



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823
Fax: (215) 560- 6893

REPORT ON THE NEAR FATALITY OF:



DATE OF BIRTH: 12/22/2010

DATE OF NEAR FATALITY INCIDENT: 7/18/2011

**FAMILY WAS NOT KNOWN TO
ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY**

REPORT FINALIZED ON: 10/25/2011

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. 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 not convened a review team because this case was [REDACTED] before the 31st day.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim child	12/22/2010
[REDACTED]	Mother	1994
[REDACTED]	Maternal aunt	2000
[REDACTED]	Maternal aunt	1997
[REDACTED]	Maternal grandmother	1978
[REDACTED]	Paramour of maternal grandmother	1986

Other family members:

[REDACTED]	Father	1993
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*Lives between this household and his mother's

Notification of Child Near Fatality:

On 7/18/2011, Philadelphia Department of Human Services (DHS) received a report concerning seven month old [REDACTED]. The mother was giving the baby a bath. She left the child alone in the tub while she went downstairs to get a towel. When the mother returned, she found [REDACTED] face down in the bathtub. 911 was called while the maternal grandmother performed [REDACTED].

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed current case records pertaining to this family. Follow up interviews were conducted with the social worker, [REDACTED].

Children and Youth Involvement prior to Incident:

No prior involvement with this family.

Circumstances of Child Near Fatality and Related Case Activity:

The report was initially [REDACTED] for lack of supervision on 7/18/2011 because of the near drowning. The child was [REDACTED] at the Children's Hospital of Philadelphia (CHOP), [REDACTED] to the [REDACTED]. On 7/22/2011, [REDACTED] that report should be considered a near fatality.

The mother was interviewed at Philadelphia's Special Victims Unit (SVU) on 7/18/2011, and [REDACTED]. Charges were [REDACTED]. The mother was taken to the [REDACTED]. The mother was interviewed by the DHS worker at [REDACTED]. The mother reported bathing the baby in the tub, not a baby tub, as [REDACTED] had outgrown the baby tub they had. The mother had planned to purchase a new tub. The mother reported that she had never left [REDACTED] alone in the tub prior to this; she had thought that he would okay because he had been sitting up for almost a month. It should be noted that at the time of the incident the mother was getting ready to begin 11th grade [REDACTED].

During the investigation, the DHS worker completed a safety assessment of the children in the home, who are the victim child's two aunts. It was determined that these children were safe in the care of their mother, who is [REDACTED] grandmother. During the investigation, the DHS worker discovered that the grandmother was not aware that [REDACTED] had been left alone in the bathtub while the mother searched for a towel. When the mother returned from the basement with a towel, [REDACTED] was under water.

The DHS worker consulted with [REDACTED]. It was reported that the maternal grandmother and two aunts had been [REDACTED] and they have been compliant with [REDACTED]. A dependency court hearing was scheduled for 7/25/2011 at 1801 Vine Street. The following was ordered: dependency petition filed for [REDACTED], and an Order of Protective Custody (OPC) was to be secured for [REDACTED] when he was [REDACTED]. (Note: DHS frequently secures dependency petitions for youth when [REDACTED].) DHS was ordered to obtain [REDACTED] on all household members over the age of 18. Order of Protective Custody (OPC) was obtained for [REDACTED]. The court ordered that he was placed in [REDACTED] with a maternal aunt after two weeks in the hospital. The court further ordered that the family and DHS meet at the home to develop a [REDACTED], and that after the mother completed her [REDACTED], the child could be discharged to his mother. [REDACTED] on 8/4/2011.

Current Case Status:

At the hearing on 9/26/2011, the judge ordered the mother to [REDACTED]

[REDACTED] could be returned home [REDACTED], and the other [REDACTED].

The adjudication of Delinquency could be deferred based on the mother's compliance.

On, 10/20/2011, DHS met with the mother and maternal grandmother to discuss [REDACTED] to the mother's care, as the mother had completed her [REDACTED]. [REDACTED] continues in good health. Aftercare services will be provided by Bethanna, the foster care agency. DHS will discharge the family from services at the next court date in December. At that time, the dependency petitions on [REDACTED] would be [REDACTED].

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 did not convene a review team because the case was [REDACTED] before the 31st day.

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

- Consultation with [REDACTED] to obtain [REDACTED] on family members
- Consultation with DHS nurses and [REDACTED] from the hospital and to assess the family's capacity to provide for the child.

County Weaknesses:

None identified

Statutory and Regulatory Areas of Non-Compliance:

None identified

Department of Public Welfare Recommendations:

Since the Department has seen a number of babies and young children who have nearly drowned in the bathtub, perhaps educational services could be offered to parents in the community, such as at pediatrician's offices, health centers, obstetrician's offices, and hospitals.