



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: 09/17/2009

DATE OF NEAR FATALITY: 04/07/2012

DATE OF ORAL REPORT: 04/07/2012

**FAMILY NOT KNOWN TO ANY
PUBLIC OR PRIVATE CHILD WELFARE AGENCY**

REPORT FINALIZED ON: 03/29/2013

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 in accordance with Act 33 of 2008 related to this report on 05/04/12.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	09/17/09
[REDACTED]	Sibling	[REDACTED]/08
[REDACTED]	Mother	[REDACTED]/90
[REDACTED]	Mother's Paramour	[REDACTED]/89
[REDACTED]	Paramour's Grandmother	[REDACTED]/35

Non-Household Members:

[REDACTED]	Biological Father (Incarcerated)	[REDACTED]/86
[REDACTED]	Maternal Grandmother	[REDACTED]/66
[REDACTED]	Step Father of [REDACTED]	Adult
[REDACTED]	Husband of [REDACTED]	

Notification of Child (Near) Fatality:

On 04/07/12, at approximately 2:15pm, the Philadelphia Department of Human Services (DHS) Hotline received a [REDACTED] from [REDACTED] at Jeanes Hospital which stated that [REDACTED], age 2, was admitted due to a serious physical injury to the spinal cord as certified by Dr. [REDACTED] and named the biological mother, [REDACTED] DHS Hotline subsequently reported the abuse allegation to ChildLine at 3:45 pm. The Reporting Source stated that the mother carried the child into the ER at approximately 12:16 pm, stating that her daughter was tripped by their dog while walking down wooden steps two (2) days ago on 04/05/12. The mother stated that her daughter

slipped and fell down a half flight of stairs. The Reporter stated that the mother pointed out that her daughter initially complained of pain in her lower back area and woke up the following day, 04/06/12, walking funny- stiff like, but was walking. Mother further stated that her daughter didn't "wanna get up" this morning and has not walked since. The mother stated that the child was incontinent.

The attending physician, Dr. [REDACTED], stated that the child suffered [REDACTED]

Once the child [REDACTED], she was immediately transferred to St. Christopher's Hospital for Children for a [REDACTED] with a diagnosis of [REDACTED]

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all case records pertaining to the [REDACTED] family through the course of its review of this Near Fatality [REDACTED], which included: the review of the medical records from Jeanes Hospital, St. Christopher's Hospital for Children, and the Shriners Hospital for children; the DHS assessment and investigation records and their ongoing structured case notes and progress notes along with the safety and risk assessments completed until the case decision was made on 04/20/12; and transferred for ongoing services. SERO initiated and maintained contact with [REDACTED] of the Multi Disciplinary Team Investigator (MDTI) worker, and her supervisor, [REDACTED] throughout the completion of the [REDACTED] investigation. The SERO continued to monitor the victim child's progress after her case was transferred to the Ongoing Services Unit with social worker, [REDACTED] and her supervisor, [REDACTED]. Several follow up interviews were conducted once this case was transferred to ongoing services in order to monitor and track the child's progress following her transfer from St. Christopher's Hospital to Shriners Children's Rehabilitation Hospital with both the DHS social worker and [REDACTED] social worker at Shriners.

SERO also participated in the DHS Act 33 Review Team meeting at the Medical Examiner's Office on May 4, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

No prior Agency involvement with this family.

Circumstances of Child Near Fatality and Related Case Activity:

On 04/07/12 – DHS received a [REDACTED] allegation from Jeanes Hospital Emergency Room (ER [REDACTED] stating that the attending physician, Dr. [REDACTED] was certifying that a recent admission of patient, [REDACTED], age 2, was in serious condition as a result of suspected abuse, with mother, [REDACTED], suspected [REDACTED]. The Reporting Source (RS) stated that the mother carried the child into the ER at about 12:16 pm indicating that her daughter fell down the steps from tripping over the dog at around dinnertime time on 04/05/12; and stated that initially she showed no signs of serious injury but was unable to get out of bed this morning and was not able to walk.

The initial medical assessment and examination described the child as being conscious, fussy, crying when attempts were made to move her, dark colored bruises about the size of a dime on right cheek and bruising on left hand with two (2) scratches, [REDACTED].

On 04/07/12 – The victim child, [REDACTED], was medically [REDACTED] at Jeanes Hospital with the initial diagnosis of [REDACTED] by Dr. [REDACTED], examining physician, who recommended that victim child required a higher level of care through the immediate transfer to St. Christopher's Hospital for Children for further medical assessment, care and follow-up treatment at 1:20 pm.

