COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:

[redacted]

DATE OF BIRTH: 12/10/09
DATE OF NEAR FATALITY INCIDENT: 8/23/10

FAMILY NOT KNOWN TO:
Any Public or Private Child Welfare Agency

REPORT FINALIZED ON: 05/16/2012

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. The Philadelphia Department of Human Services has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth
[redacted]	Victim Child	12/10/2009
	Mother	[redacted]1979
	Mother's Paramour/ [redacted]	[redacted]1980

Non- household members

[redacted]	Sibling	[redacted]/2004
	Maternal Grandmother	Adult
	Biological Father	[redacted]1981

The sibling, [redacted], lives with [redacted], maternal grandmother. The mother moved out of maternal grandmother's home in December 2009 when [redacted] was born. [redacted] remained living with the maternal grandmother. The address for the biological father for [redacted] and [redacted] is unknown. The Victim Child, Mother and Paramour live in the same household.

Notification of Child Near Fatality:

On August 23, 2010 DHS received a [redacted] that [redacted], 8 months old was currently [redacted] with [redacted]. The [redacted] reported the injury was inconsistent with a fall of three feet. The Reporting Source stated that [redacted] also has a 3 cm bruise on the left thigh. The doctor certified [redacted] to be in critical condition and expected to live.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office received and reviewed the case file for the near fatality [redacted]. Documents reviewed: structured case notes, Medical Consultation from St. Christopher's Hospital dated 8/23/10, safety assessments and safety plans. The initial contact with DHS was conducted 8/24/10 with [redacted] Child Fatality Program Administrator. Follow up interviews were conducted with [redacted], DHS Social Worker and [redacted], DHS Administrator. On 9/17/2010 the Regional Office participated in the Act 33 Review Meeting held at the Medical Examiner's Office in Philadelphia.

Children and Youth Involvement prior to Incident:

The family was not known to any child welfare agency prior to this report.

Circumstances of Child (Near) Fatality and Related Case Activity

On August 23, 2010 the Department of Human Services (DHS) received a [redacted] alleging a female child, 8 months old, was [redacted] at St. Christopher's Hospital for [redacted] and a bruise to the left thigh. DHS made a visit to the hospital to assess the victim child's (VC) safety. Present at the hospital were the mother and MGM. DHS interviewed the mother and the MGM while they were at the hospital. During the interview, the mother reported she has a second child named [redacted] (8 years old), that was not at home at the time of the incident. On 8/23/10, DHS conducted a safety visit to ensure the safety of [redacted] [redacted] lives with the MGM and has lived there since June 2010. According to the documentation, the mother, VC and sibling were living with the MGM .The mother and VC moved into an apartment in July of 2010. The sibling child wanted to stay with the MGM.

The comprehensive safety plan dated 8/23/10 ensured the safety of the VC and [redacted] DHS identified safety threat #3 on the safety assessment worksheet because the caregivers did not explain the injuries to the VC.

The mother reported she was at work when the incident occurred on August 22, 2010; the victim child had appeared to be fine when they dropped her off at the Day Care Center between 7:30am and 8:00am. The mother reported earlier in the week the victim child was not feeling well. The mother described the symptoms as vomiting, nasal congestion, and eye discharge. On August 20, 2010, the mother made a telephone call to the primary physician and explained the VC's symptoms. The primary physician said that the VC probably had a viral illness. The mother reported the VC wasn't taken to the Day Care on August18, 19th, and the 20th. The VC stayed home with [redacted] mother's paramour, while the mother went to work. The mother reported on Saturday August 21, 2010, the VC was feeling much better. On Sunday August 22, 2010, mother stated it was a

rainy day and everyone including VC slept late and stayed home all day. On August 23, 2010, [redacted] drove the mother to work and dropped off the VC at the daycare. Later that day, the day care called [redacted] and told him VC appeared to be sick. [redacted] went to the day care and picked up VC and took her home. The mother reported she remained at work and called several times to check on VC. [redacted] reported when he and the VC arrived home, he gave the VC a bath and fed her. [redacted] reported while they were on the couch the VC was reaching for her bottle and she fell on the floor. [redacted] reported when he picked up the VC, she went blank and her body became limp. According to [redacted] he called the cousin for assistance. The cousin and [redacted] transported the VC to St. Christopher's Hospital. [redacted] reported that he had spoken with the day care on August 23, 2010 and they told him that the VC had several falls at the day care. According to documentation, DHS was unable to substantiate that the VC had fallen at the day care. The mother met [redacted] at the hospital.

On August 24, 2011, the hospital conducted a [redacted] that revealed prior injuries: [redacted] (lower leg) and [redacted] (forearm). The [redacted] were healing which indicated [redacted]. The [redacted] also revealed [redacted]. According to the medical documentation, the VC was a victim of [redacted]. In addition, according to medical opinion the VC did not incur the head injuries due to a fall of a distance of 1 ½ feet onto a carpeted floor. The doctor reported the injuries were a result of [redacted]. On 9/20/10, the VC was [redacted] St. Christopher's Hospital and [redacted] Children's Hospital of Pennsylvania Seashore House for [redacted]

Current Case Status:

- [redacted] On September 30, 2010 the VC was [redacted] Children's Hospital Seashore House to the care of the MGM. Due to the severity of the injuries, the VC has an [redacted] by which she receives feedings during the day and night. The MGM received assistance from a nurse to monitor feedings. The VC receives weekly [redacted] to assist with medical needs The VC will be required to continue with wellness visits and [redacted]
- On October 10, 2010, DHS named the mother and [redacted] as the [redacted] The [redacted], based on the medical evidence and the criminal investigation.
- [redacted] was criminally charged and is presently incarcerated. [redacted] has no contact with the family.
- The mother has supervised visits with [redacted] and the VC at the MGM's home. The mother will be referred to the [redacted] for services

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

Strengths: The Act 33 Review was held on September 17, 2010. The DHS social worker conducted collateral contacts with Children and Youth in other states to follow up on the [redacted] [redacted]. The DHS social worker collaborated with the medical and legal team to ensure the appropriate treatment for the victim child's [redacted].

Deficiencies: The Act 33 team discussed the timeliness of law enforcement obtaining a warrant for [redacted] arrest. Initially, [redacted] fled to North Carolina. [redacted] was eventually arrested and criminally charged.

Recommendations for Change at the Local Level and State Level:
There were none identified.

Department Review of County Internal Report:

The Regional Office participated in the Fatality Review that was held on September 17, 2010. The Act 33 Review is a team of professionals that have the expertise in prevention and treatment of child abuse.

Department of Public Welfare Findings :

County Strengths: There were none identified.

County Weaknesses: There were none identified.

Statutory and Regulatory Areas of Non-Compliance: There were none identified.

Department of Public Welfare Recommendations:

The Department did not have any recommendations regarding the monitoring and inspection of DHS.