



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: 04/12/2007
DATE OF NEAR FATALITY INCIDENT: 10/20/2010

This family was not known to:
The family was not previously known any Children and Youth agency

REPORT FINALIZED ON: 06/12/2012

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. The Philadelphia County has not convened a review team in accordance with Act 33 of 2008 based on their determination that this case was an accident.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	0 4/12/2007
██████████	Mother	██████████ 1998
██████████	Brother	██████████ 2004
██████████	Brother	██████████ 2005

Non- Household Members

██████████	Father	██████████ 1988
██████████	Paternal Grandmother	Adult
██████████	Paternal Aunt	Adult
██████████	Maternal Cousin	Adult
██████████	Cousin	██████████ 2002
██████████	Cousin	██████████ 2005

Notification of Child (Near) Fatality:

On 10/20/2010, The Department of Human Services received a ██████ report that ██████ was brought to the Children's Hospital of Pennsylvania (CHOP) with visible strangulation marks around his neck. ██████ wasn't opening his eyes and he appeared confused. The paramedics reported when they arrived at the home the child had a rope or a string around his neck. The mother told the paramedics that she found ██████ hanging from the top bunk bed. Initially the hospital reported that there was a possibility that ██████ may have ingested something because his pupils were dilated. Dr. ██████ at CHOP certified the near fatality as a result of alleged abuse. The child was ██████ to CHOP ██████.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office received notice of the Near Fatality on 10/20/10. On 10/21/2010, 10/25/2010, 10/26/2010, 10/29/2010, 11/3/2010, 12/8/2010, 12/9/2010 and 01/25/11, The Regional Office made follow-up telephone and email contacts with the DHS Social worker, [REDACTED] [REDACTED] and [REDACTED], Child Fatality Administrator.

Summary of Services to Family

Children and Youth Involvement prior to Incident:

Prior to the near death incident on 10/20/10 the family was not known to DHS or any other child welfare services.

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

On 10/20/10 DHS received the [REDACTED] report for [REDACTED] (3yrs old). The child was transported to CHOP by paramedics. The child was in an altered state and he had visible strangulation marks around his neck. When the paramedics arrived at the home they reported the child had a string or rope around his neck. The child was [REDACTED] to the [REDACTED] at CHOP, Dr. [REDACTED] from CHOP certified the near fatality as a result of alleged child abuse. Initially the medical staff thought there was a possibility that the child may have ingested something maybe drugs or alcohol [REDACTED] was placed in the [REDACTED] and a [REDACTED] test was completed. The [REDACTED] test was clear.

On 10/20/10 DHS made a safety visit to the hospital to assess [REDACTED]. The mother has three children including [REDACTED]. DHS also assessed the safety of [REDACTED] two other siblings by visiting with them in the family home. DHS completed a safety plan for the siblings while the case was [REDACTED]. The paternal grandmother and the maternal aunt agreed to supervise the children in the home. The mother was not allowed to be alone with the children while the [REDACTED] was pending. DHS interviewed the mother, [REDACTED], adult cousin and the cousin's children that were present at the time of the incident. According to DHS the mother reported [REDACTED] has a history of playing and wrapping things around his neck. The mother reported she and the adult cousin were downstairs in the kitchen and one of the children ran downstairs and said [REDACTED] was choking. The mother reported when they arrived upstairs [REDACTED] was hanging from the upper bunk bed post with the shoulder strap wrapped around his neck and he appeared to be unconscious. The mother reported she and the adult cousin pulled him down. The adult cousin administered [REDACTED] and revived [REDACTED]. According to the paramedics, the child was fortunate. The child was [REDACTED] to CHOP by the paramedics. When the mother arrived to the hospital the [REDACTED] reported the mother appeared to be under the influence. According to DHS the mother

was not intoxicated. DHS reported the mother appeared to be overwhelmed by the incident.

DHS interviewed the children who witnessed the incident. The children present were: [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The children reported that [REDACTED] had a shoulder bag and unhooked the strap. The children reported he made a loop around the top bunk bed post and around his neck and tried to jump. The child was playing (bungee jumping) and the strap became entangled and choked him around the neck. The adult cousin and the mother were downstairs. One of the children alerted the adults. The adult cousin knew [REDACTED] and she revived [REDACTED]. On 10/25/10 the child was stabilized and [REDACTED] from CHOP to his mother.

Current Case Status:

- On 10/25/10, [REDACTED] was [REDACTED] from CHOP and returned to his mother with a safety plan. The paternal grandmother and maternal aunt rotated supervision in the home during the [REDACTED].
- On 11/4/10 the family was provided with daily [REDACTED] services [REDACTED].
- The mother was initially identified as an [REDACTED]. This case was determined to be an accident and no criminal charges were filed.
- On 12/2/10 DHS completed a [REDACTED] and the case [REDACTED]. Based on the medical evidence and witness statements the incident was accidental. [REDACTED] was horse playing and jumped off the bed with a strap around his neck which caused the strangulation.
- Based on [REDACTED] status an Act 33 Review was not conducted.

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

An Act 33 Review was not required due to the county's [REDACTED] being completed within 30 days.

Department of Public Welfare Findings:

County Strengths:

DHS responded timely and the [REDACTED] was thorough.

County Weaknesses:

There were no areas of concern.

Statutory and Regulatory Areas of Non-Compliance:

There were none identified.

Department of Public Welfare Recommendations:

None identified.