pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/18/2016
Date of Incident: 09/15/2016
Date of Report to ChildLine: 09/15/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN WAS NOT KNOWN TO THE PHILADELPHIA COUNTY CHILDREN AND YOUTH AGENCY, KNOWN AS THE PHILADELPHIA DEPARTMENT OF HUMAN SERVICES (DHS) AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS.

REPORT FINALIZED ON:
05/12/2017

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))

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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 10/07/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	03/18/2016
	Mother	[redacted]1989
	Father	1970
*	Maternal Uncle (MUN)	1985
*	Paramour of MUN	1984
*	Mother of MUN's paramour	1959
*	Half sibling [redacted]	2009
*	Half sibling [redacted]	2010
*	Half sibling [redacted]	2013

* Denotes Non-Household Members who are relevant to the report.

Summary of OCYF 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 County Fatality Review Team meeting on 10/07/2016.

Children and Youth Involvement prior to Incident:

There was no prior Children and Youth (C&Y) involvement in Philadelphia County.

The mother was known to Berks County Children and Youth Services (BCCYS), prior to 16 months before this incident, from 2009-2013. [redacted]

On 09/23/2009 BCCYS received a report that a child born 07/18/2009, weighed less than 2 pounds at birth. The report also stated that the mother was intellectually limited, and the father may also be intellectually limited. There were concerns about the parents' ability [redacted] There were concerns that the parents would not be able to take care of the baby.

On 09/24/2009, the parents missed a scheduled [redacted] A referral was made [redacted] to assist the parents with parenting skills and education. They would also monitor the situation with the parents and the child. Due to the parents' limitations, it was decided that the child would not be returned to her parents. [redacted]

[redacted] The child was placed in a specialized foster home and [redacted] arranged for visitation to take place at the parents' home. Then on 11/20/2009 the child was returned home, where the parents lived with the MGM. The MGM signed a Safety Plan assuring that the parents would be adhering to the child's medical needs and to contact the agency if there were any concerns regarding the care and well-being of the child. Shortly thereafter, the parents relocated to Lancaster County and resided with the brother of the mother's paramour, at that time, because of drug dealers and home invasions in their neighborhood. The father confronted a drug dealer for hiding drugs in his mailbox. Father's home was robbed shortly thereafter, with personal property destroyed, except for the baby items.

The Mother was pregnant again shortly after they moved and on 10/01/2010 she gave birth to her child [redacted]

On 3/9/11 BCCYS received a report that the oldest child, who would have been 20-months-old at the time was admitted to Reading Hospital the day before, for failure to thrive. The mother reported that the child would not eat more than 2 spoonfuls of food at a time, for the preceding 2 weeks, and failed to seek medical attention for the child. BCCYS implemented a Safety Plan, where the mother agreed to live with her mother (MGM), and that the MGM would supervise all contact between the mother and the children.

[redacted] The oldest child had been [redacted] Services had been provided to assist the parents to address the cognitive limitations of the mother and the failure to meet the children's basic needs which resulted in the child's [redacted] inability to care for an infant with medical needs, failure to establish and maintain appropriate housing, lack of income, concerns regarding the mother's mental health status, and domestic violence.

On, 07/26/2013 Mother gave birth to her third child. [redacted]

[redacted] From September 2009 through July 2013, the mother reportedly continued to struggle with her mental health issues, intellectual delays, and domestic violence, which led to issues with employment and unstable, inappropriate housing.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/15/2016, the victim child, 6 months of age, was taken to St. Christopher's Hospital with unexplained injuries. [redacted] Two days prior to that hospitalization, 09/13/2016, the child was [redacted] at the Albert Einstein Medical Center (AEMC) [redacted]

Reportedly on 09/15/2016, the child had been in the care of the maternal uncle's paramour, who was watching the child while both parents were working. The mother was at work when the child was transported to the hospital. The mother later came to the hospital, and while at the hospital, she did not appear to understand what was being said, because she speaks Spanish and very little English. It was noted that the uncle's paramour was said to have been inconsistent with her story, regarding what happened to the child.

The paramour's mother reported that she was home with her daughter, the maternal uncle's paramour, who was caring for the child, while the child's father was working an overnight shift. The child was being watched in the paramour's home. The paramour's mother further stated the child had been crying a lot and she thought something was wrong with him. She said the child had not fallen, but she did not know what was wrong. She said her daughter went upstairs to feed the child and child was discovered to be unresponsive.

The maternal uncle's paramour stated she had only been caring for the child since 09/13/2016. The father reported the mother dropped the child off with the maternal uncle's paramour at 8:00 AM, on 09/15/2016. The father said he received a phone call at approximately 10:00 AM, from the maternal uncle's paramour, and was told that the child was being taken to the hospital. The father stated he advised the mother against allowing the uncle's paramour to provide care for the child. The Intake Social Work Services Manager conducted a Safety Assessment at the hospital. The hospital staff would not sign the Safety Plan, but verbally agreed to watch the child. The child was not to be released to his parents [redacted] A paternal aunt was identified as a potential kinship caregiver.

