



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: 10/03/2007
Date of Near Fatality Incident: 6/30/2010

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

REPORT FINALIZED ON: 06/04/12

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 7/16/2010.

Family Constellation:

| <u>Name:</u> | <u>Relationship:</u> | <u>Date of Birth:</u> |
|--------------|----------------------|-----------------------|
| ██████████ | Victim child | 10/3/2007 |
| ██████████ | Mother | ██████████ 1987 |
| ██████████ | Mother's paramour | ██████████ 1983 |

Notification of Child (Near) Fatality:

On 6/30/2010, ██████████ received a call about ██████████. Paramedics were called to the apartment and found victim child unconscious. The allegations were that the ██████████ (mother's paramour) had thrown her into a wall because she had touched his video game. Victim child had closed head injuries on the right side of her head. Victim child's face had bruises all over in different stages of healing. Victim child also had bruises on her arms, legs and torso, all in different stages of healing. Victim child had small abrasions on her hands, chest and stomach, also in different stages of healing. Victim child had a split lip that went into the top of her mouth. Victim child was unresponsive. Victim child's ██████████. Victim child was taken to St. Christopher's Hospital. The mother was in the Emergency Room (ER) with the child and told the reporting source that victim child had a ██████████ two weeks ago. The mother did not report how that injury occurred. Reporting source stated that ██████████ was not at the apartment when paramedics arrived at the home.

Summary of DPW Child (Near) Fatality Review Activities:

For the purposes of this review, SERO

- Reviewed the county ██████████ notes, including Risk and Safety Assessments

- Attended the county's Act 33 review on 7/16/2010
- Interviewed ongoing worker

Children and Youth Involvement prior to Incident:

This family had no prior involvement with any child welfare services.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 6/30/2010, DHS received a call that paramedics responded to a code blue call. When first responders arrived at the home, two year old [REDACTED] was unconscious. Allegations were that the mother's paramour, [REDACTED], threw her into the wall because she had touched his video game. The [REDACTED] was not in the home when paramedics arrived. The home had no lights; victim child was found lying at the top of the stairs. The mother reported to the DHS worker over the phone that the [REDACTED] did live with her, and worked at a "car place" near [REDACTED] (she did not know the name of the employer).

On 6/30/2010, a supplemental report was called in that [REDACTED] was in critical condition with a [REDACTED] with [REDACTED]. [REDACTED] is currently on a [REDACTED]. The doctor did not know what child near fatality meant, and was going to consult with the Child Abuse team.

On 6/30/2010, the DHS worker contacted the [REDACTED] by phone. He was asked on speaker phone what had happened with [REDACTED] on 6/30/2010. His response was: [REDACTED] was in the kitchen and I was in the living room. [REDACTED] was up running around playing and saw my lit cigarette in the ashtray. She went after the cigarette and I pushed her away. I didn't push her hard, but she kind of back peddled. He said that this was about 11:00 or 11:30 pm. When [REDACTED] went to get up, her eyes rolled in the back of her head. He thought that she was having a seizure so he asked [REDACTED] to get a spoon. He had heard that a spoon is used to keep the tongue straight. He called the paramedics, but left before they arrived as he had to work the next day. The mother had told him not to go to the hospital with her as he was not the father.

The paramour was asked about his relationship with the mother. He explained that he had lived in the home for a few months. He was hesitant at first to move in because of [REDACTED] ([REDACTED]), but he did research about it and was more comfortable about sharing a household with a child with [REDACTED]. He had been living in an apartment in Bensalem prior to moving in with the mother. Since this incident, he has been staying with his mother. He reports thinking that maybe moving in with [REDACTED] was not a good idea. He had been left alone with [REDACTED] for an hour or two on occasion while the mother ran errands. He stated he had no knowledge of how [REDACTED] got the bruises, and he had never noticed any. He did observe the mother wrapping

██████████ up in a towel to give her some type of medication for the ██████████. When he was asked if the mother had any explanation for the bruising, he reported that the mother stated that it was a medical condition and that she had medical appointments for this. (Note: this last statement is contradictory, as he initially stated that he had never observed any bruises, but then stated that he and the mother had conversation about the bruises being a medical condition.)

The mother's account of how ██████████ was injured on 6/30/2010: She reported that she was in the kitchen when she heard a loud noise, and ██████████ (her paramour) was saying something about his Xbox. She went into the living room and found ██████████ "like that" on the floor. The mother described ██████████ as if she "was in slow motion"; her arms and legs were bent back and her eyes were rolled back. She went to get a spoon when ██████████ told her ██████████ might be having a seizure. The mother told the worker: "I don't really know what happened. I just found all this out this morning when ██████████ called and told me because I was upset yesterday."

The mother showed no emotion when the worker described the injuries to ██████████. The mother stated that she had done research and thought the bruises could be from ██████████. She described the bruises as just appearing. The mother was asked if any of the bruises were caused when she held ██████████ to give her medication. She responded no to this question. The mother explained that ██████████ had injured her ██████████ two weeks ago when she fell on the coffee table with her arms spread out.

