



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: [REDACTED] 2010

Date of Near Fatality Incident: October 25, 2010

**The family was not known to
any county or public or private agency**

Date of Report: September 24, 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 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 convened a review team on November 19, 2011 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	[REDACTED]/2010
[REDACTED]	Mother	[REDACTED]/1985
[REDACTED]	Father	[REDACTED]/1990
[REDACTED]	Sibling	[REDACTED]/2008
[REDACTED]	Sibling	[REDACTED]/2009
[REDACTED]	Maternal Grandmother	[REDACTED]/1968
[REDACTED]	Mother's Paramour	[REDACTED]/1982

Notification of Child (Near) Fatality

On October 25, 2010 Philadelphia Department of Human Services (DHS) received a call [REDACTED] stating that on October 17, 2010 the mother brought two-month old [REDACTED] to the hospital because the baby stopped breathing. When the baby was brought to the hospital, the ER doctor found no medical cause at that time for the baby's condition. The mother had blood on her clothes. The mother said this was because when she found baby not breathing he had blood coming from his nose. When the reporting source spoke to mother on October 25, 2010, mother did not want to answer questions about what happened. Other staff had talked to the maternal grandmother who reported that there is domestic violence between the mother, father and the mom's current boyfriend. The mother also finally reported that she takes [REDACTED]. She said she left baby with [REDACTED] while she went to the drug store to get her medication and when she came back she moved the baby to her bed. A few minutes later she came back to find the baby not breathing. Police were not notified about the incident. The doctor stated she felt the baby's injuries were suspicious and most likely the result of abuse.

Summary of DPW Child (Near) Fatality Review Activities

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to this family. The regional office

participated in the County Community Review Team meeting on November 19, 2010. SERO conducted interviews with DHS social worker, DHS SW supervisor, and DHS fatality administrator.

Summary of Services to Family

Children and Youth Involvement prior to Incident

No prior children and youth involvement.

Circumstances of Child Near Fatality and Related Case Activity

On October 17 2010, mother brought baby to the St. Christopher's Emergency Room because the victim child stopped breathing and blood was coming from his nose. The child was diagnosed with [REDACTED] which is caused by not breathing for a long time. On October 25, 2010 this near fatality was called into ChildLine due to the re-evaluation of [REDACTED] condition by the medical staff. The eight-day delay after the incident occurred was not the result of negligence but a need for further inquiry. On October 25, 2010, the DHS county worker interviewed the mother, the mother's paramour, the maternal grandmother, the hospital social worker and the hospital nurse. On October 26, 2010 the DHS county worker interviewed Dr. [REDACTED] the mother, the mother's paramour, the maternal grandmother and the father.

On November 1, 2010 [REDACTED] was [REDACTED] and he, along with his other siblings, resided with [REDACTED] godmother, Ms. [REDACTED].

Current Case Status

It was concluded that the victim child presented in the hospital ER with [REDACTED]. He was in acute respiratory distress requiring [REDACTED]. The mother responded properly by taking the child to the ER when he stopped breathing.

[REDACTED] is doing better. He and his siblings are back with their mother at their new residence as of December 8, 2010. On November 8, 2010 the mother received a full [REDACTED] assessment. IHPS was placed in the home on January 4, 2011 to assure that the mother takes [REDACTED] to his follow-up appointments, to address [REDACTED] issues of the mother, to provide parenting, to refer the mother to employment training, and to refer the mother to domestic violence [REDACTED]. The biological father was not residing in the home and the paramour was no longer involved with biological mother.

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

Strength

County did a good job investigating the case. The social work services manager discussed the investigation with the DHS nurse and DHS attorney per DHS protocol.

Deficiencies

None identified.

Recommendations for Change at the Local Level

None identified.

Recommendations for Change at the State Level

None identified.

Department Review of County Internal Report

No comment at this time.

Department of Public Welfare Findings

County Strengths

- Timely and thorough investigation
- Use of kinship resources and other community resources as deemed necessary

County Weaknesses

There was a lack of communication with this case from the county to SERO in the beginning; however, that has since been rectified after discussion.

Statutory and Regulatory Areas of Non-Compliance

No regulatory non-compliances noted.

Department of Public Welfare Recommendations

No recommendations.