REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 5/28/16
Date of Incident: 6/29/16
Date of Report to ChildLine: 7/2/16
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO PHILADELPHIA DEPARTMENT OF HUMAN SERVICES AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

REPORT FINALIZED ON:
02/07/2017

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Philadelphia County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 07/15/16.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
	Victim child	05/28/2016
	Mother	1999
	Father	1998
	Mat. Great Grandmother	1937
	Mat. Great Grandfather	1933
	Mat. Aunt	1988
*	Mat. Cousin	Unknown
*	Mat. Cousin	Unknown

* are both young children.

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current CPS investigative information including the CY 48 as well as written case documentation from the Philadelphia Department of Human Services (DHS). The case records also included medical documentation from St Christopher's Hospital for Children. The Program Representative also received updated case information within the Department's Child Welfare Information Solution (CWIS). The Program Representative also obtained periodic case updates from the Philadelphia Department of Human Services social worker and supervisory staff regarding continuing case developments.

Children and Youth Involvement prior to Incident:

The victim child's biological parents were not known to the Philadelphia Department of Human Services as parents, however both had extensive DHS histories as children dating back to 2001. Allegations centered on General Protective Services (GPS) concerns which included victimization as a result of parental D&A and mental

health issues as well as domestic violence which impacted both parents and their siblings. Neglect issues regarding inadequate food and shelter were also listed. Both parents also had issues with incorrigibility and ungovernable behavior during their adolescent years. Also listed were issues concerning poor school performance and truancy which resulted in the biological mother's inability to finish high school. The biological father has a severe history of child abuse perpetrated by his father, as well as an extensive juvenile history The mother was opened (as a child) for services from 11/30/2001 to 09/03/2003 and received Services Mother's family also received services from 06/18/2013 to 07/18/2014. The father was opened (as a child) from 09/21/2002 to 08/11/2004 and received The father's family was also opened from 03/21/2009 to 11/09/2009. As a juvenile, the father was arrested for possession of a weapon on school property on 05/31/2011 The biological mother does not have a juvenile or criminal record. The victim was the couple's only child.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 6/29/16, a 1-month-old female infant was found by her parents to be in a lethargic and unresponsive state while in the home. At the time of the incident, the victim child and parents lived with the maternal grandparents. The mother was the main caregiver of the child during the day on 06/29/2016, the day of the incident. The father worked at his usual construction job which lasted from 7am to 3pm. Upon his return home, the father states that the family participated in normal evening activities involving the child, who appeared to be well and had no issues. That evening, upon approaching the child in her crib, the father described the child as being "very hot, limp, breathing funny and at one point, appeared to be having a seizure." In the early morning hours of 06/30/2016, an ambulance was called by the father and the child was transported to Albert Einstein Medical Center where the child was evaluated in the emergency room. Later that day the child was transferred to St Christopher's Hospital for Children (St Chris's) On 07/02/2016, a Child Protective Services report (CPS) was called in to ChildLine Dr. determined the child to be in critical condition and certified the child to be in a Near Fatality condition as a result of suspected physical abuse. A CPS investigation was initiated by the Philadelphia Department of Human Services (DHS). The Child Protection Team at St Chris's, recommended that the child have a comprehensive medical work-up. indicative of being shaken. the child suffered an inflicted traumatic brain injury. A skeletal scan was also completed and found to be normal.

