



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: 06/24/2010**  
**DATE OF NEAR FATALITY: 10/26/2010**

**FAMILY KNOWN TO:**  
**Philadelphia Department of Human Services**

**REPORT FINALIZED ON: June 7, 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 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 as the [REDACTED] was [REDACTED] within 30 days of the oral report. The [REDACTED] was completed on November 23, 2010

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	06/24/2010
[REDACTED]	Twin sibling	[REDACTED] 2010
[REDACTED]	Sibling	[REDACTED] 2003
[REDACTED]	Sibling	[REDACTED] 2005
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Biological mother	[REDACTED] 1986
[REDACTED]	Maternal grandmother	[REDACTED] 1964

**Non Household Members**

[REDACTED]	Biological father	[REDACTED] 1982
[REDACTED]	Maternal aunt	unknown
[REDACTED]	Paternal grandmother	[REDACTED] 1964

**Notification of Child Near Fatality:**

On October 26, 2010 Philadelphia Department of Human Services (DHS) received a call [REDACTED] concerning the victim child. It was reported that the victim child arrived at the [REDACTED] of St. Christopher's Hospital in critical condition. The child presented with a [REDACTED]. Mother stated that she was upstairs and heard a thump. When mother came down stairs, she saw the victim child on the floor face down near the couch. She picked her up and noticed that she was pale, weak and felt heavy. The mother reported that she did not shake her to revive her. Mother checked her for broken bones, she then ran to a neighbor who [REDACTED] to the

Temple Hospital. Temple Hospital [REDACTED] the child to St. Christopher's Hospital for Children.

While at the hospital, the [REDACTED] [REDACTED] that she was not sure what happened as she was upstairs changing the diaper of the victim child's twin brother. She reported that she was upstairs for approximately 3-4 minutes. She also reported that she had left the victim child in the swing and the 5 year old and 7 year old brothers were also in the home.

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to this family. An interview was conducted with the Caseworker on October 30, 2010.

#### **Summary of Services to Family:**

##### **Children and Youth Involvement prior to Incident:**

On October 27, 2007, the agency received a report that a baby was not properly monitored, was climbing in and out onto the porch roof and the child and mother were asking people for stuff. The [REDACTED] [REDACTED] completed on November 20, 2011 was [REDACTED].

On November 28, 2008, the agency received a report that there was no heat or hot water in the home, that the roof was collapsing, and the home was not fit to live in. The [REDACTED] completed on December 15, 2008 was [REDACTED].

On December 3, 2008, the agency received a report that there was no heat or hot water in the home and the home was falling down. The report also alleged that the mother and father were drinking and using drugs. The [REDACTED] completed December 15, 2008 was [REDACTED].

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

On October 26, 2010, the victim child was [REDACTED] to St. Christopher's Hospital for Children for a [REDACTED]. The diagnosis was [REDACTED]. Her ears were normal without bruises. The [REDACTED] was negative; the skull was not fractured, only [REDACTED] on her brain.

The Radiology Department of St. Christopher's indicated that the victim child had [REDACTED], her [REDACTED] [REDACTED] were [REDACTED] and [REDACTED] and [REDACTED]s were [REDACTED]. The result of the survey was [REDACTED].

The [REDACTED] determined that the 5 year old sibling of the victim child picked her up out of her swing and was holding her by the blanket. He tripped with the blanket, falling on top of the victim child. The five year old sibling then picked the victim child up and she fell off the blanket. Mother did not witness the incident as she was upstairs changing the diaper of the victim child's twin brother. [REDACTED] initially reported that the victim child fell off the couch as she found her on the floor near the couch.

The Child Protection Program at St. Christopher's Hospital for Children provided a [REDACTED] of the incident and allegations. The assessment reports that "Her injuries could possibly be due to a short fall and an accidental injury." The assessment states "with the additional information of the 5 year old dropping the child twice and additionally falling on top of the infant while tripping adds a significant amount of energy to the fall." The physician Dr. [REDACTED], [REDACTED] of [REDACTED], reports "I cannot say that it is impossible that it happened in this way." The [REDACTED] continues to report "there was no delay in seeking care and the histories are consistent, therefore, this was likely an accidental injury."

The victim child [REDACTED] from St. Christopher's Hospital for Children on October 30, 2010 and returned home to her mother and family.

#### **Current Case Status:**

The family received [REDACTED] ([REDACTED]) through Carson Valley Children's Aid. The focus of the services was age appropriate child care and supervision, safety and parenting. The case was closed on November 23, 2010. The victim child has made a full recovery with no need for special services or interventions. The [REDACTED] was determined [REDACTED] on November 23, 2010. According to medical evidence, this was determined to be an accidental injury.

#### **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 Department of Human Services did not convene a review team in accordance with Act 33 of 2008 related to this report. A review is not required as the [REDACTED] was [REDACTED] within 30 days of the oral report.

- Strengths: N/A
- Deficiencies: N/A

- Recommendations for Change at the Local Level: N/A
- Recommendations for Change at the State Level: N/A

**Department Review of County Internal Report:**

No internal report required.

**Department of Public Welfare Findings:**

**County Strengths:**

- The Philadelphia Department of Human Services completed a comprehensive [REDACTED]. All necessary and required documents were obtained. The interviews of the 3 siblings of the victim child were age appropriate. The interviews of the children revealed that the 5 year old sibling picked up the victim child out of her swing and was holding her by the blanket. The sibling tripped with the blanket falling on top of the baby. He then picked her up and she fell off the blanket and he landed on top of her.
- Timely completion of safety assessment and safety plan:  
The safety assessments were conducted on October 26, 2010 and October 27, 2010. The safety assessment for October 27, 2010 determined that the children would be safe with a comprehensive safety plan. The safety plan was for maternal grandmother to move into the home and assist mother with parenting the children. The safety assessments on October 26 and 27, 2010 identified the safety threat number 3: Caregiver(s) cannot or will not explain the injuries to a child. The protective capacities were identified as follows: Cognitive: Mother has adequate knowledge, is reality oriented and articulate, and is aligned with child to protect. Emotional: Mother expresses love, empathy and sensitivity towards the victim child and the other children. Behavioral: Mother took immediate action by [REDACTED] immediately. The safety plan was to have maternal grandmother move into the home with mother and to have [REDACTED] in the home.
- Comprehensive collaboration with medical professionals.  
The county obtained all necessary medical records and reports. The county had significant collaboration with the medical team at St. Christopher's. All of the siblings were [REDACTED] through St. Christopher's Hospital.
- Timely and comprehensive [REDACTED].

The [REDACTED] included extended family members and incorporated them into the safety plan.

County Weaknesses: There are no weaknesses identified

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

**Department of Public Welfare Recommendations:**

In review of all reports of child abuse involving a child fatality or near fatality in the Southeast region during 2009 thru 2010, the regional office has noticed that a common factor in several of the families is the fact that the mother and father were identified as the alleged [REDACTED] of the [REDACTED]. The lack of parenting skills was the contributing factor or precursor leading to the [REDACTED]. Another common factor is that the family had a lack of social support. In some cases the family may have had past [REDACTED] with a county children and youth agency. There were no safety threats identified during the assessment/[REDACTED] of the reports and the investigation of the family was closed in most cases without follow up services to ensure that the family made connections to prevention/community support services in a timely manner. It is recommended that the Department have on-going public service announcements regarding the parenting skills and community supports.