



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF

[REDACTED]

BORN: [REDACTED] **2009**
DATE of NEAR DEATH INCIDENT: **May 14, 2010**

Date of Report: **03/31/2011**

FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE WELFARE AGENCY

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 Governor Rendell on July 3, 2008 and went into effect December 30, 2008 This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected 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	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1966
[REDACTED]	Father	[REDACTED] 1974
[REDACTED]	Brother	[REDACTED] 1997
[REDACTED]	Brother	[REDACTED] 1999

Notification of Near Fatality:

[REDACTED] received in Montgomery County on 05/14/2010 stating that 15 month old [REDACTED] was on the couch at the babysitter's [REDACTED] home and fell off (approximately 2 feet) head first onto a carpeted floor. [REDACTED] sustained a "[REDACTED] Dr. [REDACTED] from St. Christopher's Hospital for Children stated that [REDACTED] injury was not consistent with the description of the circumstances surrounding the injury [REDACTED]. Dr. [REDACTED] confirmed that [REDACTED] but was expected to live.

Documents Reviewed and Individuals Interviewed:

- For this review, the Southeast Regional Office (SERO) reviewed:
- The county investigation notes, including Risk and Safety Assessments
 - Upper Moreland Township Police-Investigation Interview Records
 - Abington Memorial Hospital Medical Record
 - St. Christopher's Hospital for Children Medical Record

SERO interviewed [REDACTED], the assigned case worker from Montgomery County C&Y, and [REDACTED] Head of Quality Assurance, Montgomery County C&Y

Circumstances of Child's Near Fatality:

On 05/14/2010, [REDACTED] was received stating that 15 month old [REDACTED] had fallen two feet off the couch while at the babysitters [REDACTED]. According to the Upper Moreland Township Police Department's Investigation Interview Record, the babysitter (and [REDACTED], stated that

[REDACTED] stood up on the couch (excited about a show he was watching on Nick Jr.). She told him to sit down and turned back to working on her lap top. Ms. [REDACTED] said the next thing she knew, [REDACTED] was falling and landed "head first" on the carpet. The babysitter said she threw her lap top and ran over to lift him up; he was crying. Ms. [REDACTED] said she stood [REDACTED] up and saw he had a little red mark on his forehead at which point she started toward the kitchen where she knew she had a 'single portion of frozen fish' which she was going to place on [REDACTED]'s forehead. Ms. [REDACTED] reported that, as she was walking toward the kitchen, [REDACTED] fell again, backwards and hit the back of his head on the floor. Ms. [REDACTED] said she stood him up again and helped him lean against the couch and then went to get the fish for his head. Ms. [REDACTED] said that [REDACTED] had stopped crying but he had a "sleepy baby look" and he was "whiney" and didn't "seem like himself." Ms. [REDACTED] said she fed [REDACTED] some applesauce (his favorite) and kept the frozen fish on his head. Ms. [REDACTED] said that [REDACTED] vomited and had a "blank look" on his face. He was groggy like he wanted to fall asleep; so she kept talking to him to keep him awake. Ms. [REDACTED] said that she did not call [REDACTED]'s mother, Mrs. [REDACTED], because she knew Mrs. [REDACTED] was about to get off work; however, Mrs. [REDACTED] called Ms. [REDACTED] advised her of [REDACTED]'s falls and subsequent behavior. Mrs. [REDACTED] told her to keep [REDACTED] awake. Mrs. [REDACTED] called [REDACTED]'s pediatrician who instructed her to take [REDACTED] to Abington Hospital's Emergency Room. Mrs. [REDACTED] said that when she arrived to the ER, [REDACTED] was evaluated and [REDACTED]. Mrs. [REDACTED] spoke with the attending physician, Dr. [REDACTED] who stated that he believed that the details of the incident which brought [REDACTED] to the ER were inconsistent with his injuries and that by law, he had to report it. Dr. [REDACTED] spoke with [REDACTED]'s parents and relayed that, because of [REDACTED] age and the trauma he suffered due to his falls, he recommended that [REDACTED] be transferred to a [REDACTED] for further treatment. [REDACTED] agreed and [REDACTED] was transferred to St. Christopher's Hospital for Children in Philadelphia.

