

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: ██████/2011
DATE OF NEAR FATALITY INCIDENT: 10/13/2011

FAMILY KNOWN TO:
Family was not known to any county agency

REPORT FINALIZED ON: 10/01/2012

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. Montgomery County has not convened a review team in accordance with Act 33 of 2008 related to this report. The investigation was determined Unfounded within 30 days of the report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	██████████/2011
██████████	Mother	██████████1988
██████████	Friend	██████████/86
██████████	Grandfather of friend	Adult
██████████	Grandmother of friend	Adult

Non-Household Members:

██████████	Father	██████████/1986
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Notification of Child Near Fatality:

██████████, the mother, reported that on October 12, 2011 she was at Shop Rite with her son 2-month-old ██████████, who was unrestrained in a shopping cart. As she went down the ramp, the child fell face first onto the ground. Paramedics were called to the scene and did not take the child to the hospital. The child had no visible injuries. Four hours later, the child was crying at home, so the mother took him to Suburban Hospital. The child was still fussy and was then transferred to CHOP. He was examined and determined to have ██████████ with small bleeds and ██████████ on both sides of his head. At that time, because of the way the mother described the incident, the hospital believed the injury was not accidental and that the physical injury was not consistent with the mother's account of the incident. The child was admitted to CHOP's ██████████. The child was responsive upon admission and expected to survive. ██████████ was ██████████ home from CHOP on 10/14/11 to his mother, ██████████ father was reported to have been at CHOP arguing with ██████████ being in the hospital.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted with the investigating caseworker, [REDACTED]. There was no community review meeting; the case was [REDACTED] within the first 30 days.

Children and Youth Involvement prior to Incident:

The family had no contact with Montgomery County CYS prior to this incident. The [REDACTED] investigation was unfounded because [REDACTED] injury was determined to be accidental, as per the medical professionals at CHOP.

Circumstances of Child Near Fatality and Related Case Activity:

On October 12, 2011, [REDACTED] reported she was at Shop Rite with her son, [REDACTED], who was unrestrained in a shopping cart. As she went down the ramp, the child fell face first onto the ground outside. The county confirmed that paramedics were called to the scene and did not take [REDACTED] to the hospital. Four hours later, the child was crying at home, so the mother took him to Suburban Hospital. The child was still fussy and was then transferred to CHOP. He was examined and Dr. [REDACTED] at CHOP stated the injury to [REDACTED] did not match the description of what happened. Dr. [REDACTED] was also surprised that the ambulance did not send Ms. [REDACTED] to the hospital right away [REDACTED] was examined and determined to have [REDACTED] with small bleeds and [REDACTED] on both sides of his head. Upon completion of an [REDACTED] reported there was no injury to [REDACTED] brain, but it did show a [REDACTED] and bleeding around the brain. After further medical evaluation and assessment, CHOP determined [REDACTED] fall and injuries resulting from the fall were accidental.

The Safety Assessment dated 10/12/11 for [REDACTED] determined he was Safe with a Comprehensive Safety Plan. The caregiver admitted using prescription drugs [REDACTED] illegally, and is unable to control the effects of her addiction. At that time, an in home CYS managed safety plan was needed. Ms. [REDACTED] was staying at the home of her friend, [REDACTED], who resided at [REDACTED] in Norristown. Ms. [REDACTED] agreed to supervise Ms. [REDACTED] 24/7. [REDACTED] was [REDACTED] from CHOP as being Safe with a Comprehensive Safety Plan.

