



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: 05/12/2010

Date of Near Fatality Incident: 06/04/2010

Family was not known to Philadelphia DHS

REPORT FINALIZED ON: 02/04/2011

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 No. 1147, now known as Act 33 was signed by [REDACTED] on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	05/12/2010
[REDACTED]	Biological mother	[REDACTED]/1990
[REDACTED]	Biological father	[REDACTED] 1990
[REDACTED]	Maternal grandmother	[REDACTED] 1970

Notification of Child Near Fatality

On June 4, 2010 the Philadelphia Department of Human Services (DHS) was notified of the near fatality of [REDACTED]. It was reported that her mother, [REDACTED] had neglected to secure [REDACTED] appropriately in her car seat and the three week old baby fell out of the car seat on to the ground. [REDACTED] sustained a [REDACTED]. She was initially transported to Temple Hospital by family friend who mother the mother called after the accident and then Temple Hospital transported the mother and the child to St. Christopher's Hospital for Children for further evaluation and treatment.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current records pertaining to the [REDACTED] family. There was detailed collaboration between OCYF and the Philadelphia Department of Human Services.

Summary of Services to Family:**Children and Youth Involvement prior to Incident:**

The family had no children and youth involvement prior to the incident. The biological parents of [REDACTED] were known to Philadelphia Department of Human Services as children. Both mother and father were in juvenile detention during the same time period and actually became acquainted while in placement.

Circumstances of Child Near Fatality and Related Case Activity:

On June 4, 2010 Philadelphia Department of Human Services was notified of the near fatality of [REDACTED]. The physician Dr. [REDACTED] at St. Christopher's Hospital explained that

█████ was transferred from Temple Hospital for evaluation and treatment. The physician reported that the documents that accompanied █████ from Temple did not indicate that the incident was certified as a near fatality. The doctor further explained that █████ only experiences pain when her head is touched; she was still feeding, and she was stable and was only admitted to the hospital for observation. The physician also explained that █████ did not suffer any █████ problems and she never lost consciousness. █████ did not require any medical equipment as she was feeding and breathing on her own. The █████ investigation determined that █████ fell out of her car seat which was attached to her stroller while her mother █████ was walking down the steps to the Broad Street Subway Line at Broad Street and Erie Avenue. █████ (biological mother) reported that she was on her way to her █████ appointment and was about to go down the stairwell at the Broad and Erie Station, when she asked an unknown male to assist with taking the stroller down the steps. She further explained that she had the top of the stroller and the male had the bottom of the stroller. She reported she did not realize until she got to the bottom of the steps that █████ had fallen out of the car seat. █████ did not fall down the steps of the subway, but landed on the ground in front of the subway entrance. █████ reports that █████ was strapped in the car seat. When █████ fell out of the car seat she cried however mother continued on to her appointment. While at the █████ continue to cry and then mother contacted a friend so they could be transported to the Temple Hospital.

On June 5, 2010 a safety assessment was completed:

- The safety assessment identified safety threat number 10, which states, Caregiver lack of parenting knowledge, skill and/or motivation presents an immediate threat of serious harm to a child. The assessment determined that child would be safe with a comprehensive safety plan.
- The safety action states, █████ (maternal grandmother) will assist with the supervision and care of her grand daughter █████ Also █████ will also ensure that █████ is properly secure in her car seat. █████ (biological mother) and █████ reside in the home of the maternal grandmother.
- The responsible person for the safety plan was the maternal grandmother █████.

Current Case Status:

On June 23, 2010 the investigation was completed and █████, it was determined that the injury █████ sustained was the result of an accident. Mother was referred to community services for assistance with parenting. █████ Primary Care Physician confirmed that the injuries from the fall were the result of an accident and not due to blunt force trauma. The Special Victims Unit did not take any criminal action and their case was closed.

DHS did not close the case. DHS continued to monitor the safety plan and provided parenting educational classes to the mother through the █████.

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 in accordance with Act 33 of 2008 related to this report; as the investigation was [REDACTED] within 30 days.

Department Review of County Internal Report:

This is not applicable. The Act 33 does not require a review team to be convened if the investigation is determined within 30 days.

Department of Public Welfare Findings:

- County Strengths: The County completed a comprehensive investigation. The county had significant collaboration with the medical staff at both hospitals.
- County Weaknesses: There are no areas of weakness
- Statutory and Regulatory Areas of Non-Compliance: There are no areas of non-compliance

Department of Public Welfare Recommendations:

The Department recommends public safety announcements that address securing infants and young children appropriately in car seats and strollers as well as all other baby equipment.