



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## REPORT ON THE NEAR FATALITY OF:



**Date of Birth: 8/11/2011**  
**Date of Incident: 4/23/2014**  
**Date of Oral Report: 4/23/2014**

### FAMILY KNOWN TO:

Philadelphia Department of Human Services

**REPORT FINALIZED ON: 10/15/14**

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(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. Philadelphia Department of Human Services (DHS) has convened a review team in accordance with Act 33 of 2008 related to this report on 5/16/2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim child	8/11/2011
██████████	Sibling	██████████/2009
██████████	Sibling	██████████/2012
██████████	Mother	██████████/1991
██████████*	Mother's paramour	██████████/1989

\*Household member

**Notification of Child Near Fatality:**

██████████ received a call on 4/23/2014 that ██████████ was brought to St. Joseph's Hospital. The mother and paramour reported that that the child had been at the playground with the paramour and the child had fallen off the jungle gym. At about 8:30 am, the paramour had taken the child to the playground. It was not unusual for the paramour to take the child out. When the child returned home, he became unresponsive. The child was transported to St. Joseph's Hospital. Upon arrival at the hospital, the child was unresponsive, had a low temperature and low blood pressure. He was also hypothermic and had major bleeding. ██████████ at St. Joseph's Hospital certified the child to be in critical condition. She could not rule out non-accidental trauma due to the nature of the child's injuries. Child was transported to Children's Hospital of Philadelphia (CHOP) and was ██████████. The medical team determined that the injuries suffered by this child were not explained by the paramour's explanation, and that these injuries were the result of child abuse.

**Summary of DPW Child Near Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the ██████████ family. The regional office also participated in the Act 33 meeting on 5/16/2014. The Medical Examiner is the chair of this team and presented the findings of his office.

**Children and Youth Involvement prior to Incident:**

5/28/2009 GPS report [REDACTED]  
This was a [REDACTED] report concerning [REDACTED] birth. The mother tested positive for marijuana at [REDACTED] birth. The mother was a minor at this time, and did not receive any prenatal care. [REDACTED]

5/9/2012 GPS report [REDACTED]  
[REDACTED] had been found in the street and taken to the home of a neighbor. The mother had left [REDACTED] in the home of her mother without informing her mother that she was leaving him in her responsibility. The maternal grandmother was contacted by phone and agreed to return to pick up [REDACTED]. The family's case was closed and [REDACTED].

9/1/2012 [REDACTED] GPS report [REDACTED]  
This was a [REDACTED] report. The mother tested positive for marijuana at [REDACTED] birth on 8/31/2012. The mother admitted to smoking marijuana since she was 17 years old, and had not participated in [REDACTED]. Case notes indicated that the three children, [REDACTED] were current with their immunizations and well-baby care. The family [REDACTED]

1/31/2013 [REDACTED] GPS report [REDACTED]  
[REDACTED] was found home alone by a maintenance worker who was repairing the door to the family's home. The report stated that the mother was returning to the home as the police were arriving at the home. The mother reported that she had gone to the store that was a block and a half from her home; she had been gone about 20 to 30 minutes. During the investigation, the mother was argumentative and confrontational. A service need was not established.

**Circumstances of Child Near Fatality and Related Case Activity:**

On 3/27/2014, [REDACTED] had been examined in the [REDACTED]. At that time, he suffered from abdominal pain and constipation, but was released to his mother's care.  
On 4/23/2014, DHS received [REDACTED] Child Protective Services (CPS) report concerning two year old [REDACTED] had been brought to St. Joseph's Hospital after being unresponsive in the home. The hospital reported that [REDACTED] suffered from major trauma as a result of suspicious neglect and/or abuse. He was hypothermic, had [REDACTED], and had low blood pressure. The child did not have visible marks, bruises or head trauma. The mother was not present at the time of the incident. The child had been with the mother's paramour at the time of the injury; his explanation was not consistent with the child's injuries. He reported that the child had fallen at the playground.  
The child was transported to CHOP and [REDACTED]. He required a [REDACTED]. [REDACTED] was determined to be in critical condition and was taken to the [REDACTED]. At this time, the mother did not appear to have an understanding of the seriousness of the child's injuries. She was joking and laughing while in the hospital. The safety of the other two children was assessed. They underwent medical exams at CHOP. The Safety Plan for [REDACTED] was to be in the care of maternal cousin, [REDACTED]. [REDACTED] had been living with Ms. [REDACTED] prior to this incident; the family reported this was due to lack of space in the mother's residence.

