



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Southeast Regional Director

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

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

REPORT ON THE NEAR FATALITY OF:



Date of Birth: November 3, 2009
Date of Near Fatality Incident: June 11, 2010

**The family was known to the
Philadelphia Department of Human Services**

Date of Report: January 20, 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 Child Line 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 Child Line. The Philadelphia Department of Human Services (DHS) convened a review team 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 (VC)	11/03/2009
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Maternal Great-grandmother (MGGM)	Adult
[REDACTED]	Maternal Aunt (MA)	Adult

The above-mentioned family members live at [REDACTED] Philadelphia, Pa.

Non Household Members

[REDACTED]	Biological Father to Victim Child/ Alleged Perpetrator	[REDACTED]/1988
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The biological father to VC lives at [REDACTED] Philadelphia, Pa. The biological father and the mother had an unofficial agreement that the VC would reside with each parent for a period of two weeks at a time.

[REDACTED]	Brother	[REDACTED]/2008
[REDACTED]	Maternal Grandmother (MGM)	Adult
[REDACTED]	Maternal Aunt (MA)	Adult

The above-mentioned family resides at [REDACTED] Philadelphia, PA. The brother lives with the MA and MGM.

[REDACTED] Biological father to VC's brother, [REDACTED]

The biological father to the brother, [REDACTED] resides at another location.

Notification of Child (Near) Fatality

On June 11, 2010 Philadelphia DHS received a [REDACTED] report for VC [REDACTED]. The VC had been staying with the father for approximately one month. The VC returned to the mother on June 10, 2010. The mother took VC to

Children's Hospital of Pennsylvania (CHOP) emergency room on June 11, 2010. The child was vomiting and crying throughout the night. When they arrived at the hospital, the medical team reported the VC appeared to be dehydrated and the hospital ran tests. [REDACTED] was performed and the results revealed that he had [REDACTED]. The VC also had [REDACTED]. He was admitted to the [REDACTED] at CHOP. The medical staff certified him to be in serious condition and the injuries appeared to be as a result of suspected child abuse.

Summary of DPW Child (Near) Fatality Review Activity

The Southeast Regional Office (SERO) reviewed the structured case notes provided by DHS. SERO interviewed [REDACTED], hotline social worker, regarding the initial [REDACTED] investigation. SERO attended the Act 33 Review Meeting held on July 2, 2010. SERO conducted follow up interviews with DHS to discuss the preliminary findings. Interviews were conducted with [REDACTED], social worker, and [REDACTED] Administrator.

Summary of Services to Family

Children and Youth Involvement prior to Incident

April 3, 2009: [REDACTED] Investigation – [REDACTED] The family became known to the Philadelphia DHS on April 3, 2009 as a result of a [REDACTED] report alleging that [REDACTED] (one year old) had a swollen, bloody upper lip and a swollen left eye. It was reported that it was not known what caused the injuries and the injuries appeared to be recent. The mother, [REDACTED], reported the incident happened when [REDACTED] was living with her paramour, [REDACTED]. While at the hospital, additional tests were conducted. [REDACTED] also had an old [REDACTED] tear in his mouth and a scratch on his face. According to the documentation the scratch may have been a result of [REDACTED]'s long finger nails. [REDACTED] report was [REDACTED] because the injury did not meet the definition [REDACTED].

On May 1, 2009, at the conclusion of the investigation, the social worker was informed that the mother was expecting another child and she did not have stable housing. The social worker referred the mother for case management, counseling, daycare, housing, job training, community-based support, Parent Action Network and parent education. In addition, the mother was willing to accept Family Support Services.

Circumstances of Child Near Fatality and Related Case Activity

On June 11, 2010 DHS received a [REDACTED] Report for [REDACTED]. The mother reported the VC was vomiting and crying throughout the night and day. She initially took the VC to Woodland Avenue Health Center, Philadelphia. The mother was instructed by the medical team to take her son to CHOP because the VC had a fever of over 100 degrees. CHOP reported the child was dehydrated and a series of tests, including a [REDACTED], were conducted. The doctor at CHOP determined that the VC was in serious medical condition and the child was placed in the [REDACTED]. The VC was diagnosed in serious condition as he showed evidence of [REDACTED] to

the brain. There were [REDACTED]. The mother stated the injuries occurred while the VC was staying with his father. The father was interviewed and denied allegations of child abuse.

