



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR DEATH OF**



**BORN: 12/23/08**  
**DATE OF NEAR DEATH : 6/19/09**

**REPORT FINALIZED: 02/08/10**

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

**I. Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	VICTIM CHILD	12/23/08
[REDACTED]	Mother	[REDACTED] 1983
[REDACTED]	Mother's Paramour	[REDACTED] 1985

**Non Household Members:**

[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Father/ [REDACTED]	Adult
[REDACTED]	Father/ [REDACTED]	Adult
[REDACTED]	Maternal Grandmother	[REDACTED] 1962
[REDACTED]	Step Mother	Adult

**Notification of Fatality / Near Fatality:**

[REDACTED] reported that [REDACTED] was brought to CHOP on 6/19/09 for the second time in a week. On Wednesday, June 17, 2009, [REDACTED] had been seen at CHOP and diagnosed with [REDACTED]. However, on the night of June 19, 2009, [REDACTED] was brought in by the mother and her paramour, [REDACTED] because [REDACTED] was not leaning on and moving his right leg as he usually would.

[REDACTED] Reporter stated that some of the injuries are similar to a baby that has been shaken and that [REDACTED] had been admitted to [REDACTED]. Despite the victim child's injuries, he was sleeping comfortably and looked good. Reporter stated that the [REDACTED] was very quiet. However, [REDACTED] did ask, "will someone be arrested for this?"

Over the course of several days, [REDACTED] was seen at three different hospitals for multiple medical concerns. On 6/15/2009, he was seen at Jefferson Hospital for circumcision. On 6/16/2009, he was seen at St. Christopher's Hospital for uncontrollable crying. On 6/17/2009, he was seen at Children's Hospital of Philadelphia (CHOP) and diagnosed with [REDACTED]. On 6/18/2009, he was seen at St. Christopher's for a possible carbon monoxide leak in the home. On 6/19/2009 he was seen by Dr. [REDACTED] from CHOP, who diagnosed the current injuries and determined this as a "near fatality" on 6/22/2009.

**Documents Reviewed and Individuals Interviewed:**

SERO reviewed the complete case file provided by the Department of Human Services (DHS). SERO interviewed the DHS Social Worker who worked with the family and is still employed by DHS. The DHS SW interviewed [REDACTED], [REDACTED] (mother), [REDACTED] (paramour), [REDACTED] (MGM), [REDACTED] (father of [REDACTED]), [REDACTED] (father), [REDACTED] (CHOP), [REDACTED] and Detective [REDACTED] from the Special Victims Unit. On 7/17/09, [REDACTED] (SERO) attended the Act 33 Near - Fatality Review for [REDACTED].

**Case Chronology:**

Prior to [REDACTED] near death incident on 6/19/2009, the family and children were not known to DHS.

**Circumstances of Child's Fatality or Near Death Fatality:**

On 6/19/09, DHS received the [REDACTED] report on 6/19/09. On that same date, DHS visited the child at CHOP. The [REDACTED] verified the allegations and stated [REDACTED] was having trouble using his left leg. [REDACTED] had [REDACTED]. [REDACTED] was placed on the [REDACTED] for 24 hours to closely monitor his behavior. On 6/19/09 DHS conducted a safety assessment at CHOP. [REDACTED] was safe at the hospital and the Mother agreed not to remove [REDACTED] from CHOP against medical advice and she will adhere to the guidelines of the safety plan. The report alleged that the victim child had been to several hospitals every day this week for different ailments. Monday: Jefferson Hospital (circumcision); Tuesday: St. Christopher's Hospital (crying uncontrollably); Wednesday: CHOP (diagnosed with [REDACTED]); Thursday: St Christopher's Hospital (carbon monoxide leak in the home) and Friday: CHOP (current injuries). This case was determined a "near fatality" by [REDACTED] on June 22, 2009. [REDACTED]

On 6/25/09, the mother was interviewed by Detective [REDACTED] from Special Victims Unit. The mother was given a polygraph test which was inconclusive. The mother admitted hurting [REDACTED]. She stated she was gripping [REDACTED] by his sides, and his head was flipping back and forth. Mother stated she thinks she broke his femur when she got him home from the doctor on 6/12/09. She stated when she took [REDACTED] out of his baby carrier she laid him on the bed and grabbed him by his left arm and leg and flipped him, and his leg was caught under his body. [REDACTED] asked her if it was possible that anyone else could have done this and the mother replied, "No possibility at all- I did it" Detective [REDACTED] asked her if she was sure and she stated "Yes". Detective [REDACTED] believes that the hospital diagnosed [REDACTED] correctly with [REDACTED], and he believes that [REDACTED] shook [REDACTED] due to his screaming and crying.