During the investigation, the DHS worker viewed video taken by the perpetrator on his phone of [REDACTED] playing at the playground. None of the video showed him falling. The paramour reported that [REDACTED] told him that his stomach hurt and he needed to use the restroom. The paramour reported that [REDACTED] soiled himself on the way to the paramour's mother's residence. The paramour reported that he cleaned up [REDACTED] at this home, and then carried him to the mother's home. He reported placing [REDACTED] on the couch since he was asleep. The mother reported that when she went downstairs to wake [REDACTED], she found him slouched over with his eyes rolled backward. She reported blowing in his eyes and he did not respond. The mother realized that his condition was serious and decided to carry him the 20 blocks to St. Joseph's Hospital.

**Current Case Status:**

- On 4/29/2014, DHS returned [REDACTED] to the care of his father after securing child abuse and police criminal history of him. The child had been visiting the father on weekends, and the father had a blow up bed for the child to sleep on.
- DHS worker consulted with [REDACTED] about the mother. Recommendations were that the mother should complete a [REDACTED].
- DHS worker contacted ChildLine on 5/19/2014 about adding the mother as perpetrator for medical neglect based on her not seeking immediate medical attention for Tyree. ChildLine would not accept this report as the mother did seek medical attention; she just chose to carry child herself rather than call 911.
- [REDACTED]  
[REDACTED]  
[REDACTED]. The mother tested positive for marijuana and benzodiazepine.
- On 6/9/2014, [REDACTED]  
[REDACTED]  
[REDACTED] The mother violated the agency Safety Plan; the Safety Plan stated that the mother was not to have unsupervised visits with her children. [REDACTED] resides with his biological father.
- CPS case was Indicated against [REDACTED] for physical abuse based on medical evidence and agency investigation.
- [REDACTED] and his sister, [REDACTED] are in the same foster home through [REDACTED]. This is the kinship home of the mother's cousin. They attend day care together. [REDACTED]  
[REDACTED]
- The mother [REDACTED] visitation at the foster parents' home, as well as weekly supervised visits at the foster care agency.

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

- Strengths:
- The MDT social worker completed a comprehensive investigation and conferenced with his chain of command.

- Deficiencies:
- The social worker and supervisor reviewed the DHS information and information gathered during the investigation and believed that as a result of the January 2013 investigation the county should have determined that findings were present and that the family should have been accepted for in-home services.
- The investigative team also had concerns that there were other missed opportunities with the May 2012 investigation.
  
- Recommendations for Change at the Local Level:
- None identified
  
- Recommendations for Change at the State Level:
- None identified

**Department Review of County Internal Report:**

The Act 33 review convened on 5/16/2014. The Regional Office received the report on 8/15/2014. The Department concurs with the county report's findings and recommendations. A letter was sent to the county on 8/26/2014.

**Department of Public Welfare Findings:**

- County Strengths:
- DHS worker did a comprehensive investigation.
- The Safety Assessment was completed on siblings in a timely manner. The siblings were medically evaluated at CHOP prior to placement with the maternal cousin. An appropriate Plan of Safety was developed utilizing a family member who was already an approved foster parent.
  
- County Weaknesses:
- The county received several reports concerning this mother. Two of the reports were related to lack of supervision of the very young children. The family was not accepted for services, and was referred to community services. Perhaps, the family should have been accepted for services at the second report of lack of supervision.
- The mother utilized the maternal grandmother as a child care resource, but the maternal grandmother admitted to the DHS worker that she did not want the responsibility of caring for the children, and that sometimes the mother left the children in her home without letting her know the children had been left there. This mother seemed to need support in caring for her children. Perhaps, efforts such as Family Group Decision-Making could have helped this mother identify appropriate family resources to assist her.
  
- Statutory and Regulatory Areas of Non-Compliance:  
None identified.

**Department of Public Welfare Recommendations:**

- Whenever county agencies receive multiple reports with similar themes on the same family (such as [REDACTED] or lack of supervision), the county should develop a mechanism for administrative review to evaluate how the county could respond to prevent future reports.
- When parents present as overwhelmed and in need of supports, county agencies should consider the use of Family Finding or Family Group Decision-Making to enlist the support of extended family.