pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/05/2015
Date of Incident: 10/14/2016
Date of Report to ChildLine: 10/14/2016
CWIS Referral ID: [redacted]

FAMILY WAS 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:
05/02/2017

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 11/04/ 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	03/05/2015
	Mother	[redacted]1995
	Father/Maternal Uncle	[redacted]1989
	Mother's Paramour	[redacted]1989

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed current Child Protective Service (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 the St. Christopher's Hospital for Children. The SERO Program Representative also obtained periodic case updates from the Philadelphia DHS social worker and supervisory staff regarding continuing case developments. On 11/14/17, the Program Representative also attended the Act 33 meeting where a thorough case presentation was given.

Children and Youth Involvement prior to Incident:

Both parents of the victim child as well as the mother's paramour have extensive [redacted] histories as children with Philadelphia DHS. At the time of this near fatality incident, the mother and the victim child were both in placement through the Philadelphia DHS. [redacted] Historical records before the incident reveal that there was a General Protective Services (GPS) report which occurred in November of 2015 with concerns for the extremely poor condition of [redacted] apartment where the mother and the victim child lived. A Philadelphia

DHS assessment did occur and it was confirmed that the home was not safe for the victim child. The victim child was voluntarily removed from the home by the parent for a brief period so that the home could be cleaned at which time the victim child did return. [redacted] At the time of this near fatality incident, the mother and [redacted] were actively planning the mother and the victim child's [redacted]

The father of the victim child has never resided with or parented the victim child and there is a court order barring him from contact with the mother. It should be noted that the father of the victim child is the biological brother of the victim child's mother. The victim child's mother claims that she was raped and threatened by her brother not to disclose this information. The allegations have never been investigated or confirmed [redacted] Family members have stated that they do not believe that the mother was raped and they believe that the sex may have been consensual [redacted]

The mother's paramour had been dating the mother for the past six months before this near fatality incident. The mother's paramour has a history of GPS involvement as a minor which stems back to the mid-1990's. The mother's paramour also has a [redacted] history as a result. The mother's paramour does not have a history with DHS as a parent. The mother's paramour is a Megan's Law offender. He also has an adult criminal record pertaining to drug related offenses. On 10/18/ 2016, the mother's paramour was detained by [redacted] Police and sent to the [redacted] due to a parole violation which was unrelated to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/14/ 2016, the mother's paramour who was babysitting the victim child at the time of the incident, gave the victim child a bath and placed the victim child in the water without adequately testing the temperature. The water was too hot and burned the victim child. During the incident, the mother's paramour admitted to leaving the bathing area to take a cell phone call. The mother's paramour then returned to the bathroom after hearing the victim child scream. Shortly after the incident an ambulance was called by the mother's paramour and the victim child was taken to St Christopher's Hospital for Children (St. Chris's). The victim child suffered 2nd degree burns over 40% of her body. [redacted]

On 10/14/2016, [redacted] a physician at St. Chris's determined the victim child to be in critical condition and certified the report as a near fatality as a result of alleged abuse. It was also felt that the victim child suffered substantial bodily injuries as a result of a scalding which caused the burns to the child. On 10/14/2016, [redacted] and a Child Protective Services

(CPS) investigation was assigned to the Philadelphia DHS. On 10/17/2016, the mother's paramour was interviewed by the DHS social worker and the Philadelphia Police. The mother's paramour admitted to causing the child's injuries as a result of a lapse in judgment when he stepped away from the tub to answer the cell phone. The mother's paramour appeared remorseful regarding his actions and stated that he had been dating the mother for 6 months and felt the child to be like his own daughter. After the interview, the mother's paramour was detained by the [redacted] Police for violation of his probation on another matter (failing to pay restitution). He is currently at [redacted] On 11/15/2016, the mother's paramour was arrested and charged with endangering the welfare of a child and recklessly endangering another person as a result of the child's injuries. The mother's paramour continues to be incarcerated and is scheduled for trial on 2/28/2017. On 10/17/2016, the child's mother was also interviewed. The mother was receiving [redacted] Services through [redacted] at the time of the incident. The mother was not present at the time and left the child in the care of her paramour while she attended [redacted] classes. The mother is described as being very young, with possible mental health issues and cognitive delays. She stated that she trusted her paramour with the care of her daughter even after only knowing him for a short period of time. The mother was not named as an alleged perpetrator. There are no other children in the home. A police investigation is continuing, however no charges are expected with respect to the mother of the child. On 10/20/ 2016, the child was assessed by the Child Protection Team at St Christopher's Hospital. [redacted] the child was left unattended in the bathtub which created the potential for [redacted] injuries to have occurred. [redacted] On 12/06/2016, the results of the CPS investigation conducted by the Philadelphia DHS was determined to be "indicated" with the mother's paramour being the sole perpetrator who admitted to causing the child's injuries. The child continues to reside in a certified kinship foster home through private foster care agency [redacted] where her physical and emotional needs are being met. The mother has weekly supervised visits. [redacted] The child appears to be making good progress [redacted] and has a good bond with the kinship parent. [redacted] She will continue to receive [redacted] services in an effort to reunite her with her daughter. The mother is expected to participate in a [redacted] as well as to complete [redacted]

[redacted] training, as well as to address employment and housing concerns, all which must be completed before the return of the child is considered. There are no other children the home.

