pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/11/2015
Date of Incident: 08/03/2016
Date of Report to ChildLine: 08/03/2016
CWIS Referral ID: [redacted]

NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
05/11/2017

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 09/02/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	09/11/2015
[redacted]	Sibling	[redacted]2015
[redacted]	Biological Mother	[redacted]1982
[redacted]	Biological Father	[redacted]1988
[redacted]	Maternal Grandmother	[redacted]1956
* [redacted]	Paternal Grandmother	unknown

*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:
The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the Caseworker and the Supervisor. The SERO also participated in the County Near Fatality Review Team meeting on 09/02/2016 where copies of the medical examiner's reports were presented.

Children and Youth Involvement prior to Incident:
This family had no previous involvement with Philadelphia Department of Human Services.

Circumstances of Child Near Fatality and Related Case Activity:
On August 03, 2016, the Philadelphia Department of Human Services (DHS) received a Child Protective Services report that an 11-month old male child was brought into the Children's Hospital of Philadelphia (CHOP) [redacted]
It was reported that the child was suffering from vomiting, diarrhea, and extreme sleepiness and he was not responsive. [redacted]

[redacted] reviewing the child's condition deemed this event as a near fatality. The child's family, his mother, father and twin sister were all at the hospital with him as well as other relatives, including his maternal grandmother. [redacted] The victim child's twin sister was also examined on 08/03/2016 [redacted] as the child had no injuries and/or bruises. The twins were the only children in the home currently; however, it was reported that the mother was pregnant at the time.

When the parents were initially asked what occurred to the child they stated that they didn't know what happened to cause this type of injury. However, the victim child's mother stated that the child was seen at St. Christopher's Hospital when he was about three months old [redacted] due to a fall at home. The mother went on stating that her sister had dropped the child onto the floor [redacted] She added that the child was wrapped up in a blanket and as the aunt tried to un-wrap the child while holding him close to her, he slipped out of the blanket and hit the hardwood floor. The mother added that she took the child to Aria Health Hospital in Philadelphia where he [redacted] then transferred to St. Christopher's Hospital. The mother added that the victim child was followed up with at St. Christopher's [redacted] The father stated during his interview that the family had been house hunting on 08/02/2016. He stated that they returned home around 5:00pm or 6:00pm. He added that the maternal grandmother was with them but she left to run an errand so she did not come into the house with the family. The father reported that the victim child crawled to him as he normally does and tried to pull up on him due to his inability to walk at this time. During this incident the victim child slipped off dad and fell back onto his pamper then backwards onto his head. The dad explained that the child fell backwards from the sitting position and banged the back of his head onto the floor. The mother stated that she did not see any bumps and/or bruises on the child's head. The child cried awhile and then continued playing until he began to appear unsteady. The mom stated that the child began sweating a lot and crying. The child was put down for a nap where it was noticed by the parents that he was vomiting and sweating heavily. He was picked up by the mother and wiped off and place down again. After about 10 minutes, the mother checked on the child again and he was drenched in sweat and the decision was made by the mother to take the child to the hospital. The father drove the family to the hospital.

[redacted] The parents' explanation of the child falling backwards from the seated position is not consistent with the child's injury. The child had [redacted] when he was 3 months old which was just 8 months ago. Philadelphia DHS interviewed all family members as well as CHOP's hospital staff and staff at St. Christopher's Hospital. [redacted] Special Victims Unit also completed their investigation in collaboration with Philadelphia DHS.

Due to the serious nature of the injuries of the victim child, the victim child's sibling was placed with the paternal grandmother on 08/04/2016 to ensure safety. [redacted] on 08/09/2016, the victim child was also placed with the paternal grandmother.

On 09/29/2016, Philadelphia DHS rendered this investigation as Unfounded citing that the incident could have been accidental after a consult with a CHOP medical professional. Moreover the child had two completed skeletal surveys [redacted] at CHOP was unable to determine if the injury the child did sustain was inflicted or accidental. [redacted] Special Victim Unit determined that no charges would be pressed against either parent and ended their investigation.

While with the paternal grandmother, the victim child received [redacted] and had regular visitation with his parents. The victim child and his sibling remained in placement with the paternal grandmother until 12/21/2016. Once reunified with their parents, the family remained open for ongoing case management services until 04/03/2017.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:
The DHS team had confidence in the information received by the MDT team was appropriate [redacted]

The DHS team explored the history of this family as it relates to Domestic Violence concerns in evaluating the children's safety in unsolved cases. It was learned that this family had four 911 calls made over a two year period but there were no details available; also, there were no Protection from Abuse Orders filed on or by this family.

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

  None noted.

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

  None noted

- 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 DHS team was concerned about the communication between some CHOP staff and the DHS Investigative Team as it relates to the medical assessments and the level of abuse concerns discussed in this case initially. However, [redacted]

[redacted] the CHOP Team supported the conclusion that this could be an accidental injury. Nevertheless, it was reported that the MDT team contemplates that there is only a small chance that the injury was accidental. However, there was no sufficient information to support abuse.

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

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

The DHS Management Team agrees to engage into discussion with the CHOP Team on achieving "best practices" protocol on how to best communicate with each other when dealing with multidimensional medical information within investigative cases. The Department approves this action.

Department Review of County Internal Report:

The Department received the investigative package from the county to review on 10/12/2016. The Department looked at the challenges between the county investigator and CHOP's medical team over the term "accidental". This term was extremely important as it relates to rendering a decision for this investigation. The Department was present with the County in the initial interviews of this report. They interviewed medical professionals, the parents and grandmother as well as consulting with law enforcement. As additional medical information became known, the County investigator felt comfortable rendering this investigation with an unfounded determination. The County had the results from [redacted] negative for any additional injuries. During the investigation, it was learned that the parents did follow up with medicals appointments for the children as well as seek medical attention when it was warranted. With the medical exams results, the County had concluded that the child's injury was not caused out of physical abuse by the parents. The County utilized all the information that was available to come forth with their decision that the injury to the child was accidental.

Department of Human Services Findings:

- County Strengths:
  The collaboration between the County Investigative Team, [redacted] Special Victims Unit, and St. Christopher's hospital staff as well as CHOP's staff was viewed as strength in this investigation in arriving at the determination outcome.

- County Weaknesses:
  None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  None noted

Department of Human Services Recommendations:

The Department recommends that Philadelphia DHS and the medical community continue to engage each other in finding effective ways of communicating complex medical information relating to investigations. This partnership should strengthen the relationship between the agencies resulting in a more collaborative working environment and supportive determinations and outcomes.