



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE Near Fatality OF:



BORN: 02/19/2010
Near Fatality: 06/05/2010

FAMILY KNOWN TO:

Family is known to DHS

REPORT FINALIZED ON: 1/26/2011

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 Governor Edward G. Rendell. 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.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	02/10/2010
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Mother's Paramour	[REDACTED]
[REDACTED]	Half-Sibling	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Half-Sibling	[REDACTED]

Notification of Child (Near) Fatality:

On 06/05/2010 the Department of Human Services (DHS) received a [REDACTED] report stating that [REDACTED] was brought to the Children's Hospital of Philadelphia (CHOP) with head trauma. [REDACTED] was having seizures, bleeding around the brain, had damage to the brain and bleeding in the back of the eye. [REDACTED] was in critical condition in the [REDACTED] but was expected to survive. According to the report, [REDACTED] symptoms began on 06/01/2010. [REDACTED] was taken to CHOP by his mother on 06/01/2010 where he was seen and released [REDACTED] condition progressively worsened and his mother brought him back to the hospital on 06/05/2010, the date the report was made. Reportedly, mother did not have any idea of how [REDACTED] suffered his injuries. The case was certified as a near-fatality.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families reviewed the current county case record, attended the Act 33 meeting and interviewed the social worker assigned to the case.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

- 03/21/2007- [REDACTED] Child endangerment; paramour allegedly pulled a knife on [REDACTED] and [REDACTED], and pretended he was going to stab them.
- 07/22/2005- [REDACTED] on mother for medical neglect. Mother was not following through with caring for [REDACTED] [REDACTED] Mother had missed several medical appointments which caused the child to get a [REDACTED]
- 08/17/2005- [REDACTED] on mother for medical neglect. [REDACTED] had been transferred to St. Christopher's Hospital because the [REDACTED] had worsened; the sores were oozing and she had a high fever. Mother reported using the medicine, but reporter believed she was not using it. Mother had not followed through with seeing a [REDACTED]
- *Family received SCOH from 11/2005-05/2006 through the Family Support Center*
- 06/21/2001 [REDACTED] that mother's housing conditions were "deplorable." The home was roach and mice infested and that there were "crack bags" and multiple "marijuana roaches" in the master bedroom; report also alleged that mother was intellectually limited.

Circumstances of Child Near Fatality and Related Case Activity:

On June 5, 2010 the Philadelphia Department of Human Services (DHS) received [REDACTED] report alleging that four [REDACTED] was brought into the Children's Hospital of Philadelphia (CHOP) on June 4, 2010; [REDACTED] was brought to CHOP by his mother, [REDACTED] because he would not stop crying. [REDACTED] was examined and diagnosed with having seizures, bleeding around the brain; damage to the brain and bleeding in the back of the eye; [REDACTED] was in critical condition and the case was being certified as a near fatality; [REDACTED] is expected to survive. [REDACTED] lives with his mother, [REDACTED] and [REDACTED] who is the father of [REDACTED] half sibling, [REDACTED] denied that anything happened [REDACTED] to cause his trauma. [REDACTED] states that she believes that [REDACTED] "symptoms" all started on June 1, 2010; she went on to explain why [REDACTED] said that on May 31, 2010 (Memorial Day) she and the children went to a cookout, at which [REDACTED] was laughing and appeared to be "normal." [REDACTED] also said that she was home the whole week prior to the cookout and [REDACTED] appeared to be normal. On June 1, 2010, [REDACTED] demeanor was completely different, he was crying and it appear that something was wrong with him but she did not know what. [REDACTED] said that she wonders if [REDACTED] older half- brother the son of paramour, [REDACTED]) hit the baby because he is "rambunctious and bad", she jokingly said. [REDACTED] states that she left home at about 7:40 AM Tuesday, June 1, 2010, on her way to Chester, Pennsylvania to accompany her nephew on a school trip; [REDACTED] was left at home in the care of [REDACTED] paramour, [REDACTED] states

