pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/15/16
Date of Incident: 12/24/16
Date of Report to ChildLine: 12/26/16
CWIS Referral ID: [redacted]

FAMILY 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:
07/20/2017

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 not convened a review team in accordance with the Child Protective Services Law related to this report, because the report was determined to be unfounded within 30 days of the referral date.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Biological Mother	[redacted]1988
	Biological Father	[redacted]1988
	Victim Child	07/15/2016
	Full Sibling	[redacted]2014

Summary of OCYF Child Near-Fatality Review Activities:
The Southeast Regional Office reviewed the county case files and spoke with the Catholic Community Services Supervisor and Case Manager on 04/21/17.

Children and Youth Involvement prior to Incident:
The family did not have children and youth involvement prior to the incident.

Circumstances of Child Near-Fatality and Related Case Activity:
The victim child came into St. Christopher's Hospital on 12/24/2016, after she was airlifted from Aria Hospital a little after midnight, after falling down the stairs in her mother's arms. [redacted] The parents described two incidents which occurred at two different times, where the victim child had fell. [redacted] It was reported that the mother stated that she had blacked out and that she could not remember what had happened. The parents reported that the victim child had fallen out of her car seat. Medical professionals did not feel that the child's injuries were consistent with the parents' explanations.

On 12/26/2016, Philadelphia Department of Human Services staff met with the [redacted] who stated that the parents appeared to be genuinely worried

about the child's welfare, and that the only concern was that the father had some [redacted] issues. Department of Human Services staff also met with the child and both parents.

On 12/28/2016, the investigating worker visited with the victim child's sibling in the hospital, where the sibling was being evaluated to determine if the sibling had any injuries. The victim child's sibling was medically cleared. The investigating worker also met with each parent individually. The mother stated that the victim child would sleep about 12 hours a night. They had gone to the father's cousin's house for Christmas Eve. The father took the sibling upstairs to change her, and the mother changed the victim child upstairs as well. The father took the sibling downstairs, and the mother was following with the victim child. The mother stated that she was wearing flat shoes, and slipped on the carpeted step at the top and fell down. The mother had hit her head on some of the steps during her fall, and she had blacked out by the time she reached the bottom. The father, who had been trained as a fire department emergency medical technician through the [redacted] Fire Department, took the victim child to Aria Torresdale Hospital, a 2-minute drive from their location. Both parents stated that they do not discipline the victim child. They admitted to a "tap on the butt" of the victim child's sibling, and denied hitting either child.

On 12/28/2016, the investigating worker met with the mother in the family's home. The home appeared to be appropriate.

On 12/29/2016, the Philadelphia Department of Human Services investigating worker assisted with the transport of the 2-year-old sibling of the victim child to the maternal aunt's house for the child's safety after it was determined that she could not remain safely in the home. The parents were not allowed to have unsupervised contact with the victim child's sibling. The investigating worker also spoke briefly with the father, and noted that the father appeared to have a flat affect.

On 01/06/2017, the case was transferred to Catholic Community Services for case management services.

On 01/07/2017, the investigating worker met with the paternal cousins, whose home the incident had occurred at. The paternal cousin stated that the family was rushing to change the children into their Christmas pajamas. The rest of the family heard loud noises. They thought it was the other children playing upstairs. The paternal cousins saw the mother and the baby on the landing at the bottom of the steps, both in and out of consciousness. The baby was seizing at the mouth. The father grabbed the victim child and put the child in the car seat without taking the mother. Other family members helped the mother to the car, as she was incoherent and bruised.

On 01/11/2017, the victim child was transferred [redacted]

On 01/17/2017, the report was determined to be unfounded, as the incident was determined to be an accident.

On 01/18/2017, both children returned to their parents' care.

The family has been receiving [redacted] services through Catholic Community Services. Their goals were for the parents to be involved in the victim child's medical appointments and care, [redacted] Both parents have complied with the goals. A closing team conference was held on 04/20/2017. The case was closed 6/21/17.

The father [redacted]
has returned to school part-time [redacted]

[redacted]

The victim child is progressing well. [redacted]
The child was struggling to maintain the core strength to sit up, but is now meeting developmental milestones. The victim child has had seizures since the incident. [redacted] It is unknown at this time if the child has further lasting effects. [redacted]

The victim child's sibling is also doing well. Family members have helped the mother by taking care of the victim child's sibling during the victim child's medical appointments.

No criminal charges were filed regarding this incident.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near-Fatality Report:
The county did not complete a near-fatality report, because the report was determined to be unfounded within 30 days of the date of referral.

Department of Human Services Findings:

- County Strengths:
  The County implemented the appropriate level of services to assist the parents.

  The Community Umbrella Agency case management team has worked well with the medical team.

- County Weaknesses: None identified

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

Department of Human Services Recommendations:

None identified