On 10/19/11, the caseworker received a phone call from [REDACTED], stating [REDACTED] was no longer permitted in her home. Ms. [REDACTED] stated [REDACTED], the child's father, were constantly fighting on the phone, [REDACTED] offered no help around the home, and Ms. [REDACTED] stated she was not able to handle [REDACTED] behaviors in the home. The Safety Assessment dated 10/20/11 for [REDACTED] determined he was Unsafe in the home. The caregiver admitted using prescription drugs [REDACTED] illegally. [REDACTED] mother violated the comprehensive safety plan by leaving the home of [REDACTED] 10/20/11. [REDACTED] was placed in foster care in the home of [REDACTED] on 10/20/11 due to concerns of alleged drug use by both parents, a history of domestic violence between the

parents, and lack of medical care for [REDACTED]. Kinship care was considered and determined not to be an option at this time. The paternal grandmother expressed interest in caring for [REDACTED], but has not followed up on completion of her application nor kept in contact with OCY. She had attended only 1-2 visits with [REDACTED]. She recently changed her mind and reported she did not wish to be considered as a resource.

In seeking out family history, the record reflects that the Conshohocken Police told the Montgomery County CYC case worker that there was a long history with the [REDACTED] family with their department. The police stated there were over 30 contacts with Mr. [REDACTED] [REDACTED] also known as [REDACTED]. There were also other domestic charges with Mr. [REDACTED] and another female in Plymouth Township. The East Norriton Police reported the [REDACTED] family was known to have had contacts with their department, as well. The East Norriton Police had contact with [REDACTED] and her sister prior to and unrelated to this current incident. The nature of the incident was not specifically stated.

According to the case record, [REDACTED] has another son who resides with his father because [REDACTED] was unable to provide adequate care for him. The father is said to have custody of his son due to [REDACTED] drug use. Mr. [REDACTED] father, had been incarcerated for dealing drugs and is well known to police in Conshohocken. Mr. [REDACTED] also has a set of twin boys that were adopted by another family while he was in prison.

Current Case Status:

- Montgomery County completed its investigation and determined, based on additional medical evidence, that this injury was accidental; no arrests were made. The report was filed as unfounded.
- Mr. [REDACTED] has not yet cooperated with a drug and alcohol assessment, which is concerning due to his history of substance abuse and previous drug related incarceration.
- [REDACTED] completed her [REDACTED] and had not located [REDACTED]. She is awaiting Time Limited Family Reunification Services, which is a [REDACTED] service that provides assistance to parents whose children are placed in foster care. Due to [REDACTED], there may be a short waiting list at times for this service.
- [REDACTED] remains in the foster home of [REDACTED]
- Both parents attend regular supervised visits with [REDACTED] at Montgomery County CYC office.
- Neither parent has taken steps to address their drug and alcohol issues, or [REDACTED] issues. They have not achieved [REDACTED] goals, such as: completing parenting classes, following through with the [REDACTED] and recommendations, services for [REDACTED] needs, and a [REDACTED]. [REDACTED] are to follow through with recommendations of the various [REDACTED]
- [REDACTED] are to arrive on time for visits and devote their total attention to [REDACTED] and not talk on their cell phones during the visits. [REDACTED] will actively seek employment and [REDACTED] will enroll in an [REDACTED]

program, attend meetings on time, stay for the entire session each session, and complete the program.

- [REDACTED] is receiving services through [REDACTED] and is reported to be doing well.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) 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 indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Montgomery County has not convened a review team in accordance with Act 33 of 2008 related to this report. The investigation was Unfounded within 30 days of receipt of the report.

Department of Public Welfare Findings:

County Strengths:

- Collaboration with the medical team and child abuse team at St. Christopher's Hospital for Children.
- Timely and quality safety assessments and safety plan.

County Weaknesses:

- When developing a safety plan, criminal record checks and ChildLine clearances should be checked for all adult household members.
- Structured case notes should document the activities that occur in relation to the case. Clearances were said to have been performed, but were not documented in the record with dates of birth and other demographic information.

Statutory and Regulatory Areas of Non-Compliance:

- There are none identified

Department of Public Welfare Recommendations:

- The process of clearing a home should entail obtaining clearances for all adult household members.
- Documentation in case records should reflect casework activities relating to performing clearances for all adult members of the household who have access to the child.