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

The Act 33 meeting occurred on 11/4/2016. The following information was obtained at the meeting and from the County Review Team Report submitted on 1/31/2016.

- 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 the Philadelphia DHS, the Child Protection Team at St. Chris's and the [redacted] Police Department. It was also noted that the DHS social worker did a good job in conferencing the case with her chain of command regarding case decisions at every level of the CPS investigation.

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

  The team noted that within [redacted] apartment, there appeared to be unrestricted access to the hot water controls by residents, which presented a danger to children and infants.

  The team noted that there appeared to be little educational information about water safety and the hazards of scalding water that was given to residents.

  The Act 33 team noted that there was an unauthorized adult (the mother's paramour) who had not been cleared, (ChildLine or Megan's Law) who was likely residing in the home, and was caring for the child without the knowledge and approval [redacted]

  The team expressed concerns about the routine and ongoing medical care of the victim child [redacted] and whether compliance was being monitored by the [redacted] program staff.

  The team expressed concerns as to whether there was adequate transitional planning for the mother who was 21, and victim child [redacted]

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

  Overall, the Act 33 team felt that within [redacted] programs, effective staff supervision and monitoring of young mothers who are caring for babies and small children should be a key component of the program.

  Other Team recommendations were as follows:

  The team recommended that [redacted] apartment residents [redacted], not be allowed to self-adjust water temperatures (via thermometer/appliances) to levels hot enough to burn children and babies. Water temperatures should be pre-set and maintained at a safe level which cannot cause burns, by use of a device or lock.

  A policy, tool and/or checklist should be developed to assist casework staff in making water safety a regular part of the assessment/discussion for new and/or teen parents with infants and toddlers. This information should also be included in life skills programs for parents with cognitive limitations.

  The team also recommended the development of pamphlets for SIL parents (clients) of small children which contains educational information and water safety precautions.

  A policy should be developed to check clearances on paramours and other persons who provide care to children under Philadelphia DHS supervision. A Megan's Law registry search should also be completed.

  A visitor's log should be developed, implemented and maintained for [redacted] program.

  Random checks by [redacted] staff should be made to determine if unauthorized guest are in fact living in the apartment. Regular discussions regarding program rules and implications and actions should be held if staff suspects that co-habitation is occurring. [redacted] staff should also review child care plans and baby-sitting arrangements with parents in the program on a regular basis.

  Information should also be giving to young mothers about the higher level of risk of Child abuse and Neglect (CA/N) to pre verbal children and the need for extra caution in choosing babysitters.

A policy should be developed (if not already in place) to assess the judgement and skills of young teenage parents for appropriate referrals to mental health evaluation and parenting skills training.

Checks should be implemented to determine when [redacted] shows up in class or other program activities, what arrangements have been made regarding child care.

[redacted] staff should monitor compliance in ensuring that parents are up to date with child's routine medical care and immunizations on an ongoing basis.

[redacted] staff should determine if there is an appropriate transition plan particularly in [redacted] programs [redacted] There should be efforts to make sure that the parent has appropriate shelter [redacted] and can provide for the child.

- 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 SERO 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 1/31/ 2017 and is in agreement with their findings. A written response from the Pennsylvania Department of Human Services was submitted on 2/3/2017.

Department of Human Services Findings:

- County Strengths:

  The Philadelphia DHS conducted and completed an appropriate CPS investigation within 60 days, fulfilling all regulatory requirements of the Child Protective Services Law and Chapter 3490. The investigation required additional time over the regulatory limit of 30 days to include

the examination of an expansive amount of case information as the parent was [redacted] receiving [redacted] services at the time of the incident. It was also noted that the Philadelphia DHS worker did a competent job in sifting through and interpreting a substantial amount of information related to the child's medical condition, police investigation as well as relevant parental activities, all factors which were considered in the final determination of the CPS investigation.

- County Weaknesses:

  The Department agreed with County weaknesses noted above.

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

  No recommendations were noted.

Department of Human Services Recommendations:

The Department also agrees with the findings contained in the Act 33 report which support efforts to educate parents regarding the safety and supervision of children around bath time and appropriate caution and attention regarding water temperature. The Department recommends a statewide media campaign which includes the development and dissemination of pamphlets for parents of small children which contains information (attractive, eye catching and easy to read and comprehend) on water safety precautions.