



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: 8/20/11**

**DATE OF NEAR FATALITY REPORT: 10/10/11**

**FAMILY WAS NOT KNOWN TO:  
Philadelphia Department of Human Services**

**REPORT FINALIZED ON: May 22, 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. Philadelphia County has convened a review team on 12/4/11 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

Mother's Household: Mother lived with her godmother at the time of the incident.

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Mother	██████████1991
██████████	Victim Child	8/20/2011
██████████	Household Member	Adult
██████████	Household Member	Age 19
██████████	Household Member	Age 2
██████████	Household Member	Age 20

Father's Household: Father lived with his mother at the time of the incident.

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Father	██████████1990
██████████	Sibling	██████████2009
██████████	Paternal Grandmother	Adult
██████████	Paternal Uncle	██████████1989
██████████	Paternal Aunt	Age 16
██████████	Paternal Uncle	Age 25
██████████	Paternal Uncle	Age 19

**Notification of Child Near Fatality:**

On 10/10/11, the Philadelphia Department of Human Services received a call from ██████████ concerning ██████████, stating that the parents ██████████ the child to ██████████ because he was not breathing. The child was still in ██████████ distress, so he was sent by ambulance to CHOP. CPR was done for 3-5 minutes. He was ██████████ and placed on a ██████████. According to the ██████████, the child was medically sedated. CHOP medical staff was unable to do a body scan, due to the severity of ██████████ injuries. Doctor ██████████

suspected massive head trauma. A CAT scan showed a [REDACTED] with a [REDACTED], [REDACTED] with [REDACTED] (caused by [REDACTED] in the [REDACTED]). Dr. [REDACTED] from the CHOP [REDACTED] ( [REDACTED] ) team, stated on 10/10/11 that he [REDACTED] [REDACTED] bus. The doctor certified this to be a near fatality. It was unknown if the child was expected to live.

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

The Southeast Regional Office of Children, Youth and Families obtained all current and past case records pertaining to the [REDACTED] family. Follow-up interviews were conducted with the [REDACTED], [REDACTED], on 10/17/11 and 10/24/11, and [REDACTED], [REDACTED], 12/20/11. Contact was also made with Dr. [REDACTED] at CHOP, and [REDACTED] [REDACTED] and [REDACTED].

### **Summary of Services to Family:**

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

The family had no prior history with the children and youth agencies.

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

On October 5, 2011, [REDACTED] took 2-week-old [REDACTED] to the PCP's office, where he was [REDACTED] with an [REDACTED]. He was not given any new medications, nor was his medication ([REDACTED] for [REDACTED]) changed. On October 7, 2011, at 5:30pm she dropped him off with his father for the first time. Ms. [REDACTED] took [REDACTED], their 2-year-old daughter who resides with the father, back with her to her godmother's house. The next day, October 8, 2011, [REDACTED] mother arrived at the father's house to pick him up. At that time the father, noticed that [REDACTED] was not breathing, and the couple took him by personal automobile to his primary care physician at St. Agnes hospital a few blocks away. Staff at the doctor's office called 911 right away, and the baby was taken to Jefferson University Hospital by ambulance. At 12:40 pm, doctors placed [REDACTED] on a [REDACTED] did a [REDACTED], an [REDACTED], and numerous tests and procedures in consultation with staff at Children's Hospital of Philadelphia (CHOP).

The child was [REDACTED] to CHOP at 3:35pm, via ambulance transportation. When the team arrived at his bedside he was having a 30-second seizure-like event. He was given further tests, and transported to CHOP. At CHOP, doctors [REDACTED] him with [REDACTED] and a [REDACTED]. On October 10, 2011, a report was made to DHS, saying that [REDACTED] injuries, a [REDACTED] with [REDACTED] [REDACTED] and a [REDACTED] were serious, and that the parents did not provide an explanation for these injuries. DHS filed a Dependent Petition, stating that Aggravated Circumstances exist in this case, as

██████████ was the victim of ██████████ resulting in ██████████. The safety assessment was completed by the intake worker and it was determined that the children were unsafe inside of their home and needed to be placed in foster care at this time. The sibling was placed into the home of ██████████ a foster parent through Asociacion Puertorriquenos En Marcha (APM).