██████████ (paramour) was interviewed by DHS and CHOP SW. ██████████ denied allegations and stated he works long hours everyday and spends limited time with ██████████.

The mother has another child, ██████████ (5 yrs old). ██████████ primarily lives with her father, ██████████. ██████████ would visit her mother on prescheduled weekends. ██████████ was not visiting her mother's home on the night of the incident. All mother's visits with ██████████ have been suspended. DHS made a home visit to ensure the safety of ██████████. DHS determined that she was safe with her father, and that there were no safety concerns.

DHS made contact with ██████████ father, ██████████, and gave him verbal notification of the ██████████ report. ██████████ informed DHS that the mother had informed him of ██████████ hospitalization. ██████████ stated this was his second time seeing ██████████. ██████████ he did not know ██████████ was his son until February 2009. The father decided to take a paternity test, and had not yet received the results. ██████████ reported that if ██████████ was his biological son, he would be in ██████████ life.

On 6/26/09, ██████████ was ready for discharge from the hospital. DHS was initially searching for a medical foster home. CHOP felt that this level of care was unnecessary, which resulted in an unnecessary delay in ██████████ discharge from the hospital. On 6/30/09 the father received the results from the paternity test indicating that ██████████ was his biological son.

DHS obtained information for clearances for father, ██████████ and step mother, ██████████. DHS conducted a safety visit to the father's home on 07/06/2009. The father filed for emergency custody for ██████████.

On 7/2/09 ██████████ was discharged to the care of his father and step-mother.

**Current / most recent status of case:**

- ██████████.
- The mother admitted to causing the injuries and she has been arrested.
- ██████████ safely lives with her father, ██████████, and the mother's visits have been suspended.
- ██████████ is healing and living with his father, ██████████, and his step-mother, ██████████.

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:**

Strengths- The DHS worker did a thorough job investigating this case. Pursuant to regulations and DHS policy, all relevant parties were seen and interviewed in a timely manner. The DHS intake social worker explored all family placement options. This resulted in the child being cared for by his biological father and avoiding a foster care placement.

The DHS worker made a safety visit to the home of [REDACTED] sibling, [REDACTED]. Whereas, [REDACTED] did not reside with [REDACTED], the worker was diligent in her efforts to ensure the safety of [REDACTED].

Deficiencies- Throughout the record review, there were no deficiencies noted.

**County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:**

The Act 33 Review Team recommended when children are admitted to the hospital as a result of abuse or neglect, the DHS SW and one of the DHS nurses should discuss the medical concerns and appropriate discharge planning for the child.

DHS suspected there was domestic violence between [REDACTED] mother and her paramour. The team recommended that DHS develop specific guidelines to screen domestic violence. DHS staff will be trained on how to apply domestic violence training in their investigations.

The Act 33 Review Team was concerned that [REDACTED] was seen on 6/15/09 by his pediatrician, 6/16 at St. Christopher's Hospital, 6/17 at CHOP, 6/18 at St. Christopher's Hospital and 6/19 at Jefferson Hospital and later in that evening [REDACTED] was seen at Children's Hospital where his injuries were identified as resulting from [REDACTED]. The team recommended that the Commissioner of the Department of Public Health and the Commissioner of DHS invite the hospitals involved in this case to a meeting for the purpose of trying to understand why [REDACTED] injuries were unidentified.

**SERO Findings:**

County Strengths- According to Senate Bill No.1147 DHS conducted the review timely and the members of the team exemplified expertise in prevention and treatment of Child Abuse.

County Deficiencies-

The County raised the issue of domestic violence, but did not provide supporting documentation of why this was suspected.

**Statutory and Regulatory Compliance issues:**

[REDACTED] and [REDACTED] safety and well being were addressed by DHS in a timely manner. DHS was in compliance with Title 55 Public Welfare statues and regulations.