



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

RASHAAN ANDERSON

BORN: 10/24/2008
DIED: 7/2/2010

**The Family was not known to
The Philadelphia Department of Human Services**

Date of Final Report: May 4, 2011

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 by [REDACTED]. 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 [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. The Department of Human Services has convened a review team in accordance with Act 33 of 2008 related to this report

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Anderson, Rashaan	Victim Child	10/24/2008
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Mother's paramour	[REDACTED] 1989

Non- household members:

[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Maternal Grandmother	Adult

Notification of Child Fatality:

On 7/2/10, the Department of Human Services (DHS) received a [REDACTED] report alleging that the victim child was pronounced dead at 4:49 pm at Temple Hospital. The mother's paramour was babysitting for the child when the incident occurred. The paramour reported he laid the child down for a nap and the child fell on the floor. The child was transported to Temple Hospital by ambulance. The victim child had [REDACTED].

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office interviewed [REDACTED] DHS Social Worker, and reviewed the case record. On 7/16/10, the Regional Office attended the Act 33 Fatality Review held at the Philadelphia Coroner's Office.

On 7/22/10, DHS completed their [REDACTED] and [REDACTED] causing his death. The medical professionals, SVU and the paramour's confession determined the [REDACTED] caused severe permanent damage to the child which resulted in his death.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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 [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. On July 16, 2010 The Department of Human Service convened a review team in accordance with Act 33 of 2008.

- Strengths:
DHS completed the investigation timely.
- Deficiencies:
There were no deficiencies identified
- Recommendations for Change at the Local Level:
There were none identified
- Recommendations for Change at the State Level:
There were none identified

Department Review of County Internal Report:

There were no recommendations identified.

Department of Public Welfare Findings:

The Department of Human Services provided adequate correspondence with the regional office. DHS made the appropriate contacts and follow up interviews to complete a thorough investigation. DHS conducted the Act 33 Review within the required time frame.

Department of Public Welfare Recommendations:

There was no compliance or regulatory concerns.