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:

BORN: 11/17/2009
Date of Incident: 5/7/2012

FAMILY KNOWN TO:
Montgomery County Children and Youth Services

REPORT FINALIZED ON:
March 12, 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. 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. Montgomery County convened a review team in accordance with Act 33 of 2008 related to this report on 6/7/2012.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim child	11/17/2009
	Mother	[redacted]1991
	Maternal grandmother	[redacted]/1969
	Maternal grandmother's paramour	[redacted]/1959
	Maternal uncle	[redacted]/1994

Other family members:

[redacted]	Father	[redacted]/1983

Notification of Child Near Fatality:
On 5/8/2012, ChildLine received a call about two and a half year old [redacted]. Victim child was brought to Lehigh Valley Hospital by EMS the previous evening. On 5/7/2012 about 3 pm, the child was found unconscious on the ground outside his home by a construction worker. When the police knocked on the mother's door, she was asleep. It was believed that [redacted] had fallen out of a second story window while the mother was sleeping. The child was diagnosed with a [redacted]. Child was also found to have a broken elbow.

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. Interviews were conducted with the Quality Assurance manager. The regional office also participated in the County Internal Fatality Review Team meeting on June 7, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

1/5/2010 **Opened for brief services, closed 3/23/2010**
Allegations were that the father would shake and yell at two month old The caseworker conducted two home visits and reviewed the allegations with both parents. The father denied ever shaking the child, and stated that the report was made by an angry former household member. The worker confirmed that was receiving routine medical care, and referred the parents to an agency for parenting classes. The father's probation officer informed the worker that the father had been charged with having sex with a 14 year old (when he was 18 years old).

3/13/2012
uncle, , had seen on the third floor ledge; he yelled at to go back inside. Police investigation revealed that reported that the uncle also went inside to get his mother, and went to the mother's bedroom where was crawling to. The caseworker went out to the home within 24 hours to assess the family situation. The worker observed the child's bedroom and saw that the window had storm windows with both glass and screens that would prevent the child from getting out the window. The worker suggested that the family purchase locks for the windows. While the mother did not seem concerned about the child's safety, the maternal grandmother who was also living in the home was very worried and made the commitment to purchase the locks. The worker went out to the home two weeks later and observed that all of the third floor windows had child proof locks. After discussion with the supervisor, the worker closed this case on 3/28/2012.

Circumstances of Child Near Fatality and Related Case Activity:
had a pattern of playing near the third floor window. The county agency had previously investigated this concern, and had observed that the family had installed locks on all of the windows on the upper floors. At the time of the incident, it was observed by the police that the locks were removed from the window from which fell. had been seen by a construction worker crawling along the 18" ledge outside his window on the day of the incident. It was the construction worker who heard fall and called 911. When the police came to the home, they had to pound on the door to awaken mother.

injuries included an and a broken elbow. was initially , and was placed on medication. Another was discovered.

Detective , Pottstown Police, began the investigation immediately. Pictures were taken of the scene; these pictures were shared with the county worker. Interviews conducted with the construction worker revealed that the construction worker had seen unsupervised in the back yard earlier in the day; he had warned the mother about the dangers of playing in a construction site. On the day of the incident at about 2:00 pm, the construction worker had spoken with the mother about being at an open third floor window. The grandmother and her paramour left the house about 2:45 pm. When they left, the mother and were asleep on the couch in the first floor. A little after 3:00 pm, the construction worker heard a thud and looked down to see on

the concrete with blood coming out of his nose. He immediately called 911, and then went to the back door which he pounded on and yelled for the mother. The construction worker observed that the third floor window was open about 14". The detective noted that [redacted] had fallen to the right of the open window, suggesting that [redacted] may have crawled onto the ledge for some distance before he fell. When the detective initially spoke to the mother, she did not ask where [redacted] was or where he was going. The detective walked through the home with the mother. He observed the third floor bedroom contained a crate with a small dog locked inside. The side window in this bedroom was fully open, including the screen and storm window. There were no locks on this window. The detective noted that [redacted] window did not have any locks installed on the windows. The window that [redacted] fell from did have a lock at the very bottom of the top half of the window. The detective attempted to open this window with his hands, but could not do so without a key to unlock it. The detective hypothesized that [redacted] had crawled out of the open window and crawled some distance on the ledge before he fell.

In the front bedroom occupied by [redacted] and his mother, the detective observed that the top of the bed came to the base of the window sill. On the ledge outside the window was a child's toy. The lock on this window had been moved and was secured with only one screw. This lock allowed the window to be opened over 10". The mother was taken to the station for further questioning. The detective noted that the mother was posting on Facebook about 4 pm on this date. During questioning by detectives, the family blamed the child for the fall.