When asked about the paramour, she reported that they had met on a website called [Plenty of Fish.com](http://PlentyofFish.com). They met in March 2010 and he moved in April 2010. The worker inquired if ██████████ had bruises prior to his arrival; the mother said no. She said that he was only alone with ██████████ if she had errands to run. This interview was interrupted by hospital staff. Dr. ██████████ stated to the DHS worker that during her exam of ██████████ stated that "Mommie did it" when referencing where she received her injuries. The nurse reported that ██████████ had made the same statements to her. The doctor stated that she did not want the mother to return to ██████████ room to prevent any coaching of ██████████. The DHS worker contacted her supervisor by phone. A decision was made to obtain an order of protective custody to restrict the mother's contact with ██████████. Hospital security removed the mother's belongings from ██████████ room. When the mother was informed that she would not be allowed any contact with her daughter, she began to cry and asking why. She repeated that she would never hurt her daughter and that she wanted to stay with her. DHS offered to escort the mother home since she was visibly upset (and to assess the home). The mother did not accept the offer of a ride, saying she would ride the bus around the city to clear her head.

On 6/30/2010, the DHS worker contacted the child's primary care physician (PCP) to obtain medical history. The doctor had diagnosed ██████████

██████████; he did not believe that this injury was caused by abuse. The doctor stated that he believed that the subsequent injury was caused by the mother's paramour. He noted bruising on her cheeks when she arrived. The mother explained that ██████████ received those injuries when she holds her cheeks to give her medicine. He had referred ██████████ to St. Christopher's for a ██████████ ██████████, a return visit was scheduled for 6/21/2010. At that time, the doctor noted new bruising and noted that he would make sure that the ██████████ would go through. The PCP reports that the mother is usually compliant with all medical appointments.

On 6/30/2010, an order of protective custody was obtained for ██████████ which prohibited access by the parents to ██████████

On 7/2/2010, a Risk Assessment was completed that identified Overall Risk and Severity as High. ██████████ identified the ██████████ as the mother ██████████ has multiple serious injuries for which the mother could not offer any explanation. The mother was not cooperative with the DHS ██████████; not allowing access to her home, nor providing any information about her or the father's family. The Risk Assessment stated that ██████████ was at imminent risk in the care of her mother and the mother's paramour.

On 7/7/2010, a Safety Assessment was completed that identified safety threats being present. Protective capacities were described as absent. ██████████ was determined to be Unsafe. Safety Plan was signed by DHS and foster care agency staff; the plan stated that child will be in foster care. The plan stated that the mother was not available to sign.

07/12/2010, a second supplemental report was called in to ██████████ survived and was ██████████ to foster care. Doctors certified this as a near fatality.

07/19/2010, the DHS worker made contact with the father in prison. The father reported that the mother had called him about ██████████ status. He also had received notification about ██████████ from the DHS Law Department. The father reported that he had grown up in foster care, and had a history of drug abuse. He is now drug-free and sober, and hoped to remain so after his release in September 2010. He has not seen ██████████ since October 2008. He described the mother as a good parent, and was surprised by this report.

07/25/2010, this case was ██████████, and prepared for transfer to Ongoing Services Region.

Current Case Status:

- ██████████ remains in the same foster home with Women's Christian Alliance. She requires no ██████████

- Permanency plan is reunification with her father.
- The father is no longer incarcerated. He was most recently incarcerated for parole violations. His original charge was burglary.
- Visitation with both parents has been suspended until [REDACTED] [REDACTED] indicates that [REDACTED] is ready. The county anticipates that father will be able to have visits before the mother.
- The first permanency review hearing date was November 17, 2010. Goals remain the same.
- Criminal case is still under investigation. No charges have been filed.

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

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Strengths:

- Compliance with statutes and regulations: The Act 33 team felt that the DHS Social Work Manager did an excellent job [REDACTED] the case, and staying in communication with the hospital and other parties to obtain necessary information.

Deficiencies:

[REDACTED] The Act 33 team raised concerns that the primary care physician did not file a [REDACTED] when he first noticed bruises on [REDACTED] during an office visit. The physician did not file a [REDACTED] when the mother did not follow up with the [REDACTED] for [REDACTED]

Recommendations for Change at the Local Level:

- The physician should be counseled about his requirements as a mandated reporter to complete a [REDACTED] when he noticed injuries on [REDACTED]

Recommendations for Change at the State Level:

- None identified

Department Review of County Internal Report:

The Department is in agreement with the findings of the county review.

Department of Public Welfare Findings:

County Strengths:

Timely and thorough

- Secured Order of Protective Custody when child was determined to be Unsafe
- Safety and Risk Assessments were completed in a timely and comprehensive fashion

County Weaknesses:

- None identified

Statutory and Regulatory Areas of Non-Compliance:

- None identified.

Department of Public Welfare Recommendations:

- None identified.