On 04/08/12 – Referral to the Philadelphia Police – Special Victims Unit with Detective [REDACTED] and Lieutenant [REDACTED] heading up the investigation.

On 04/09/12 – Dr. [REDACTED] Child Protection Director, at St. Christopher's Hospital for Children provided a more specific interpretation of the child's injuries and medical conditions once their trauma team was able to complete the initial medical examination and treatment of the VC, with the following notations: the child showed signs of significant pain including crying when touched and hollering out "stop it" repeatedly; left ear had an approximate [REDACTED]; no bruises behind the ears on the [REDACTED]; eyes with [REDACTED]; [REDACTED] but no lesions noted on limited exam;

[REDACTED] no movement of the lower extremities with no response to painful stimuli at the feet or lower legs; [REDACTED]

On 04/09/12 – DHS MDTI worker contacted VC's pediatrician, Dr. [REDACTED] who indicated that his most recent treatment of VC was for an [REDACTED] but has frequently treated [REDACTED] for [REDACTED] and [REDACTED] for which he has prescribed [REDACTED]. He also pointed out that VC's mother has missed many well clinic visits but then makes a lot of calls to the Clinic. VC is current with her immunization shots and

believes she is only missing 1 shot. Dr. [REDACTED] indicated when asked about his overall concern about this child's medical health and care that there was "nothing really concerning or nothing to alert". Dr. [REDACTED] also indicated that he had a previous consult with Dr. [REDACTED] and conveyed the same information.

Dr. [REDACTED] evaluation finds that physical abuse is the most likely diagnosis as the degree of injury diagnosed is a severe life threatening injury to the VC was clearly inconsistent with the history as reported by the mother and paramour during her investigative interviews. Dr. [REDACTED] reported that falls from stairs and short falls do not typically lead to life threatening or severe injuries such as seen in VC.

Furthermore, physician reported that with a [REDACTED], one would expect more immediate symptoms to be observed by the VC. Additionally, there was some inconsistency in the history in regards to the timing of the VC's symptoms as stated by the mother and her paramour when interviewed on separate occasions. The physician reported that injuries of this severity should have been brought to medical attention immediately. The bruises on the buttocks were not consistent with a fall and more consistent with being struck in light of the [REDACTED].

On 04/09/12 – DHS S/W completed a Face to Face Safety Assessment and Safety Plan as the result of the unexplained injuries to the VC requiring hospitalization at St. Christopher Hospital for Children. The outcome of the Safety Assessment indicated that the biological mother, [REDACTED], lacked the protective capacity to insure the safety of her daughter, because her explanation of how the victim child was injured did not match the victim child's injuries. It was determined that the VC was unsafe without proper supervision while in the hospital and/or once she was ready for discharge [REDACTED].

A Safety Plan was implemented outlining the terms of visitation for all family members which provide for only supervised visits by the biological mother and the maternal grandmother, [REDACTED]. The paternal family members were allowed to have unsupervised visitation. No other persons were allowed to visit until the completion of the [REDACTED] investigation.

The enforcement of the Safety Plan was being coordinated and shared between the Charge Nurse, Nurse Manager and DHS MDTI worker.

Please note that a separate [REDACTED] investigation was initiated involving [REDACTED] biological sister, [REDACTED] as a result of the DHS MDTI worker's observation of suspicious bruising at the time of her initial contact with the other household members. [REDACTED] was also hospitalized on 04/07/12 due to multiple bruises including bruises [REDACTED]. She also had some [REDACTED] that were most likely due to physical abuse. [REDACTED].

On 04/09/12 – ██████████, biological mother of ██████████, was interviewed by the DHS MDTI worker while at St. Christopher Hospital for Children and asked to explain what had happened to her daughter.

The mother stated that on 04/05/12 about dinnertime the girls were upstairs watching cartoons and she was cooking macaroni and cheese and doing other things that required her to go up and down stairs. She stated that she keeps a board across the steps to keep the dog from going up and down the steps. On the day of the incident she had forgotten to put it back. The VC's older sister went down the stairs and into the kitchen while VC followed. The mother stated that the dog was normally kept downstairs, but had gotten upstairs. When the VC was walking down the steps, about 4 or 5 steps from the top, the dog ran down and knocked her off of her feet. The VC reportedly fell down the stairs and landed on her buttocks in a sitting position. The mother stated that she ran to the VC and asked her if she was okay. The VC stated that her legs hurt, so she massaged them and the VC appeared to be alright. The mother indicated that her daughter ate okay and after dinner she took a bath and she slept through the night.