On 09/16/2016, the Intake Social Work Services Manager (SWSM) travelled to the paternal aunt's home. At that time, the SWSM learned that the mother once resided in [redacted] and had 3 children who were placed in care, [redacted] Philadelphia DHS contacted Berks County to request records regarding the mother's prior history and allegations, [redacted]

On 09/16/2016, DHS received additional information regarding the child's injuries. [redacted] The child's injuries were believed to be a result of traumatic head trauma. The child had been with multiple caregivers, and it was unknown who caused the child's injuries. The Social Work Services Manager talked to the mother with the assistance of a translator. The mother said she asked the maternal uncle's paramour and the maternal uncle's paramour's mother what happened to her child. She said they told her the uncle's paramour was downstairs making a bottle while the child was alone in the bed upstairs. The child was said to have been lying on the bed between two pillows. The uncle's paramour stated when the mother dropped the child off, the mother remained upstairs in the room with the child for approximately 15 minutes. The paramour said she changed the child's diaper around 9:30 AM, after checking on him periodically. She said she tried to feed him but he would not eat. When she tried to give him a bottle, she noticed what appeared to be blood in the child's mouth. At approximately 9:50 AM, the paramour picked the child up and found him to look pale and limp. She called 911. The child was taken to Children's Hospital.

The child [redacted] on 09/26/2016. [redacted] While her home had been cleared, the PAU did not understand why the parents could not see the child. CYS then had concerns about her ability to assure the child's safety regarding the parents' level of access to the child and the PAU subsequently decided not to be a resource.

On 10/27/2016, The CPS report was Indicated for Causing Bodily Injury to Child Through Recent Act/Failure to Act, based on an Child Protective Services Investigation conducted by the Philadelphia Department of Human Services (DHS), which resulted in indicated findings for the two perpetrators, who are the biological mother and the biological father.

The child is currently residing in foster care, [redacted] The child's medical appointments are up to date, and there are no medical concerns at this time. The child is scheduled for an appointment [redacted] The parents have supervised line-of-sight visitation and are able to attend medical appointments. A referral has been made [redacted] for services and [redacted] supports. Both parents have been [redacted]

At the Act 33 meeting, BCCYS provided information regarding the mother's cognitive limitations, and her inability to make progress on her service plan objectives. These services were provided to address concerns regarding the mother's cognitive limitations, failure to meet her children's basic needs [redacted] inability to care for an infant with medical needs, failure to establish and maintain stable and appropriate housing, lack of income, concerns regarding the mother's mental health status and domestic violence. The mother's inability to remediate any of these issues ultimately led to the placement of the three children in Berks County, [redacted] There was a bilingual staff present.

The police investigation is ongoing.

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

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

  The Team felt that the SWSM did a good job with the investigation, including thorough documentation, maintaining contact with the police, and gathering information regarding the mother's history of involvement with BCCYS.

  The Team felt that the timely response of BCCYS and their participation in the Act 33 Review was helpful and provided valuable information.

  The Team discussed the development of 3 dedicated Child Abuse Units with the Special Victims' Unit, who will investigate all fatality and near fatality cases in Philadelphia. Although the police respond the same day, under the previous configuration, reports were assigned to line staff. This report was not assigned until 10/3/16.

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

  There were no deficiencies noted in this area.

- 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 a letter be written to Einstein Hospital, encouraging them to review this case, because of the child's injuries subsequent to being [redacted] at Einstein Hospital's Emergency Room. The letter should emphasize the need for further education regarding clinical decision making rules when assessing children. Children's Hospital of Philadelphia (CHOP) can provide guidance, if requested. Meetings between

DHS representatives and Emergency Medical Personnel from various hospitals have occurred in the past.

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

  There were no recommendations made.

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

  There were no recommendations made.

Department Review of County Internal Report:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family.

Department of Human Services Findings:

- County Strengths:
  Philadelphia County did a great job of conducting and completing this investigation in a timely manner. The county also did a great job of coordinating with BCCYS regarding the mother's prior history and involvement with child welfare in Berks County.

- County Weaknesses: and
  There were none noted.

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

Department of Human Services Recommendations:

The mother had no prior history with Philadelphia DHS. Her involvement with Berks County CYS was unknown until information was disclosed after the incident. The mother had prior history with Berks County Children and Youth Services, [redacted]

- The Department recommends that discussions occur with the Department of Health regarding current procedures in identifying and discussing prior births with patients in an effort to find parents, who may not be forthcoming with information regarding CYS involvement in other counties, [redacted]

At the Act 33 meeting, the Team discussed the possibility that the child was injured prior to [redacted] at Einstein. After consulting with a physician at Einstein Medical Center, the Team learned that Einstein was concerned that the child's

vomiting was attributable to overfeeding [redacted] It remains unknown if the child had [redacted] at that time because there was no testing or imaging done at Einstein. The Team's pediatric specialist concluded that when assessing a complaint of vomiting, without diarrhea or fever, other possible causes, including non-accidental trauma should have been explored.

- The Department concurs with the recommendation that for children exhibiting symptoms of vomiting absent other symptoms additional medical testing should occur to rule out trauma, such as head injury, as a possible cause of the symptoms.