During the ██████████, the DHS worker documented thorough interviews with ██████████ biological parents, his paternal and maternal grandparents, his paternal aunt and uncles, his mother's godmother and her children, his paternal grandfather's girlfriend, the ██████████ team at CHOP, the CHOP social worker, ██████████ Primary Care Physician, and ██████████ foster mother. DHS was not able to obtain a clear explanation regarding ██████████ injuries, as the parents' accounts of how the child could have been injured were not sufficient to explain ██████████ injuries, and no other party admitted to seeing anyone else cause the injury to the child. DHS collaborated with police for interviews, and obtained documentation of police interviews with various parties. DHS also obtained documentation from ██████████ pediatrician, Jefferson University Hospital, and CHOP, and consulted with DHS medical staff in understanding and coordinating medical treatment for ██████████

On November 3, 2011, DHS staff filed the ██████████. Both parents, ██████████ and ██████████, were ██████████ for the child's injuries. ██████████ was in his father's care at the time of the injury. A few days prior to that, his mother reportedly had left him unsupervised on the couch at the godmother's house. ██████████ rolled off the couch, and received a ██████████. Per DHS worker ██████████, doctors at CHOP stated that the prior injury did contribute to the larger brain injury.

On December 14, 2011, ██████████ was ██████████ from CHOP to ██████████, where he remains.

### **Current Case Status:**

- ██████████, age 2, is placed through Asociación Puertorriqueños en Marcha (APM) with the paternal grandfather's girlfriend, ██████████. The goal is currently reunification. All visits are to be supervised at the agency, and the District Attorney's Office has issued a Stay-Away Order for the father.
- ██████████ is placed with ██████████, and the goal is for him to remain medically stable. From conversations with CHOP staff and ██████████, it is unlikely that ██████████ will progress developmentally, functioning with only a brain stem. There is a stay-away order for ██████████ father, ██████████, though he is allowed to call ██████████ if he wishes. ██████████, ██████████ mother, is

allowed to visit with [REDACTED], and all visits are to be supervised by DHS.

- Father, [REDACTED], was arraigned on 11/22/11, and he posted bail on that day. He has been charged with attempted homicide, aggravated assault, endangering the welfare of a child, simple assault, and reckless endangerment. His next hearing is scheduled for 3/12/12.
- [REDACTED] and [REDACTED] are living with the paternal grandfather on [REDACTED], [REDACTED] caregiver, has signed and committed to a safety plan that does not allow either parent unsupervised time with [REDACTED].
- At the Adjudicatory Hearing in Dependency Court on March 2, 2012, [REDACTED], mother, was granted visits that are to be supervised by DHS. [REDACTED] is allowed to attend any medical appointment if the DHS worker is in attendance.

**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 on 12/4/11 in accordance with Act 33 of 2008 related to this report.

- Strengths:  
The team felt that the county did an excellent job [REDACTED] the case. The team felt that there was good collaboration between the county, the police department and medical professionals.
- Deficiencies:  
Several medical professionals gave several different medical opinions about the case, which caused confusion about the child's medical status.
- Recommendations for Change at the Local Level:  
DHS should create protocol guidelines for DHS workers trying to obtain medical information from the two children's hospitals in Philadelphia. This protocol should specifically address whom to ask for information and medical opinions.
- Recommendations for Change at the State Level:  
None

**Department Review of County Internal Report:**

- The Department of Public Welfare is in full agreement with the County Internal Report.

**Department of Public Welfare Findings:**

- County Strengths:  
Very thorough [REDACTED]
- County Weaknesses: None
- Statutory and Regulatory Areas of Non-Compliance: None

**Department of Public Welfare Recommendations:**

- It is recommended that this family be offered [REDACTED] [REDACTED] services to address any feelings related to the loss of the child's functioning, including the parents' roles in the incident.
- There has been much improvement in the communication regarding the cause of children's injuries from the medical professionals with the addition of the DHS Medical Director. Enhancing the liaison relationship provides a direct benefit to protection of children from further abuse as a result of child abuse.