that due to "electrical problems" on the train she was scheduled to ride, she arrived at her nephew's school too late to go on the trip. [REDACTED] states that [REDACTED] called her about 12:00 pm to tell her that he thought something was wrong with [REDACTED] because he would not stop crying. When she returned home, [REDACTED] was asleep. When she woke him up, he was "fussy" and when she picked him up, he started to cry and wouldn't stop. [REDACTED] said that she took a good look at [REDACTED] and did not see any injuries or bruises; then she asked [REDACTED] if something had happened to [REDACTED] while she was gone, and he said, "No [REDACTED] continued to cry [REDACTED] to take him to the [REDACTED] at CHOP [REDACTED] said that she told the [REDACTED] personnel that [REDACTED] wouldn't stop crying, wouldn't eat and that the crying he was doing was not "normal" because he did not cry a lot [REDACTED] states that it did not appear the hospital did a thorough check of [REDACTED] because he was discharged as a child with "crying baby syndrome" within a few hours (he arrived at the CHOP [REDACTED] at 4:53 PM and was released at 6:19 PM) of his arrival to the ER. [REDACTED] stated that the doctor did say that [REDACTED] had a diaper rash and put some ointment on the rash. [REDACTED] said that no other tests or x-rays, skeletal etc. were performed on [REDACTED] maternal grandmother was concerned about [REDACTED] because he was discharged from the hospital as a "crying baby" and she felt that if he was "crying", the hospital should have tried to determine "what he was crying for." [REDACTED] said she returned home with [REDACTED] and when she arrived home, she asked [REDACTED] if there had been an accident with [REDACTED]. [REDACTED] said that her bed is up high and perhaps [REDACTED] had left [REDACTED] on the bed unattended and [REDACTED] had fallen; [REDACTED] denied that there had been an accident. [REDACTED] said that [REDACTED] cared for [REDACTED] on Wednesday, June 2nd and Thursday, June 3, 2010 for a few hours each day. [REDACTED] said that on Wednesday and Thursday [REDACTED] behavior was "tolerable", he was eating and his bowels were normal. On Friday 06/04/2010, [REDACTED] said that she left [REDACTED] care in order to accompany her oldest child, [REDACTED] on a school trip [REDACTED] phoned her to say that [REDACTED] was "crying out of control." [REDACTED] said that when she arrived home around 2:30 PM, [REDACTED] was sleep, but was making "sobbing noises" like he had cried himself to sleep. When she woke him up later in the evening and picked him up, he was crying uncontrollably. [REDACTED] stated that she tried to feed [REDACTED] but he wouldn't eat and he wouldn't stop crying. [REDACTED] said that she became very concerned because she did "everything," like [REDACTED] diaper, try to feed him, and walk with him, but he still wouldn't stop crying. [REDACTED] said that she did not know what was wrong with [REDACTED] she was unable to soothe him; and he kept crying. At this point, [REDACTED] said that she took [REDACTED] to CHOP's Emergency Room (ER) where she was told that [REDACTED] had some "head trauma." [REDACTED] went on to say that [REDACTED] has a swing, bouncy chair, car seat and she wondered if he may have "fallen over" while she was at her nephew's school; but since paramour, [REDACTED] denied anything happening and she wasn't there, she doesn't know what happened, but would like to find out. [REDACTED] and her mother, [REDACTED] maternal grandmother, [REDACTED] recalled that [REDACTED] was born with a "soft tissue mass" on the left side of his head which appear to be filled with fluid. [REDACTED] said that [REDACTED] was evaluated at Einstein Hospital (the hospital where [REDACTED] was born) and when she asked the doctor about the mass, she was told that sometimes babies develop that kind of mass when they push through a tight space like the birth canal, but it should go away on its own in 4 to 8 weeks. [REDACTED] states that the

