



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



BORN: 06/05/2009
DATE OF NEAR FATALITY: 12/24/2010

FAMILY KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON: 10/20/2011

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 [REDACTED] 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]	Child	06/05/2009
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]**	Father	[REDACTED] 1990
[REDACTED]	Step-MGF	[REDACTED] 1965
[REDACTED]	Maternal Grandmother	[REDACTED] 1972
[REDACTED]	Maternal Aunt	[REDACTED] 1988
[REDACTED]	Maternal Aunt	[REDACTED] 1990
[REDACTED]	Maternal Cousin	[REDACTED] 2005
[REDACTED]	Maternal Cousin	[REDACTED] 2008

** [REDACTED] did not reside in the house

Notification of Child Near Fatality:

On 12/24/2010 Philadelphia Department of Human Services (DHS) received a [REDACTED] report concerning [REDACTED]: The mother reported that when she checked on the child, [REDACTED] did not respond to her name being called. The mother reported noticing the injuries to [REDACTED] mouth, and that she was gasping for air. The mother called fire rescue. Fire rescue was able to regain the child's heart beat and pulse. When the child arrived at Children's Hospital of Philadelphia (CHOP), the doctors observed that the child had [REDACTED] A [REDACTED] was done; victim child had [REDACTED]. Mother could not explain injuries.

At the time of initial report, [REDACTED] was unsure if the child would survive. She was [REDACTED] to the [REDACTED] at CHOP.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the DHS Multidisciplinary Team (MDT) social worker, DHS [REDACTED] social worker, and DHS Fatality Administrator. The regional office also participated in the County Internal Fatality Review Team meeting on 01/07/2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

- [REDACTED], maternal aunt, was another household member who was known to DHS. [REDACTED]
- The [REDACTED] case became known to Department of Human Services on 10/26/2009 via [REDACTED] from [REDACTED] which alleged that the mother brought [REDACTED] in to St. Christopher's Hospital to be seen for [REDACTED]. During the interview, [REDACTED] disclosed [REDACTED] that the child had fallen from a bed while at the [REDACTED] home two weeks previously. [REDACTED] stated that the child was seen at Children's Hospital and [REDACTED]. [REDACTED] was unaware of [REDACTED] exact new address as he had just moved. [REDACTED] mother appeared totally appropriate with the child and concerned. Mother and father do not reside together. [REDACTED] revealed an [REDACTED] the child's [REDACTED]. The age of the injury is undetermined and it is undetermined if the injury was [REDACTED]. [REDACTED] why the child was on a bed and not in a crib. [REDACTED] will [REDACTED] at St. Christopher's Hospital [REDACTED]. This report was [REDACTED] on 11/17/2009 [REDACTED].
- 10/28/09 DHS learned from [REDACTED] that further tests revealed [REDACTED] in [REDACTED] and that the injuries were [REDACTED] but had been [REDACTED]. A subsequent interview with parents revealed that [REDACTED] stated he did not know how [REDACTED] was injured. He stated he had [REDACTED] on the bed with pillows around her, he left the room for a brief time period and when he returned, [REDACTED] was on the floor. He also stated that he did notice that [REDACTED] had been irritable for about two weeks.
 - On 10/29/09 DHS obtained an Order of Protective Custody (OPC) and [REDACTED] was placed in the home with her paternal aunt, [REDACTED].
 - On 11/11/2009 [REDACTED] report [REDACTED] stating that victim child [REDACTED] was brought into the hospital for a [REDACTED] on 11/10/2009 and the victim child was found to have [REDACTED] that could not be seen when a [REDACTED] was done on 10/26/2011. It was reported that the child was previously removed from the mother's care due to the current [REDACTED].

report was [REDACTED] and [REDACTED] remained in her paternal aunt's care.

- On 11/13/2009 paternal aunt requested that [REDACTED] be removed from her home and placed in foster care because she was employed full time and attended nursing school and did not have a suitable caretaker for [REDACTED]
- On 11/17/2009 [REDACTED] was placed in the foster home of [REDACTED] through Best Nest.
- On 5/13/2010 [REDACTED] was returned to the home of her mother, Ms. [REDACTED] due to Ms. [REDACTED] being in compliance with her [REDACTED] goals and working well with all agencies involved. [REDACTED] was returned home with the assistance of [REDACTED] through Presbyterian Children's Village (PCV).
- [REDACTED] began 5/20/2010 and ended 12/15/2010.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/24/2010 Department of Human Services received [REDACTED] report informing the following concerning [REDACTED]: The mother reported that when she checked on the child [REDACTED] did not respond to her name being called. The mother reported noticing the injuries to [REDACTED] mouth, and that she was gasping for air. The mother called fire rescue. Fire rescue was able to regain the child's heart beat and pulse. When the child arrived at CHOP, the doctors observed that the child [REDACTED] A [REDACTED] was done; victim child had [REDACTED] and [REDACTED] on the [REDACTED]

On 01/21/2011 the [REDACTED] was completed and [REDACTED] was submitted. DHS [REDACTED] supporting that [REDACTED] injuries were the result of [REDACTED] These injuries were certified by Dr [REDACTED] remains placed in medical foster care.

Current Case Status:

- On 8/19/2011 social worker from DHS reported that [REDACTED] is doing very well and is currently receiving [REDACTED] She remains in foster care with a goal of adoption. As per order of the court, mother and father both do not have visitation rights with [REDACTED]
- [REDACTED] is receiving [REDACTED]. All other services were discontinued due to [REDACTED] amazing progress.
- On 6/11/2012 social worker supervisor from DHS reported that [REDACTED] [REDACTED] parents' rights were terminated on 1/20/2012.

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

██████████ or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report on 01/07/2011.

Strengths:

- MDT Social Work Services Manager did a thorough job ██████████ the case.
- It is good practice to put in ██████████ as opposed ██████████, to provide the family with a more intense level of monitoring.

Deficiencies:

- Concern was that neither DHS nor PCV followed up with Mr ██████████ in regards to his ██████████ goal completion. It is very concerning that the worker from PCV was not aware that Mr. ██████████ was back in ██████████ life and failed to engage him in regards to completing his ██████████ goals.

Recommendations for Change at the Local Level:

- A policy has been developed by DHS addressing the reunification of children with parents who continue to be in denial on how an ██████████ occurred.
- DHS is in the process of developing a protocol that would define and clarify supervised visitation.

Recommendations for Change at the State Level:

- A policy should be developed by counties addressing the reunification of children with parents who continue to be in denial about how an ██████████ occurred.
- Counties should develop protocols that would define and clarify supervised visitation.

Department Review of County Internal Report:

The Department has reviewed and is in agreement with the county's recommendations.

Department of Public Welfare Findings:

County Strengths:

██████████ Multidisciplinary Team (MDT) did a very nice job with the ██████████

County Weaknesses:

- Lack of communication between the county and the provider agency.

Statutory and Regulatory Areas of Non-Compliance:

- The Licensing Inspection Summary(LIS) was issued 6/11/2012 notation are as followed: 3490.56 (d) and 3130.21 (h)(4)(i)(ii)

Department of Public Welfare Recommendations:

It is the recommendation of the Regional Office that at all times there should be clear communication from the county about the expectations of the providing agency. There was clearly a lack of communication in regards to biological father and his requirements between the two whereas the result of the lack of communication could have possibly prevented this [REDACTED] situation.