



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**Samari Campbell**

**DOB: 02/07/09**  
**DOD: 10/23/10**

**FAMILY NOT KNOWN TO:**  
**Any public or private child welfare agencies**

**REPORT FINALIZED ON: 06/12/12**

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 [REDACTED] 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), on 11/19/2010, 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>
Samari Campbell	Victim Child	2/7/09
[REDACTED]	Mother	[REDACTED] 1985
[REDACTED]	Mother's Paramour	[REDACTED] 1990
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Father	Deceased

**Notification of Child Fatality:**

The mother, [REDACTED], was at work, and left the children in the care of her paramour, [REDACTED]. On October 23, 2010, fifteen month old Samari Campbell who lived with her mother, her mother's paramour, and her two siblings, reportedly wet herself, so the [REDACTED] brought her to the bathroom, and put her in the tub. The [REDACTED] went to check on the newborn baby (age 2 months). He came back to check on Samari. He noticed the child had trouble breathing and called paramedics. The fire department was called to the house for [REDACTED] of the child. Paramedics tried to resuscitate the child. They took the child to Aria-Torresdale Hospital, where the child was pronounced dead at 7:00 pm. The child had [REDACTED]

[REDACTED] The fire department noted that the [REDACTED] did not have an explanation for the child's condition. Dr. [REDACTED], the attending doctor, stated that he believed that the bruises resulted from [REDACTED], due to the nature of the injuries. The Medical Examiner has reportedly stated that Samari had [REDACTED]. It is unclear if Samari was in the bathtub with water. [REDACTED], the 3-year-old, has stated to the [REDACTED] that

she heard the alleged [REDACTED] [REDACTED], say "Samari is sleeping," and "Samari is going to the hospital."

**Summary of DPW Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families received and reviewed the [REDACTED] report. The regional office participated in the Act 33 Fatality Review Team meeting on 11/19/10 where copies of the medical examiner's reports and autopsy were presented.

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

Not known to county children and youth agency.

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

On 10/23/10, DHS received a [REDACTED] report alleging that Samari had [REDACTED]. The victim child later died from these injuries.

Mr. [REDACTED], the alleged [REDACTED], reported that Samari had wet herself. He reported that he took her to the bathroom to wash her off in the bathtub. One of the other children was crying and he went downstairs to check on this child. When he returned upstairs, he found Samari still in the tub, but she was having difficulty breathing. Emergency Medical Services (EMS) was called and Samari was taken to the hospital. Samari died as a result of her [REDACTED].

During the [REDACTED] the DHS [REDACTED] discovered that Ms. [REDACTED] was at work during the incident and had several text messages from Mr. [REDACTED] saying that something was wrong with Samari and to come home. During the autopsy, it was revealed that Samari had [REDACTED]. The Medical Examiner (ME) deemed the child's death to be homicide caused by [REDACTED] injuries.

The safety plan for victim child's siblings was to be placed in the care of their Maternal Grandfather and his wife with kinship services through A Second Chance, Inc.

On 10/28/10, [REDACTED] was charged with Murder and Endangering the Welfare of a child and incarcerated

On 11/30/10 Philadelphia DHS determined that the case was [REDACTED] with [REDACTED], mother's paramour, as the [REDACTED]. The child died [REDACTED].

**Current Case Status:**

On 11/30/2010, this case was [REDACTED] naming [REDACTED] as the [REDACTED]

The mother of the children has monthly supervised visits with them, pending the outcome of the parenting capacity evaluation. The mother is receiving [REDACTED] services through [REDACTED]. [REDACTED] is receiving [REDACTED] at [REDACTED].

The [REDACTED], [REDACTED], was arrested and remains incarcerated in the [REDACTED] and is scheduled for a pre-trial hearing on 02/15/11, before Judge [REDACTED].

**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. Philadelphia County convened a review team on 11/19/10 in accordance with Act 33 of 2008 related to this report.

The team felt that the DHS did a thorough job [REDACTED] the case. The social work services manager consulted with the DHS nurse, DHS [REDACTED], and DHS attorneys as outlined in DHS Protocol.

The Team felt that the safety plans were completed in a thorough and timely manner.

It is believed that [REDACTED] may have witnessed her sister's death and there was confusion on where and how to interview her. The [REDACTED] felt that the child would not be credible to interview due to her age. The Team would like DHS to revisit the issue of coordinating interviews of very young children with other city agencies.

**Department Review of County Internal Report:**

The DHS did a thorough job [REDACTED] the case. The safety plans were completed in a thorough and timely manner

**Department of Public Welfare Findings:****County Strengths:**

The DHS did a thorough job [REDACTED] the case. The safety plans were completed in a thorough and timely manner.

**County Weaknesses:**

None Identified

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

None identified.

**Department of Public Welfare Recommendations:**

The Department is in agreement with the county findings.

The Department is in agreement with the DHS decision to revisit the issue of coordinating interviews of very young children with other city agencies [REDACTED]