The next day, 04/06/12, the mother indicated that she got the girls up and the VC appeared to be walking stiff and didn't respond when asked if anything hurt. The mother stated that she had to run a few errands and when she returned her daughter stated that her legs hurt. Mother stated that she put her down for a nap and later massaged her legs again. They had dinner and she gave her a bath before bedtime.

On Saturday, 04/07/12, her daughter was complaining that her legs still hurt and wouldn't get out of bed and she noticed that she had wet the bed which was peculiar since she was potty trained. Mother stated that her daughter was complaining that her back hurt and she turned her over and noticed that her back was swollen at which time ██████████ began screaming in pain. She decided to give her a warm bath but she continued to groan in pain and the mother tried to massage her legs again. Mother stated she then got her ready to take to the hospital and while waiting for her paramour to get ready she looked up ██████████ symptoms on the internet using her phone and thought it was spinal shock which is why she laid her on the back seat when driving to Jeanes Hospital.

On 04/09/12 – DHS MDTI worker attempted to interview the VC's older sister, while at St. Christopher Hospital with no success. That same day the MDTI worker interviewed the paternal grandfather, ██████████ of ██████████ at St. Christopher Hospital who indicated that the mother and girls lived with him and his wife for about four (4) years but moved out about seven months ago into her paramour's house. He stated that the only form of discipline he ever saw the mother use was keeping the girls in their room. He thought the mother was okay but he hasn't seen the children for the last week and wanted to be considered as a resource for the girls. The MDTI worker interviewed the maternal grandmother, ██████████, at St. Christopher Hospital who indicated that she wanted the children to come and live with her. She indicated that she didn't believe her daughter would ever hurt the children and felt her daughter was telling the truth.

On 04/10/10 – DHS MDTI worker interviewed mother’s paramour [REDACTED] and his 86 year old paternal grandmother [REDACTED], at their residence [REDACTED] heard the “little one” fall down the stairs and saw the mother run over and pick her up. [REDACTED] seemed to be okay on Thursday, 04/05/12, but it seemed to get worse on Friday, 04/06 and Saturday, 04/07. She indicated that [REDACTED] did not cry much and she could sit and walk. She stated that she thought the dog knocked her down the stairs. [REDACTED] indicated that she has no concerns about the mother’s parenting and has never seen her hit the children and that the children are never left alone.

The mother’s paramour stated that [REDACTED] and her two (2) daughters moved in with him and his grandmother around September 2012 but that he has known [REDACTED] since they were younger. He indicated that he was not home when the victim child fell but had noticed the next morning, 04/06, about 11 am before leaving for work that she was limping. It wasn’t until Saturday, 04/07, that the victim child lost the feeling in her leg that they decided to take her to the Hospital. The paramour stated that he believes the mother has a good parenting style and has never seen her use physical discipline.

On 04/11/12 – [REDACTED]

On 04/12/12 – ChildLine registered the child abuse case as a near fatality based on Dr. [REDACTED] certification that [REDACTED] is in critical condition with a [REDACTED] as a result of blunt force trauma.

A Forensic interview was conducted with the VC’s sibling at the Philadelphia Children’s Alliance as a possible witness to the alleged abuse of the VC. The sibling did not provide a disclosure during the interview. A Home Evaluation of paternal grandparents, [REDACTED], was completed in anticipation of identifying and securing a potential kinship placement if the either or both children were not returned to the custody of the biological mother.

A Referral was made to request a Family Group Decision Making conference for a planned placement within the next thirty (30) days in anticipation of identifying and securing a potential kinship placement if either or both children were not returned to the custody of the biological mother.

On 04/19/12 home Evaluation of maternal grandparents, [REDACTED], was completed in anticipation of identifying and securing a potential kinship placement if either or both children were not returned to the custody of the biological mother.

The MDTI worker interviewed [REDACTED], Director and [REDACTED] (Teacher) of [REDACTED] Philadelphia regarding the VC. Staff indicated that her attendance was very good, always came to the daycare dressed appropriately and well kept, on target developmentally, never noticed any injuries or bruises and was well behaved. Staff indicated that the mother always brought her to the daycare center and the mother and her paramour were "awesome".

The MDTI worker completed a Home Evaluation of paternal great aunt, [REDACTED], for possible placement of both children during the case investigation in order to place the children with relatives. The MDTI worker conducted a telephone interview of [REDACTED] biological father of the victim child who is incarcerated at [REDACTED]

On 04/20/12 - DHS submitted the status determination of their investigation to ChildLine [REDACTED] biological mother, as the [REDACTED] based on the severity of the injuries to child being considered a near fatality.

