

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

*Raheemah Shamsid-Deen Hampton*  
*Managing Director*  
*Southeast Region*

801 Market Street, Sixth Floor  
Suite 6112  
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823  
Fax: (215) 560- 6893

**REPORT ON THE Near Fatality OF:**



**DATE OF BIRTH: 10/24/2008**  
**DATE OF NEAR FATALITY INCIDENT: 01/07/2011**

**FAMILY KNOWN TO:**  
**Family was not known to any county agency**

**REPORT FINALIZED ON: 10/20/11**

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 was not required to convene a review team in accordance with Act 33 of 2008 related to this report. The [REDACTED] within 30 days of the report.

**Family Constellation:****Name:**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**Relationship:**

Victim Child  
Brother  
Sister  
Biological mother  
Stepfather

**Date of Birth:**

10/24/2008  
[REDACTED] 2006  
[REDACTED] 2010  
[REDACTED] 1988  
[REDACTED] 1980

**Non-Household Members:**

\* [REDACTED]  
\*\* [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Maternal great grandmother  
Maternal grandmother  
father [REDACTED]  
wife of [REDACTED]  
son of [REDACTED]  
godmother

[REDACTED] 1948  
[REDACTED] 1968  
[REDACTED] 1974  
[REDACTED] 1971  
[REDACTED] /2006  
Adult

\* [REDACTED] She is the biological grandmother of [REDACTED] who adopted [REDACTED] when she was a child.

\*\* [REDACTED], She is the biological mother of [REDACTED]

**Notification of Child Near Fatality:**

On January 7, 2011, the Philadelphia Department of Human Services (DHS) received a telephone call from ChildLine concerning 2 year old [REDACTED]. On 1/7/11, [REDACTED] was transported to St. Christopher's Hospital for Children by ambulance due to second degree burns covering over 30% of her body. The burns were on the interior portion of her chest, abdomen, upper arms and thighs and no burns on her hands and feet.

[REDACTED] (mother) reported [REDACTED] turned on the hot water in the bath tub while the mother was not looking. Mother reported [REDACTED] climbed in the tub and burned herself. Reporting source certified that [REDACTED] was in [REDACTED] as a result of suspected abuse. [REDACTED] was in the [REDACTED] and expected to survive. It was reported that the distribution of burns is not consistent with the explanation given by the mother of how the injury occurred. There were no burns on [REDACTED]'s hands or feet. Mother reported that the home is undergoing construction and has no cold water in the bathroom.

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted with the investigation caseworker, [REDACTED], and ongoing social worker [REDACTED].

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

On 5/13/2010, DHS received a [REDACTED] report involving the infant [REDACTED]. [REDACTED] was born positive for drugs (marijuana). No services were provided from DHS at this time. The assessment determined that the infant was safe to go home with the family.

[REDACTED] was a victim of abuse and neglect as a child. She was adopted by her maternal biological grandmother, [REDACTED] through Philadelphia County.

Mother has a history of [REDACTED] with [REDACTED] she was [REDACTED].

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

On January 7, 2011, Philadelphia Department of Human Services received a ChildLine report concerning 2 year old [REDACTED]. The initial report stated that mother's account of the incident was not consistent with the injuries. Mother had reported that she turned on the hot water in the bath tub and while she was not looking [REDACTED] climbed in the tub and burned herself. The incident occurred in the evening in preparation for bedtime. Mother called 911 and reported that [REDACTED] was burned all over her body.

On January 8, 2011, a safety assessment was completed and a safety plan was implemented. It was determined that the children would be safe with a comprehensive safety plan. [REDACTED] and [REDACTED] were medically examined and determined to be healthy and did not exhibit any signs of abuse. The safety plan was for [REDACTED] to be placed with the maternal grandmother, [REDACTED], pending the [REDACTED]. It was stated that mother could not have any unsupervised visits with the children. It was determined that [REDACTED] was safe in the [REDACTED].

On January 11, 2011, four days after the injury, the Philadelphia Department of Human Services nurse consultant and social worker collaborated with hospital staff, Dr. [REDACTED], and social work staff. The physician stated that mom's account of how the burn happened is credible and that the case is no longer a near fatality. Even though the doctor stated that the child was not considered a near fatality, the incident remained under investigation according to [REDACTED]. St Christopher's social worker informed the DHS social worker that [REDACTED] had [REDACTED] and she will need [REDACTED]. The social worker showed the DHS social worker the scanned images of [REDACTED] body. The skin was peeled off on both legs, down her chest and stomach and arms and buttocks and splatter on the upper back portion of her shoulder.

It was determined that mother was preparing a bath for [REDACTED]. Both [REDACTED] and [REDACTED] were in their bedroom watching TV. [REDACTED] left the bedroom and went into the bathroom and began playing in the bathtub. The tub does not run cold water, only hot which fluctuates from hot to cold. Mother believes that [REDACTED] was playing in the tub and the water changed to hot. The mother reported that she ran the bath water and then went into the kitchen. The mother stated that [REDACTED] was burned in the tub where the faucet is 3 feet off the ground. The mother informed that she normally puts ice in the bathtub because the water heater is set too high. The mother said that she left the bathroom and heard [REDACTED] scream. When she ran back in, she found [REDACTED] in the water and the front of her body was red. The mother said she put [REDACTED] on the victim child and called the stepfather, [REDACTED]. The stepfather was not in the home at the time of the incident.

