



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF



BORN: 11/23/2008
Date of Near Death Incident: 05/01/2009

FAMILY KNOWN TO:
Investigated by Philadelphia Department of Human Services

REPORT DATED: 10/22/09
REPORT FINALIZED: 02/16/10

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, December 30, 2008. 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.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	victim child	11/23/08
[REDACTED]	mother	[REDACTED] 92
[REDACTED]	father	[REDACTED] 83
[REDACTED]	maternal grandmother	[REDACTED] 69
[REDACTED]	sibling	[REDACTED] 07

Notification of Fatality / Near Fatality:

On 5/01/2009 Child was taken to Temple Emergency Room by maternal grandmother because child had fallen from 1.5 ft height to the floor. Child had a [REDACTED] [REDACTED] noticed child was breathing harder than usual after the incident. Temple Hospital transferred child to St Christopher's. Child [REDACTED] and mother was present. Child's condition worsened over night. Child had no other bruises.

Documents Reviewed and Individuals Interviewed:

For this review the SERO reviewed the Philadelphia Medical Examiner's file, the family record from DHS, email correspondence with [REDACTED] as well as phone dialogue, phone dialogue with Supervisor, [REDACTED], and the special victim's unit interviews.

SERO interviewed [REDACTED] with follow-up questions in regards to case. The regional office also attended the County's Internal Fatality Review Meeting regarding this case on 5/29/09.

During the initial review Philadelphia Department of Human Services (DHS) could not locate the case file. Upon further request from SERO the case file was provided by DHS on 02/04/2010.

Previous CY involvement:

mother, [REDACTED]

- [REDACTED] received Services for Children in their Own Home (SCOH) while living with her maternal grandmother from 12/93-1/01 through Juvenile Justice Center (JJC).
- [REDACTED] also has a history with DHS as a minor. She received SCOH in the home of her paternal grandfather from 5/07-5/09 through Intercultural which monitored the family.
- [REDACTED] on 9/11/08 regarding older child, [REDACTED], not being up to date with her immunizations, as well as being unkempt. This case was [REDACTED] by DHS and [REDACTED]
- [REDACTED] was also involved with court on a [REDACTED], this case was closed on 2/13/09.

father, [REDACTED]

- [REDACTED] has an extensive delinquent history dating from 1994-2001. The record does not state whether any of [REDACTED] delinquent charges [REDACTED]. [REDACTED] does not have dependent DHS history.

maternal, grandmother [REDACTED]

- [REDACTED] has had two [REDACTED] reports regarding her children, dated 12/94 and 12/97. SCOH was provided to her and her family from 12/93-1/01 through JJC. [REDACTED] and left her children with their father – this is how [REDACTED] came to live with her father and his paramour, [REDACTED].
- On 8/15/90 [REDACTED] report whereas victim child their daughter [REDACTED] was taken to St. Christopher's Hospital with [REDACTED] had experienced physical trauma. The condition was consistent with pillow being placed on infants face or infant inhaling strong fumes.

Circumstances of Child's Fatality or Near Fatality:

On 5/01/2009 [REDACTED] was taken to Temple Emergency Room by maternal grandmother, the alleged perpetrator because child had fallen from 1.5 feet height to the floor. Maternal grandmother noticed child was breathing harder than usual after the incident. Temple Hospital transferred child to St Christopher's. Child [REDACTED] and mother was present. Child's condition worsened over night. Child had [REDACTED] and was [REDACTED]. Child had no other bruises. However, due to the injuries this incident was coded as a near death.

- Based on medical evidence the report was [REDACTED]. Maternal grandmother who is the [REDACTED] account of [REDACTED] falling off of the couch on to the carpeted floor is inconsistent with the injuries [REDACTED] sustained. The injuries may have been caused by suffocating, squeezing, or throwing child against couch. Due to

██████████ age he was unable to provide an account of the incident. During the incident maternal grandmother was the sole caretaker when incident occurred.

Current / most recent status of case:

- This case was ██████████ by DHS based on medical evidence.
- ██████████ is currently residing with biological mother, ██████████ in the home of maternal grandfather. No services were provided. Case was closed 6/11/09 due to case being ██████████.
- Philadelphia Special Victim Unit (SVU) and DHS were in disagreement. SVU stated that the incident was an accident therefore there was no criminal prosecution against alleged perpetrator and the case was closed.
- No information in record to state whether SVU was aware of indicated cases.

Services to children and families:

- During the Act 33 Review Team meeting DHS Operations Director implement Rapid Response services through Carson Valley. Services were implemented the same day as the review.
- The families primary residence is overcrowded; DHS has made a referral to a housing program (PHDC) to assist family.

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

Strengths-

- Pursuant to regulation and DHS policy, all relevant parties were interviewed and seen in a timely matter. The hotline worker went to investigate the report within 1.5 hours of the report being generated.
- DHS determined that the maternal grandmother was ██████████.
- 05/02/2009 – Safety plan was developed preventing contact with ██████████, maternal grandmother with ██████████ and other child.
- 05/28/2009 – Risk assessment completed concluding the overall Severity was high due to ██████████ sustaining serious physical bodily injury around the lung area, child's injury caused him to lose air around his lungs

Deficiencies-

- Previous ██████████ was called in to the hotline on 9/11/08. This case was investigated and determined to be unsubstantiated, however; the report date and the determination date are the same date in DHS computer system.
- DHS was initially unable to locate the physical record.

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

- Per physicians at St. Christopher's Hospital, [REDACTED] was in need of a follow-up skeletal exam to further assess his injuries. The skeletal exam was scheduled six weeks out, which the medical members of the team thought were possibly too long. It was questioned whether or not the other children in the household should have been examined or had skeletal survey.
- DHS should explore a policy change that would require the DHS SW to ask the treating medical professional if the other children in a home need to be brought in for a medical examination when a child in the home is alleged to have been medically abused.
- In an effort to prevent data entry mistakes, DHS should explore updating the FACTS 2 computer system to automatically populate the determination date for all investigations. This would ensure the accuracy of the determination date and prevent any back dating of records.
- Although already in progress, DHS should explore implementing an electronic records system to prevent physical case records from being misplaced in the record room.

SERO Findings/Deficiencies:

- Although previous [REDACTED] dated 9/11/08 [REDACTED] the report date and the determination date were the same date in DHS computer system.
- DHS should share pertinent information with collaterals, such as SVU, in light of previous [REDACTED] reports of family involved.

Statutory and Regulatory Compliance issues:

At the time of the near fatality DHS could not locate the case file. DHS did locate the case file and was able to provide a copy to SERO.