During the child's stay at the hospital the child had no fever, nor was observed for seizure activity as witnessed by the father who stated that the child appeared to be having a seizure before the call for emergency assistance. Both parents were interviewed by the Philadelphia DHS social worker and the Child Protection Team at St Chris's and denied causing the child's injuries. Both parents admit that they are primary caregivers and denied that other family members directly cared for the child on the day of the incident. Both gave a different account of the activities which took place. It should also be noted that the child had a recent hospitalization for a high fever and an upper respiratory infection. At that time the child improved enough to be able to return home 3 days later. Prior to that hospitalization there did not appear to be any significant medical history in relation to the child. The infant appeared to be developmentally on target. the services of the Wordsworth Community Umbrella Agency (CUA) were initiated to provide services to the parents with the goal of reunification. They will also monitor the placement of the child including ensuring that medical follow up occurs. Neither parent can reside in the home where the child resides and a strict visitation plan was implemented which will also be monitored by the CUA. On 07/25/2016, the result of the CPS investigation conducted by the Philadelphia DHS was determined to be "indicated" on both alleged perpetrators as a result of medical evidence which indicated that the child's injuries occurred as a result of non-accidental trauma. There were also concerns that could explain the child's injuries. A criminal investigation conducted by the Police Department is pending, with no arrest made at the time of the writing of this report. The child continues to attend St Christopher's for all follow up The child has attended primary care visits, appointments. The child is reported to

be doing well. The mother and father are having supervised visit with the child on a regular basis. The Family Service Plan goal is reunification. Both parents are enrolled in [redacted] The mother is being encouraged to return to school to complete her education and obtain a high school diploma. The father is being urged to seek gainful employment and/or job skills.

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

The Act 33 meeting occurred on 07/15/2016. The following information was obtained from the County Review Team Report submitted on 10/13/16.

- Strengths in compliance with statutes, regulations and services to children and families;

  The Act 33 team felt that the Philadelphia DHS social worker did a very good job with the investigation. There was good collaboration, communication and accessibility between Philadelphia DHS, the St Chris's medical team and the [redacted] Police Department. It was also noted that the Philadelphia DHS social worker did a good job in conferencing the case with her chain of command regarding case decision at every level of the investigation.

- Deficiencies in compliance with statutes, regulations and services to children and families;

  There was a concern that after the fatality/near fatality decision was made [redacted] a subsequent call was not immediately placed directly to law enforcement [redacted] which could have delayed and hindered the initiation of the criminal investigation.

  It was noted that the CY 104 (DHS report to law enforcement) may not be sent timely or when sent, may not always receive the immediate attention of law enforcement particularly on weekends and holidays which is detrimental to the initiation and subsequent police investigation.

  It was noted that when a police officer or Emergency Medical Services van transports a child to the hospital there may be an assumption on the part of [redacted] that a police report and subsequent investigation has already been triggered, which may not be the case and could also hinder the initiation of the criminal investigation.

  Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  The team recommended that St Christopher's Hospital and the Children's Hospital of Philadelphia in conjunction with Philadelphia DHS and the Philadelphia Police Department develop protocol to ensure the immediate,

timely and consistent notification of the police when a case is certified as a near fatality/fatality.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

  There were no recommendations, however mandatory periodic reviews are conducted by the Southeast Regional Office and occur at the County on an annual basis.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  No recommendations were noted.

Department Review of County Internal Report:

The Department has received the County's report dated 10/05/2016 and is in agreement with their findings. A written response from the Pennsylvania Department of Human Services was submitted on 10/25/2016.

Department of Human Services Findings:

- County Strengths:

  The Philadelphia Department of Human Services conducted and completed an appropriate Child Protective Services investigation within 30 days fulfilling all regulatory requirements of the Child Protective Services Law (CPSL) and Chapter 3490. A subsequent police investigative outcome is pending. It was also noted that the Philadelphia DHS social worker did a competent job in sifting through and interpreting a large amount of information related to the child's medical condition which was key in determining the outcome of the CPS investigation.

- County Weaknesses:

  None were noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  None were noted.

Department of Human Services Recommendations:

The Department also agrees with the findings contained in the Act 33 report which support efforts by hospital staff to notify the police immediately regarding reports of suspected child abuse when a near fatality/fatality decision is made

It was recommended that a call be placed by the medical facility to 911 so that a police investigation can be initiated immediately (usually faster than a CY 104) and can include pertinent information based on real time activities. This effort may improve the overall success of criminal and ultimately child abuse investigations and should be incorporated statewide.