Hospital of Philadelphia (CHOP) at 7:00AM after vomiting and "looking spacey." Chest x-rays revealed that the victim child had [REDACTED]. A [REDACTED] revealed [REDACTED]. [REDACTED] The medical staff stated the injuries are consistent with [REDACTED] the attending physician, Dr. [REDACTED] determined that the victim child was in critical condition and that the case was certified as a near-fatality.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the family case file from the Department of Human Services (DHS) and interviewed the DHS social worker assigned to the case.

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

The family had no previous involvement with DHS.

Circumstances of Child Near Fatality and Related Case Activity:

On November 28, 2010, the Philadelphia Department of Human Services (DHS) was notified of the near death of the victim child. The child had been brought into the Children's Hospital of Philadelphia by his parents on November 28, 2010 after vomiting

and “looking spacey.” [REDACTED] revealed that the victim child had [REDACTED]. [REDACTED] revealed [REDACTED] itself. The injuries were suspicious for intentional injuries such as [REDACTED], the attending physician, Dr. [REDACTED] determined that the victim child was in serious and critical condition. The victim child’s mother, told the doctor that the child was fine last night other than crying during the night for several hours. The mother reported that the victim child had been a sickly baby previous to this hospital admittance and stated that she and her husband had repeatedly taken him to various doctors due to his excessive crying. The mother stated that she and her husband called for an ambulance when the victim child started breathing rapidly and appeared to be in a daze. The victim child’s father, stated that he could have rolled onto the child while sleeping, causing his [REDACTED]. The DHS investigation reveals that the family which consisted of the mother, father and four children including the victim child, lived with a church member. It was further discovered that the entire family slept together in one bedroom on two twin mattress that were pushed together on the floor. Because of the unusual sleeping arrangement, it is difficult to discern if the victim child was injured as a result of the sleeping arrangements or if he sustained the injuries in another manner. On 11/28/2010, a Safety Assessment was completed with a Safety Decision of “Unsafe” for all four children and they were put into kinship care, with a safety plan.

Current Case Status:

As of July 25, 2011 remain in foster care; the three older siblings are placed in the same foster home through Catholic Social Services. The victim child is in a [REDACTED] foster home through Best Nest. There are court ordered supervised visits at the agency with parents and siblings. The parents have not yet obtained housing and are still living in the same home they were in when this report was filed. The parents have been ordered to have a [REDACTED] where a psychologist will determine if they are capable of raising their children; to date this evaluation has not been completed. The DHS supervisor states that the permanency goal for the victim child is reunification; however, if that does not work out, DHS has received information from a family member in Florida that they are interested in doing kinship care for the children.

The Police Department’s Special Victims Unit (SVU) is not bringing any criminal charges against the victim child’s parents, as a medical expert could not state for certain that the [REDACTED] he sustained were the [REDACTED]. The child was also determined to have [REDACTED] an extremely [REDACTED] [REDACTED] which the medical expert advised caused his [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. Philadelphia County convened a review team on December 17, 2010 in accordance with Act 33 of 2008 related to this report.

- Strengths:
 - The team felt that DHS did a thorough job investigating the case.
 - The team felt that the safety plans were completed in a thorough and timely manner.
 - The team felt that the communication between the Social Work Services Manager and the hospital staff was excellent.
 - DHS was successful in placing the siblings together to ensure family unity.
 - The team was concerned that parents were being given inside information about the investigation and the case, from an unknown source. For example, the parents knew that the case was going to be certified as a near fatality. The parents also knew when the Act 33 review was going to be held and where. The parents stated they received this information from a [REDACTED] DHS is in the process of exploring how this may have occurred.
- Deficiencies:
None Identified.
- Recommendations for Change at the Local Level:
No recommendations at this time.
- Recommendations for Change at the State Level:
No recommendations at this time.

Department Review of County Internal Report:

The Department feels that the county did a through job investigating this case and is in agreement with the internal report.

Department of Public Welfare Findings:

- County Strengths:
The assigned DHS SW did an excellent job in convincing the victim child's father to cooperate with DHS after the father had initially refused to speak with her due to his religious beliefs.
- County Weaknesses:
According to the county team, information about the date, time and location of the Act 33 review was given to the parents from an unknown source. There is concern that the information was leaked by a county employee; the concern will be investigated by the county.
- Statutory and Regulatory Areas of Non-Compliance:
None identified.

Department of Public Welfare Recommendations:

The Department should provide more guidance to the community service providers about the critical need to educate new mothers about the dangers of co-sleeping. Information could be offered by their medical providers after delivery and at each well baby checkup. The Department should ensure that pamphlets and brochures are distributed in the community at places frequented by families with young babies, such as pediatricians' offices, WIC offices, etc.