



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: 4/16/11
DATE OF NEAR FATALITY INCIDENT: 08/27/11

FAMILY KNOWN TO:
The Family was Not Previously Known to the County Agency

REPORT FINALIZED ON: 6/7/12

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 has convened a review team on 9/15/11 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Case Child	4/16/2011
██████████	Mother	██████/82
██████████	Father	██████/84

Notification of Child Near Fatality:

On 8/27/11, the Philadelphia Department of Human Services (DHS) received a call from ██████████ concerning ██████████, age 4 months. At Children's Hospital of Philadelphia (CHOP), ██████████. CAT Scans revealed that ██████████ had acute and chronic injuries. He was certified to be in critical condition as a result of his injuries, which were believed to have resulted from non-accidental trauma. ██████████ father, ██████████, initially denied abusing his child. ██████████ later stated to the ██████████ that, on 8/24/11, the child was in a bouncer that was 2 feet off the floor, and that ██████████ was not strapped into the bouncer when he fell. ██████████ stated that he stepped away from the child, and when he returned, ██████████ was lying face down on the floor. The child went for a well-baby visit on 8/24/11, and his pediatrician noted that ██████████. On 08/27/11 both parents took the child to Abington Memorial Hospital, where ██████████ of Abington Memorial Hospital, stated that the child's injuries were certified as a near-fatality. ██████████ was then transferred to CHOP for further diagnosis and treatment.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all records pertaining to ██████████, including ██████████ records from the pediatrician, Abington Memorial Hospital, and CHOP, and the

██████████. Follow-up interviews were conducted with the intake and ongoing workers. The regional office also participated in the County Internal Fatality Review Team meeting on 9/15/11.

Summary of Services to Family:

The family was not previously known to the Department of Human Services.

Circumstances of Child Near Fatality and Related Case Activity:

The child was brought to Abington Memorial Hospital on 8/27/11, because the mother reported that he had been vomiting for the past 2 days. ██████████ was ██████████. Dr. ██████████, Abington Memorial Hospital, reported that the case was a near-fatality. The child was transferred to CHOP, where it was ██████████ that he had a previous ██████████. ██████████ father, ██████████ ██████████ has presented inconsistent statements regarding the incident. On arriving at the Emergency Room on 8/27/11 at Abington Memorial Hospital, ██████████ reported that on 8/24/11 the child had fallen out of a bouncy seat onto the floor.

On 9/2/11, ██████████ visited DHS, stating that his previous statement was not true, and in fact, he had knocked over the pack and play while the child was inside. He reported that he had "lost it" due to the child's crying, and kicked the pack and play.

Per the 9/9/11 ██████████ this case was ██████████ on the father for the new injury, and on both parents for the old injuries, as neither parent could or would say how the baby sustained the earlier injuries. The child lived with both parents at the time, and a specific time was never given for the injury, so it was unclear which parent was caring for ██████████ at the time. ██████████ mother, ██████████, was working at the time of the most recent incident, but in a conversation with DHS, the worker stated that the report was ██████████ for her because it seemed that she may have been covering up for his father, ██████████.

Current Case Status:

According to the 9/5/11 Safety Assessment, it was determined that ██████████ would have been unsafe living with his parents. The safety plan was for him to remain in the home with ██████████, family friends, but they were not able to care for ██████████ for longer than 1 month. DHS made arrangements for him to live with ██████████ his paternal cousin. ██████████ received ██████████ through A Second Chance, Inc., and the case has been transferred to Episcopal Community Services. The ██████████ goal was ██████████ as of the initial 9/27/11 ██████████ meeting ██████████, ██████████ mother, has been going to the ██████████, maintains full-time

employment, and is working on a bachelor's degree. [REDACTED] mother and father have liberal visits in [REDACTED] home, and his mother, [REDACTED], also has 6 hours of unsupervised visitation. Per the court 11/8/11 court order, the father's visits with the child were to be supervised by the caregiver, [REDACTED]. The court also ordered that the child may return to the mother prior to the next court date upon agreement of all parties. Per the 2/14/12 court order, the child was returned to the mother, who had moved to [REDACTED], and all visits with the father were supervised by DHS for 60 days. The criminal case is pending.

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 on 9/15/11 in accordance with Act 33 of 2008 related to this report.

Strengths:

- The Team felt the Multi-Disciplinary Team (MDT) [REDACTED] did an excellent job [REDACTED] the case.
- The Team felt the MDT [REDACTED] did an excellent job securing a written statement from [REDACTED] when he changed his account of the incident.
- The Team felt there was good collaboration between DHS and the Special Victims Unit.

Deficiencies: None

Recommendations for Change at the Local Level:

- DHS will clarify the definition of near-fatality for staff and outside stakeholders by devising a script for the DHS hotline to use when asking hospitals to certify a near-fatality.

Recommendations for Change at the State Level: None

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county. The County should collaborate with other professionals in the community who are serving families with infants and explore methods to educate young parents, especially utilizing methods such as social networking sites.

Department of Public Welfare Findings:

█ County Strengths: Timely █

- County Weaknesses: None
- Statutory and Regulatory Areas of Non-Compliance: None

Department of Public Welfare Recommendations:

Maternity hospitals could increase parenting education, highlighting the need to take time for self, how to take care of the baby's needs, swaddle the baby & put him in a crib safely, so the parent can leave the room and take some time for self.

The Department should ensure that State and Public social service agencies have available resources for new parents, such as Baring House or Sally Watson Center, could be made more visible for parents not involved in the social service system.