lump went down a few weeks ago and [REDACTED] maternal grandmother, wonders if the lump was filled with blood and if that was the cause of the old blood that was detected around [REDACTED] brain when he was examined at the hospital. [REDACTED] mother's paramour, was interviewed by the DHS Hotline Social Worker when he brought the other children to CHOP the evening of 06/04/2010. [REDACTED] denied that anything happened to [REDACTED] while [REDACTED] was in his care. [REDACTED] denies seeing [REDACTED] do anything to [REDACTED] and denies he did anything to [REDACTED] even accidentally while he was caring for [REDACTED]. [REDACTED] states that [REDACTED] left to go on her nephew's class trip, when she left [REDACTED] was still asleep. [REDACTED] said that [REDACTED] woke up around 12:30 PM screaming and crying at which point he tried to give him a bottle but [REDACTED] would not take it. [REDACTED] said that he called [REDACTED] because [REDACTED] would not stop crying and would not eat; [REDACTED] said that she was on her way home. Shortly after [REDACTED] arrived home, she took [REDACTED] to the hospital. [REDACTED] said that he never really handled [REDACTED] because he always had that "lump" on his head and he [REDACTED] was always concerned about that lump, so he never really handled him. [REDACTED] went on to say that [REDACTED] had [REDACTED] by someone else when [REDACTED] was "locked up." [REDACTED] said that when he was released from prison, he was still in love with [REDACTED] so they got back together. [REDACTED] said that [REDACTED] dad was never [REDACTED] life and he [REDACTED] is the only father [REDACTED] has ever known.

On 06/05/2010, Dr. [REDACTED] CHOP certified [REDACTED] to be in Serious/Critical Condition, [REDACTED] is expected to survive; the report is to be processed as a Near Fatality. 06/05/2010-Safety Plan dated June 5, 2010 outlined that maternal grandmother, [REDACTED], was willing to temporarily care for [REDACTED] siblings, [REDACTED] remained hospitalized.

06/07/2010- SW [REDACTED] went to hospital and was told [REDACTED] had surgery related to his injuries. [REDACTED] maternal grandfather, [REDACTED] was at the hospital and told [REDACTED] that he had no concerns pertaining to [REDACTED] that he was pleasant and that the children did not say they were being mistreated.

07/08/2010- An [REDACTED] was obtained for [REDACTED] and he was placed in a [REDACTED] Foster home thru Jewish Family & Children Services.

07/08/2010-the non-victim children, [REDACTED], [REDACTED] and [REDACTED] were returned to their mother, [REDACTED] and In Home Protective Services (IHPS) were placed in the home.

Current Case Status:

[REDACTED] was arrested on 6/16/2010 and charged with aggravated assault and related charges. He is currently incarcerated.

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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths and Deficiencies:

- The team believed that DHS social workers did a good job investigating this case.
- The team believed that the issue of domestic violence needed to be addressed with mother along with her choice in partners as it relates to the safety of her children. This issue should have been addressed in 2007 when the [REDACTED] report alleged her paramour threatened her children with a knife.
- The team believed that the CHOP physician missed the signs of abuse when [REDACTED] was seen at the first visit on 06/01/2010. He was seen and diagnosed with “crying baby syndrome” and released. One of the physicians on the team stated that there was no such syndrome, and that [REDACTED] should have been evaluated for trauma at this point. The doctor added that this might have prevented him from becoming re-injured.

Recommendations for Change at the Local Level:

- The team had no recommendations.

Recommendations for Change at the State Level:

- The team had no recommendations.

Department Review of County Internal Report:

Act 33 Review Meeting held June 18, 2010 at the Philadelphia Medical Examiner’s Office. Their report did not separate Strengths and Deficiencies.

Department of Public Welfare Findings:

- County Strengths:
DHS did a thorough investigation.
- County Weaknesses:
The issue of domestic violence needs to be addressed, but it was not discussed in this case. Domestic violence issues should be addressed through ongoing training and supervision.
- Statutory and Regulatory Areas of Non-Compliance:
None identified.

Department of Public Welfare Recommendations:

- DHS has identified that staff need training in the identification and assessment of domestic violence (DV) in families, and have implemented training. DPW should review the training curriculum with the Child Welfare Training Center and provide guidance if needed. The DPW should also provide DV training to other county agencies.