



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: JUNE 11, 2010
DATE OF NEAR FATALITY INCIDENT: August 16, 2010

FAMILY NOT KNOWN TO ANY AGENCY

REPORT DATED 05/17/12

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 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 fatality that was suspected to have occurred during 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>
██████████	Victim Child	06/11/2010
██████████	Mother	██████████ 1992
██████████	Father	██████████ 1979

Notification of Fatality / Near Fatality:

On the evening of August 16, 2010, 2-month-old ██████████ was brought into St. Christopher's Hospital via ambulance. ██████████ presented in respiratory arrest and he was having ██████████ upon arrival. ██████████ also had a ██████████ on the upper lip which is common in ██████████; a bruise on his upper back and his ██████████ ██████████ for a ██████████. In addition, ██████████ had ██████████

██████████ mother, ██████████ stated that she noted that ██████████ was bright red when she was about to feed him a bottle. Ms. ██████████ then changed her story and said that ██████████ was pale and she shook him to make him alert. Ms. ██████████ said that ██████████ was appeared to be having seizure-like behaviors at home and she splashed water on his face. Ms. ██████████ said that she called a neighbor for help and the neighbor came and tried rescue breaths. EMS was called and ██████████ was intubated. Dr. ██████████ stated that ██████████ was a Near Fatality based on suspected abuse. ██████████ was ██████████ to St. Christopher's ██████████

Documents Reviewed and Individuals Interviewed:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the current case record pertaining to the ██████████ family, attended the Act 33 Review meeting on September 3, 2010 and spoke with DHS SW, ██████████

Case Chronology:**Previous CY involvement:**

Prior to this incident, there was no CY involvement with this family.

Circumstances of Child's Fatality or Near Fatality:

On August 16, 2010, [REDACTED]' mother, [REDACTED] and father, [REDACTED] were interviewed by Department of Human Services (DHS) Social Worker (SW), [REDACTED] and the following account was found in the Structured Case Progress Notes. Ms. [REDACTED] states that she was home alone with [REDACTED] when he appeared to be choking. Ms. [REDACTED] said that she ran out of the house in a panic, called her neighbor and then called 911. [REDACTED] father, Mr. [REDACTED] stated that he was at work when the incident took place and said that he met the family at St. Christopher's Hospital. Ms. [REDACTED] asked the family if [REDACTED] had fallen or would have any reason to have a head injury to which Ms. [REDACTED] stated that he had fallen out of his portable swing about three weeks ago.

On August 17, 2010, mother, [REDACTED] and father, [REDACTED], were involved with a face-to-face assessment/visit; present at the visit was, Detective [REDACTED], Philadelphia Special Victims Unit (SVU), [REDACTED] St. Christopher's Social Worker, Dr. [REDACTED] Child Protection Team Physician, and Dr. [REDACTED] St. Christopher's Resident. According to the Structured Progress Notes, Ms. [REDACTED] began to describe the events of the day of the incident. Ms. [REDACTED] said that she laid [REDACTED] down in his swing as he was feeding on his bottle. Ms. [REDACTED] said that she stepped out to go to the bathroom and left [REDACTED] in the swing with the bottle in his mouth. Ms. [REDACTED] said that when she returned from the bathroom 2-3 minutes later, [REDACTED] began to turn red, then pale and would not blink. Ms. [REDACTED] said that she took [REDACTED] to the sink and splashed cold water on him at which time he became very stiff and was staring at her non-responsive. Ms. [REDACTED] said that she picked [REDACTED] up and "shook him", then ran outside and got a neighbor who performed CPR and the Heimlich maneuver; another neighbor called 911. Ms. [REDACTED] said that Fire and Rescue came and began working on [REDACTED] with machines and masks and he started crying. Upon questioning from Dr. [REDACTED], Ms. [REDACTED] stated that the only other people in contact with [REDACTED] were members of his family, both maternal and paternal grandparents on some weekends and never had she or [REDACTED] father suspected or had any concerns that any of them would hurt [REDACTED]. Ms. [REDACTED] did say that the 19 year old niece of Mr. [REDACTED] assisted her with the care of [REDACTED] and stayed for two weeks after she delivered [REDACTED] via [REDACTED]. However, the last time the niece had cared for [REDACTED] was over a month ago. Mr. [REDACTED] was interviewed and stated that he was at work at the time of the incident. (Mr. [REDACTED] works for South Eastern Pennsylvania Authority (SEPTA) paratransit and often works over 60 hours a week)

On August 19, 2010, per the Structured Case Notes, SW [REDACTED] returned a phone call to Detective [REDACTED] who informed her that yesterday, [REDACTED] mother Ms. [REDACTED] 'confessed to harming [REDACTED]'. According to Detective [REDACTED] Ms. [REDACTED] said that a friend named [REDACTED] from high school came over to visit baby [REDACTED] at the [REDACTED] home while Mr. [REDACTED] was at work. Ms. [REDACTED] said that she went to the bathroom, came back and suddenly the friend wanted to leave. Ms. [REDACTED] said that after the friend left, she noticed that her iPhone was missing. Ms. [REDACTED] said that she became very angry and at the same time [REDACTED] began to cry. Ms. [REDACTED] said she put a pacifier in [REDACTED] mouth but he kept crying. Ms. [REDACTED] confessed to Detective [REDACTED] that she grabbed [REDACTED] by the waist real hard, shook him and threw him back into the bouncer real hard. Detective [REDACTED] phoned Ms. [REDACTED] at 6:30AM and asked for the friend, "[REDACTED] phone number; mother initially said she couldn't find it, yet gave a number to the detective who learned that" [REDACTED] was actually [REDACTED]. Detective [REDACTED] contacted Mr. [REDACTED] who confirmed knowing mother and being in her home. Mr. [REDACTED] said he had not been to the home lately, but all indications are that Ms. [REDACTED] was having an affair with Mr. [REDACTED] who left the home, causing Ms. [REDACTED] to become angry. Detective [REDACTED] spoke with Mr. [REDACTED], who states that he had suspicions that Ms. [REDACTED] was cheating because he was always at work.

Current / most recent status of case:

DHS [REDACTED] the report on mother, [REDACTED], for causing [REDACTED] injuries. DHS SW.

Ms. [REDACTED] was arrested and charged with causing the injuries to [REDACTED] bail was set at \$100,000; she is currently in prison awaiting trial.

[REDACTED] states that baby [REDACTED] was [REDACTED] to his father, [REDACTED] and the DHS case was closed. Ms. [REDACTED] states that Mr. [REDACTED] has a host of family support. Ms. [REDACTED] also states that baby [REDACTED] is doing "extremely" well and shows no signs of developmental delay.

Services to children and families:

Mr. [REDACTED] was referred to Focus on Fathers Support Group and did well. Family Reunification Services were also offered but the referral was discharged from the court.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

Strengths-

The Act 33 Review team felt that DHS did a thorough [REDACTED]

Deficiencies-

None identified.

County Recommendations for changes at the Local (County or State)**Levels as identified by way of County's Near Fatality Report:**

The Act 33 Review team recommended that DHS develop protocols and procedures for visitation by offending parents during [REDACTED]. This recommendation was offered as there were concerns expressed by the father as to permitting contacts with the mother.

SERO Findings:County Strengths-

DHS SW referred Mr. [REDACTED] to Focus on Fathers. Mr. [REDACTED] completed the program and did very well. Mr. [REDACTED] stays in contact with SW in reference to [REDACTED] (who is doing very well) even though DHS has closed the case due to the positive relationship that had been forged.

Deficiencies-

None identified.

Statutory and Regulatory Compliance issues:

None identified.