The Risk Assessment was completed at the conclusion of the investigation on 4/20/12 with severity of risk for re-abuse assessed as high with the safety decision that it would be unsafe for either child to be returned to the supervision and care of the biological mother. The case was open for placement services and transferred to DHS ongoing services unit and assigned to [REDACTED], social worker and [REDACTED] Supervisor.

Current Case Status:

On 04/23/12 the VC was transferred from St. Christopher Hospital for Children to the [REDACTED] at Shriners Rehabilitation Hospital in Philadelphia for [REDACTED] and treatment with the eventual [REDACTED] to their [REDACTED] program which will include a parent caregiver education program for the eventual involvement of VC's caregiver.

The VC was [REDACTED] on 06/22/12 from the [REDACTED] unit at Shriners Rehabilitation Hospital and admitted into their [REDACTED] program and placed [REDACTED] into the kinship home of her maternal grandmother, [REDACTED] and [REDACTED], her husband, stepfather of [REDACTED]. The VC was reunited with her older sister who was also placed into this home earlier following her [REDACTED] from the medical foster care placement.

[REDACTED]

A Second forensic interview was conducted on 07/20/12 with the VC's older sister, at Philadelphia Children's Alliance at which time she disclosed that her mother pushed the VC down the stairs.

A Bench warrant was issued on 08/02/12 charging [REDACTED] with Aggravated Assault, Recklessly Endangering Another Person and Simple Assault. She was arrested 8/02/12 and incarcerated at Philadelphia Detention Center – Female Unit.

On 08/13/12 [REDACTED], social worker, Shriners Outpatient Rehabilitation Clinic reported that the VC participates twice per week in both [REDACTED] [REDACTED] to promote independent mobility. Her maternal grandmother completed the parent caregiver educational training and has played an integral part in her recovery. The maternal grandmother participates in all of her treatment.

The VC is continuing to show progress each week which has led to her being able to utilize a wheelchair daily and is beginning to walk with assistance and by wearing braces although she still meets the criteria as a paraplegic.

The maternal grandmother has been trained to meet the VC's physical care needs at home which includes an extensive regiment of medications for her [REDACTED]. The VC functions at age appropriate cognitive limits and a recent referral to Elwyn for [REDACTED] services has occurred.

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 convened a review team on May 4, 2012 in accordance with Act 33 of 2008 related to this report.

- Strengths:
 1. Act 33 Team pointed out that MDT Social Work Services Manager (SWSM) completed a thorough investigation which was further enhanced by cross system collaboration that occurred with the Special Victims Unit throughout the course of the investigation.
 2. The Act 33 acknowledged that the SWSM presented a well documented case file that included a complete chronology of all key stakeholders involved throughout the investigation and into the ongoing service delivery phase.
- Deficiencies:

None
- Recommendations for Change at the Local Level:
 1. The Act 33 Team determined that the SWSM implemented an appropriate safety plan that included input by the hospital's nurse managers and a sign

off by a resident physician addressing important issues related to the need for the supervision of the Victim Child by the parents during her hospital stay. The action of the nurse managers may have been contrary to hospital policy. It is recommended that DHS issue a statement of current practice around safety plans for hospitalized children so that hospitals can build their internal policies and procedures with full knowledge of DHS' practices. The document should clarify points of contact, including information about who the hospital should contact if they object to elements of the safety plan.

- Recommendations for Change at the State Level:

None

Department Review of County Internal Report:

The regional office received and reviewed the county's internal Act 33 report. The regional office agrees with the report as written. Philadelphia DHS established and maintained an open dialogue and timely exchange of reports and case file information with the Southeast Regional Office throughout the course of their investigation and into the post investigation phase of developing a service plan with the family.

Department of Public Welfare Findings:

- County Strengths:

1. DHS insured that the Southeast Regional Office was kept updated with the changing disposition of this case throughout their investigation and into the period of providing services to the family.
2. The Southeast Regional Office received timely documentation of their CPS Investigation Report and related case notes; and safety and risk assessment that supported their implementation of the different safety plans as the case evolved.
3. Timely action on the part of the DHS Hotline S/W occurred to intervene and identify the existing presence of risk to the victim child's older sibling, [REDACTED], who required hospitalization resulting from unexplained physical injuries.
4. All relevant parties involved with this case were interviewed in a timely manner with appropriate safety plans implemented involving both the victim child and her older sibling.
5. Aggressive planning efforts were implemented to establish an eventual support system to be available once decisions regarding discharge were apparent that focused on kinship placement opportunities with the backup alternative of a medical foster care home.

- County Weaknesses:

None

- Statutory and Regulatory Areas of Non-Compliance:
None

Department of Public Welfare Recommendations:

None