On 1/11/11 [REDACTED] was interviewed by the county social worker. He informed that [REDACTED] "got burned by the water." He stated that "she jumped into the water in the tub". He stated that he and [REDACTED] were in their room eating a cookie and [REDACTED] left the room and went into the bathroom then got into the tub. She began screaming and mom got her out of the bathroom. [REDACTED] stated that dad was not home at the time of the incident. The [REDACTED] [REDACTED] determined that the mother called dad after the incident occurred and dad came home from work. [REDACTED] reported that when dad came home he began yelling at mom; [REDACTED] denied any "hits" were exchanged between his mother and father. [REDACTED] denied being hit by his mother or father when he is bad. He reported that the mother calls him a "good boy."

The Safety Assessment dated 1/8/11 for [REDACTED] and [REDACTED] determined that the children would be safe with a comprehensive safety plan. Safety Threat #3 was identified: Caregiver (s) cannot or will not explain the injuries to a child. The safety plan for the children was to have the children placed in the home of maternal great grandmother [REDACTED]. Mother was not allowed to have any unsupervised visits with the children.

The Safety Assessment dated 1/8/11 for [REDACTED] determined that she would be safe with a comprehensive safety plan. The Safety Threat #3 was identified: Caregiver (s) cannot or will not explain the injuries to a child. [REDACTED] was hospitalized at St. Christopher's Hospital for Children. The plan stated that the hospital will not [REDACTED] [REDACTED] to the mother or any family member until further notice from DHS.

The safety plan had to be amended as [REDACTED] was admitted into the hospital. The children were moved into the home of godmother, [REDACTED], on 1/10/11.

The Safety Assessment dated 1/14/11 in the home of [REDACTED] for [REDACTED] and [REDACTED] the Safety Threat #9 was identified; Caregiver (s) in the home are not performing duties and responsibilities that assure child safety. The safety plan stated that [REDACTED] will ensure that [REDACTED] does not have any unsupervised visits with the children. [REDACTED] continues to be safe in the St. Christopher's Hospital.

The Risk Assessment dated 1/18/2011 determined that the overall severity is moderate and the overall risk is moderate.

On 2/1/11 The [REDACTED] reported that the [REDACTED].

On 2/1/2011 the children were returned to mother and father and [REDACTED] into the home to [REDACTED].

**Current Case Status:**

- The Philadelphia Special Victims Unit investigated this case. It was determined, based on additional medical evidence, that this injury was accidental; no arrests were made.
- The family was reunited on 1/26/2011; and the [REDACTED] through DHS. The provider agency is Youth Services Inc. [REDACTED].
- [REDACTED] is developing and healing well, and will make a full recovery. All of the children's needs are being met.

**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 not convened a review team in accordance with Act 33 of 2008 related to this report. The [REDACTED] 2/1/11 within 30 days of receipt of the report.

**Department Review of County Internal Report:**

Not applicable

**Department of Public Welfare Findings:****County Strengths:**

- Collaboration with the medical team and child abuse team at St. Christopher's Hospital for Children.
- Timely and quality safety and risk assessments and safety plan.
- The assessment of the child functioning of the three children. The assessment focused on developmental milestones of childhood development and determined that the children are developing age appropriately and reaching developmental milestones.
- [REDACTED] was interviewed using child centered techniques.

**County Weaknesses:**

- There are none identified

**Statutory and Regulatory Areas of Non-Compliance:**

- There are none identified

**Department of Public Welfare Recommendations:**

- The Department should collaborate with local licensing and inspection offices to ensure that landlords are held liable when children are injured due to inadequate and poor conditions of the home. The fact that the water pipes only ran hot water in this structure was not safe for young children. Nor was the structure of the house fit for human habitation. This injury may not have occurred if the family was not living in the home while the home was under construction.
- When referrals are made to the county agencies as a result of [REDACTED], the counties should partner with other community agencies that would follow and monitor the safety and wellbeing of the newborn. The Department recommends that collaboration should occur among community agencies such as health departments, local hospitals, physicians to ensure that these newborns are receiving appropriate medical care after the county has completed their investigations.
- The Department recommends that there should be significant collaboration between [REDACTED] and DHS when parents are [REDACTED]. This mother had a history with [REDACTED] receiving [REDACTED] and [REDACTED]. When parents are receiving [REDACTED] and [REDACTED] their cognitive and emotional behaviors may impact their parenting abilities and skills. [REDACTED] partner with DHS to develop strategies that would assist parents who receive services from [REDACTED] in their caretaking of their children, whether the case is accepted for county services or is referred to community prevention services.
- The Department recognizes that the medical community continues to require information and education regarding recognizing child abuse and the responsibilities of mandated reporting.