As the police interviewed the family members, inconsistencies in their accounts emerged. The maternal grandmother reported that the landlord and maintenance man had both been inside the house on this day. The mother also alleged that the construction worker had been on the third floor on the day of the incident. The construction worker denied ever being on the second or third floor, but had been on the first floor to use the bathroom.

[redacted] had been flown to Lehigh Valley Hospital. He [redacted]. His injuries included [redacted]. Initial prognosis was that this was a [redacted] which would result in [redacted]. Doctors were questioning whether [redacted] was experiencing [redacted] results were abnormal, consistent with [redacted]. On 5/19/2012, [redacted] was removed from the [redacted]. He remained at Lehigh Valley Hospital until 5/29/2012, when he was [redacted]. Staff was working with him to [redacted].

While [redacted] was in the hospital, his mother stayed with him. The police detective observed that the mother did not touch or try to comfort [redacted]. Hospital staff reported that the mother had numerous visitors, which was disruptive to the other patients. The mother was reportedly loud, used vulgar language, and would not pay much attention to [redacted]. It was noted that sometime between 5/10/2012 and 5/12/2012, one of the family

members [redacted]. This was not reported to nursing staff; nursing staff discovered this when they were completing routine checks on [redacted].

Current Case Status:

- Prior to the development of the Family Service Plan, the OCY worker had spoken with the family about the safety concerns in the home. The mother and maternal grandmother were advised that [redacted] would probably not be discharged home to them.
- On 6/18/2012, this case was [redacted] The mother did not provide adequate supervision for the child which resulted in multiple serious injuries. Six weeks prior to this incident, the county agency had investigated similar concerns and noted that the family had installed locks on the windows. The county worker had also provided information to the family about proper supervision of a toddler.
- The police, in consultation with the District Attorney, have decided not to press charges.
- Family Service Plan was completed 6/27/2012 with the family. Signatures of the mother, maternal grandmother and maternal grandmother's paramour were on the plan.
- At the [redacted], staff posted rules in [redacted] room, which resulted in the mother becoming more compliant with the rules.
- The county worker was evaluating family members as resources. One complication was that the mother stated that the man named as father on the birth certificate was not actually the father. This man's mother had volunteered herself as a resource. The mother reported that she would be going to her step-mother's home to live once home repairs were completed. However, the step-mother is currently living in a hotel. The step-mother's mother also lives in the home and is a RN.
- The [redacted] had consulted with OCY about their communication with [redacted] father. The mother did not want the father to be given any information about [redacted]; however, as his name was on the birth certificate, the [redacted] made the determination that they would be releasing information to him. The plan for [redacted] was to be discharged to a [redacted]. The foster family has already been trained. The mother's visitation at [redacted] was supervised due to the mother not following the safety protocols. The mother only visited [redacted] three times after this restriction was put in place (OCY transported mother on those times.)
- Upon discharge to the foster home, the mother is being offered weekly visits. Visits will alternate between the Pottstown office and a location closer to the foster home.
- [redacted].

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

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- Strengths:
- None identified

- Deficiencies:
- None identified

- Recommendations for Change at the Local Level:
- Community members and professionals should be educated about the need for young children to receive appropriate education and stimulation.
- Local municipal governments should include in their ordinances that screens should not be removed from second and third floor windows.

- Recommendations for Change at the State Level:
- None identified

Department Review of County Internal Report:

The Department has received the county's internal report and has reviewed the findings. The county assessed safety of the physical environment during a scheduled visit. The Regional Office is concerned that the family should have been assessed during an unannounced visit.

Department of Public Welfare Findings:

- County Strengths:
- Good collaboration with local police
- Request for 24 hour contact by Lehigh County, since this is where child was hospitalized

- County Weaknesses:
- During the previous referral, the county worker completed only one scheduled visit to home to verify use of locks on window. Prior to case closure, the worker should have completed at least one unscheduled visit to the home to verify that the window locks were being used.

- Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendations:
In situations such as this where environmental factors affect child safety, the Department recommends that the agency should also conduct unannounced visits to the home prior to closing the case to verify that the family was using the safety locks that were installed. This family did report having a child safety gate, but admitted that the child was able to open it. While this family did voice concern for [redacted] safety, their follow up was inconsistent. This family might have benefited from receiving some type of in-home services that would have addressed child safety in terms of environmental factors and the level of supervision needed for a toddler.