Case Chronology:

05/15/2010- [REDACTED] was examined at St. Christopher's Hospital for Children and, in addition [REDACTED]. The Child Protection Team's Assessment & Plan states that [REDACTED]'s injury had "low suspicion for intentional abuse"; however, due to [REDACTED], the examining doctor determined that [REDACTED] required "in-patient care" and [REDACTED] was admitted to the hospital on 05/15/2010. [REDACTED]'s parents were not named as [REDACTED] for his [REDACTED], therefore, there were no restrictions placed on their visitation with [REDACTED]. As per the Montgomery County Children and Youth Case Notes, the assigned caseworker phoned Philadelphia DHS to request a courtesy contact with the [REDACTED] family; the county was advised that [REDACTED], caseworker DHS, made contact with [REDACTED] family; [REDACTED] was presently "safe" in the hospital.

05/21/2010- [REDACTED] was [REDACTED] to his mother.

05/24/2010- Dr. [REDACTED] and Dr. [REDACTED] worked jointly on [REDACTED]'s case and they have questions on how [REDACTED]'s injury took place. Dr. [REDACTED] reported that the [REDACTED] was inconsistent with the story that the mother originally reported, that [REDACTED] "slid" off the couch. The assigned CW informed Dr. [REDACTED] that [REDACTED] was standing and dancing on the couch while watching one of his favorite TV shows, and subsequently "fell" head first off the couch onto a carpet covered concrete floor. Dr. [REDACTED] agreed that it was possible that [REDACTED]'s injury could have been sustained by the fall. Dr. [REDACTED] said that the "odd" thing about the injury was that the [REDACTED] was small compared to the [REDACTED] and that this could be explained by the fact that [REDACTED] had also been [REDACTED].

Previous CY involvement:

The family had no previous history with any child welfare agency.

Current / most recent status of case:

On June 10, 2010, [REDACTED] was generated by Montgomery County C&Y stating that this case [REDACTED].

06/10/2010-CW spoke to Dr. [REDACTED] who states that she was under the impression that [REDACTED] "slid" off the couch and was not aware that he actually "fell" off the couch while dancing. Dr. [REDACTED] said the "fall" from the couch is more believable. Dr. [REDACTED] said that she is very concerned about Mrs. [REDACTED] ability to follow up with medical care for [REDACTED] as [REDACTED] had a follow up appointment [REDACTED] on June 3, 2010 for which she did not show. CW advised Dr. [REDACTED] that he would follow up with the family to ensure that Mrs. [REDACTED] keeps all appointments for [REDACTED].

06/11/2010-CW spoke with Mrs. [REDACTED] to explain that the [REDACTED] and closed, however, mother must call and CW would confirm that mother was keeping her follow up appointments. Mrs. [REDACTED] admitted that she had to cancel an appointment because she could not get out of work; however, she has worked something out with her employer that will allow her to take [REDACTED] to the doctor every week.

Caseworker advised [REDACTED] doctor to contact him if [REDACTED] misses an appointment.

Services to Children and Families:

There were no services provided to the family.

County Strengths and Deficiencies as identified by the County's 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. Montgomery County has not convened a review team in accordance with Act 33 of 2008 related to this report.

- [REDACTED] on June 10, 2010 [REDACTED] Because the [REDACTED] within 30 days of the May 14, 2010 referral; an Act 33 review team was not convened.

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

N/A; The county was not required to complete an Act 33 review team meeting because the investigation was concluded within 30 days.

SERO Findings:

- The county completed a thorough investigation of this CPS incident; both medical and law enforcement personnel were interviewed before making a timely determination that [REDACTED].
- Philadelphia DHS completed the courtesy interview in a timely manner and worked well in a collaborative effort with Montgomery County during the time period [REDACTED] was a patient at CHOP.
- A Safety Assessment was completed on 05/26/2010- All children were determined to be "Safe." The [REDACTED] does not live in the home and will not have access to the child.
- A second closing Safety Assessment was completed on 06/10/2010-All Children were determined to be "Safe."
- The Regional Office agrees with the county's assessment and findings during the investigation.

Statutory and Regulatory Compliance issues:

There are no statutory or regulatory compliance issues to report.