



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**BORN:** [REDACTED]/2011

**Date of Near Fatality: 3/18/2012**

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

**REPORT FINALIZED ON:**  
**3/7/2013**

**DATE OF ORAL REPORT:**  
**3/18/2012**

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 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 ChildLine. Philadelphia County Department of Human Services (DHS) was not required to convene a review team in accordance with Act 33 of 2008 as the report was unfounded within 30 days following the oral report to ChildLine.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	[REDACTED]/2011
[REDACTED]	Bio-Mother	[REDACTED]/1995
[REDACTED]	Bio-Father	[REDACTED]/1988

**Relevant Family Members**

[REDACTED]	Maternal Grandfather	[REDACTED]/1960
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**Notification of Child Fatality:**

Paramedics responded to the home on 3/18/2012 as a result of a 911 call. Paramedics were told that the victim child was choking, had aspirated formula, and blood was coming out of her mouth and nose. [REDACTED] stated that the victim child's bleeding was suspicious. [REDACTED]

[REDACTED] The mother stated that she had hit her head on a wall, but could not describe how or when. According to the mother, she fed the victim child and then laid her down on her stomach. The mother reported that she then began choking. The father was not home at the time of this incident. The victim child was admitted to the [REDACTED] at the Children's Hospital of Pennsylvania (CHOP). She had no visible injuries.

A supplemental report was received to the 3/18/2012 report on 3/20/12 at which time [REDACTED] reported that the victim child has had previous incidents of [REDACTED]

due to [REDACTED]

[REDACTED] The event occurred while the victim child was in bed with the mother while both were sleeping. The victim child was sleeping on her stomach due to concerns for asphyxia. She was in [REDACTED].

A second supplemental report received on 3/21/12 indicated that the victim child was in [REDACTED] condition due to suffocation, possibly due to bed sharing. She was too ill at this point to conduct further tests. The doctor was suspicious that her condition was due to abuse. She exhibited no other trauma and only [REDACTED] x-rays had been done as she was very ill. She was diagnosed with [REDACTED]

[REDACTED] The victim child will be hospitalized for a couple of weeks.

#### **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 the [REDACTED] family. Follow up interviews were conducted with the caseworker, [REDACTED] and the supervisor, [REDACTED]. The county was not required to conduct an Act 33 team meeting as the case was unfounded within 30 days of the date it was reported to ChildLine.

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

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

The child's father was involved with DHS as a child. The child's mother's family had brief contact when she was a child; the family was not accepted for services. The mother had a [REDACTED]

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

A [REDACTED] report (Near Fatality) was reported to DHS regarding the victim child on 3/18/2012. The victim child had been found by her mother with blood coming out of her mouth and nose. Paramedics were called who transported the victim child to the Emergency Room. Victim child had no visible injuries. The mother and grandfather were in the home at the time. The parents did not live together. It was initially believed that the victim child's bleeding may have been due to choking, however [REDACTED] felt the bleeding was suspicious and reported it [REDACTED].

According to the reports, the paramedics transported the victim child to CHOP and upon asking the mother if she had hit her head, the mother told [REDACTED] "yes" that she had hit her head on the wall, although when and how had not been determined. [REDACTED], the mother stated that she fed the victim child on the date of the incident and had laid her on her stomach and she started choking. She took her to the bathroom and splashed cold water on her head. She opened her eyes and she took the victim child to the maternal grandfather and he called 911. Upon initial arrival at the hospital, the social worker spoke with Special Victims Unit representatives who were present: [REDACTED]. The police informed the social worker that the victim child's father was being investigated for statutory rape, and that her grandfather had some involvement in a past case with his grandson obtaining brain injuries which resulted in his death. Furthermore, the police had some suspicions with this case, due to grandfather being present for both injuries. Moreover, they reported that the family previously

refused to speak to them without their lawyer and that they suspect that they would not speak to the social worker either. This information suggested a possible perpetrator to the [REDACTED].

It was reported that the victim child was in critical condition and that she had [REDACTED]. Supplemental reports were received [REDACTED] on 3/20/2012 and 3/21/2012. The first report indicated that the victim child had a history [REDACTED]. The doctor described in lay terms that basically the victim child's throat is [REDACTED]. Due to concerns for asphyxiation, the mother had placed the victim child on her stomach to sleep. The second supplemental report was received 3/21/2012 which indicated that the victim child was in [REDACTED] condition due to suffocation, possibly as a result of co-sleeping.

During the investigation, DHS received information that the mother, [REDACTED], had left the victim child with a number of caregivers. The family was referred to In Home Protective Services (IHPS). The [REDACTED] based on medical information, but it was determined that the family could benefit from IHPS, as there were domestic violence issues between the mother and father. The DHS Safety Assessment of 4/23/2012 noted that the father becomes angry at the mother when he feels that she is not caring appropriately for the child. DHS recommended that the parents should seek legal counsel about obtaining protection from abuse orders against one another. The father, who is 24 years old and the mother, who is 16 years old do not reside in the same home.

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

On 4/21/12 the victim child was [REDACTED] from the hospital to her father, [REDACTED]. It was determined that mother could not provide the proper care and supervision for the child. A [REDACTED] consult was completed by [REDACTED], on 4/26/2012. She reported that the victim child looked well. The victim child had a follow-up appointment with her PCP [REDACTED] on 4/27/2012.

This case was [REDACTED]. The victim child will require medical follow-up due to [REDACTED]. The father required assistance with ensuring that he is making the victim child's medical appointments. DHS determined that the father could also benefit from parenting skills, [REDACTED], and that IHPS will be responsible for implementation of these services.

The investigation did not reveal adequate evidence to [REDACTED]. [REDACTED], the victim child's condition was a result of her [REDACTED]. Therefore, the case was Unfounded.

#### **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 Child Line. Philadelphia County was not required to convene a review team in accordance with Act 33 of 2008 related to this report. The investigation was Unfounded on 04/13/2012 based on medical documentation gathered during the investigation.

**Department Review of County Internal Report:**

- The County was not required to complete a review as the investigation was unfounded within 30 days.

**Department of Public Welfare Findings:**

County Strengths:

- Collaboration with the Medical and Child Protection team at CHOP
- DHS made their determination based on medical documentation of the child's pre-existing condition.

County Weaknesses:

- None Identified

**Statutory and Regulatory Areas of Non-Compliance:**

- None identified

**Department of Public Welfare Recommendations:**

- More public service announcements are needed to address Parenting Skills and Education in Early Childhood Development.
- Young parents need education and training in the care of infants, including communicating with medical providers. Because these parents did not articulate the child's past medical history to the Emergency room doctors, the medical staff made the assumption that the injuries were due to co-sleeping or child abuse.
- The child had been seen previously at this hospital. The doctors did not review this record prior to making the report. Ongoing training with Emergency Room doctors should address the need to review children's medical files prior to filing reports to ChildLine.