According to the interview, the mother reported that she and the father; [REDACTED], shared in the care giving of the VC. The mother reported that she, along with her two children, resided with [REDACTED] until March 14, 2010, but that they did not get along when living together. Although the mother moved out, she reported that she and the father maintained a good relationship. The mother and father made an unofficial agreement for the VC to reside with each parent for a period of two weeks at a time since the mother and father lived in separate households. The VC was with his father for some time, but returned to his mother's care on April 16, 2010. On May 5, 2010, the VC returned to his father and remained in his care until June 10, 2010 when he returned to his mother's care.

DHS made a visit to the hospital on June 11, 2010 to ensure the safety of the VC and the older brother was brought to the hospital for testing and to ensure his safety. The brother was examined and no injuries were found. A safety plan was completed and an Order of Protective Custody was obtained for both children. On June 12, 2010, the brother was removed from the home and temporarily placed with the maternal great grandmother, because there was no explanation for the VCs injuries and there were concerns that the older brother might be at risk due to his age. The maternal great grandmother and maternal aunt agreed to supervise visits with brother and mother. While the VC was in the hospital, the mother was granted supervised visits with both children. The visits were supervised by the on duty nurse and monitored by DHS. The hospital agreed to contact DHS before the VC was discharged. The VC was [REDACTED] on June 17, 2010 into the care of the maternal great grandmother, but the child later went to live with the MGM, as his mother, who was an [REDACTED] was living with the MGGM.

Current Case Status

- The [REDACTED] report was [REDACTED] on July 11, 2010 [REDACTED] based on the safety assessment dated June 11, 2010, as the mother and the father were unable to explain the VC's injuries. The father was the caregiver of the VC from May 6, 2010 through June 10, 2010. On May 1, 2010 the mother took the VC to the Woodland Avenue Health Center, Philadelphia for a wellness visit. The medical team reported there were no injuries found. The father admitted he had the VC in his care from May 6, 2010 through June 10, 2010.
- In the initial safety plan dated June 11, 2010, the MGGM and MAU agreed to take care of the children without the mother being in the home. On June 17, 2010 the safety plan was amended and the VC and brother were placed with MGM, as their mother presently lives with MGGM and MAU. The mother was not seeking treatment for [REDACTED] that were identified so was not being considered as a resource for the children.
- DHS submitted a referral for kinship care through A Second Chance.
- Both children were adjudicated dependent and committed to DHS.
- The mother was granted supervised visits at the agency.

- The [REDACTED] goal is reunification. As well as the mother receiving parenting classes and additional services with ARC, she was scheduled to receive a parenting capacity evaluation.
- DHS has attempted to meet with the father on several occasions. The father has refused to cooperate.
- According to the detective, the father has a criminal history and two outstanding warrants for his arrest. On May 28, 2007 and June 12, 2007 the father was arrested and charged with intent to manufacture, deliver and possess a controlled substance. The father failed to appear for two scheduled hearings and a bench warrant was issued for his arrest.
- Criminal charges for the father are pending as of the writing of this report.
- No criminal charges were filed against the mother as of the writing of this report because the father was the sole caretaker at the time of the incident.
- The safety decision dated June 15, 2010 was determined unsafe since the mother and father were unable to explain the injuries to the VC.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report

Strengths: [REDACTED] safety and well-being were addressed by DHS within a timely manner and DHS was in compliance with statutes and regulations.

Deficiencies: There were no deficiencies identified.

Recommendations for Change at the Local Level and State Level: None identified.

The Department Review of County Internal Review

The Act 33 Near Fatality Review Team was held on July 2, 2010. DHS conducted a timely review and the Child Fatality team consisted of individuals who had expertise in prevention and treatment of child abuse.

Department of Public Welfare Findings

- **County Strengths:** DHS collaborated with family members to ensure the children were placed with family when out-of-home care was warranted.
- **County Weakness:** None identified.
- **Statutory and Regulatory Areas of Non-Compliance:** No areas of non-compliance identified.

Department of Public Welfare Recommendations

The team recommended that DHS explore online training to refresh the staff on subjects such as sexual abuse, domestic violence and child protective services.