pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

Also Known As [redacted] and [redacted]

Date of Birth: 05/09/2012
Date of Incident: 02/14/2017
Date of Report to ChildLine: 02/18/2017
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 (DHS)

REPORT FINALIZED ON:
8/3/2017

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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 3/17/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/09/2012
[redacted]	Biological Mother	06/16/1988
* [redacted]	Biological Father	10/05/1985
* [redacted]	Full Sibling	03/15/2011
* [redacted]	Half Sibling	01/06/2014
[redacted] (aka [redacted])	Half Sibling	05/11/2016
	Maternal Uncle	unknown
	Paramour of Maternal Uncle	unknown
* [redacted]	Biological father of [redacted]	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.

*[redacted] resides with his maternal aunt. He has been in care with maternal aunt since August 2015.

*[redacted] resides with his biological father. He is currently in kinship care with sibling [redacted]

*[redacted] resides with his biological mother and father. His name is also spelled [redacted] He is currently in kinship care with sibling [redacted]

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the [redacted] family. SERO staff reviewed various reports, assessments and case documentation provided by Philadelphia Department of Human Services. The Human Services Program Representative attended the Act 33 on 03/17/2017.

Summary of Circumstances Prior to Incident:

On 02/25/2011, the family became known to the Philadelphia Department of Human Services (DHS). This was a General Protective Services Report (GPS) alleging the biological mother was co-sleeping with child [redacted] At this time, the mother and child resided [redacted] The report was not accepted for investigation or assessment.

On 09/01/2011, DHS received a GPS alleging that mother had been [redacted] since 03/30/2011. [redacted] reported that mother tested positive for marijuana on two occasions. She was residing [redacted] with [redacted] It was reported that mother was providing appropriate care for [redacted] The report was not accepted because there were no allegations of abuse or neglect.

On 07/25/2012, DHS received a 24 hour response GPS Report that alleged mother failed to provide proper supervision of [redacted] and [redacted] on an ongoing basis. Mother was living in a rooming house at the time of this report. It was reported that mother's room was dirty and that there were maggots in her bed on one occasion. It was reported that mother smoked marijuana and consumed alcohol. A safety assessment was completed on 07/26/2012. The assessment determined that mother's cognitive, emotional and behavioral protective capacities were diminished. On this date, a safety plan was implemented. It was determined that the children were safe with a plan. The safety plan was for the family to reside with an identified relative. It was noted that the family's whereabouts became unknown. A search was completed and it was determined that the family had moved to [redacted] New York. The New York State Office of Children and Family Services was contacted. The agency conducted an unannounced home visit and it was determined that mother and children moved back to [redacted] The mother and children could not be located in [redacted] The case was closed on 01/23/2013 and determined unable to assess, as the family could not be located. There were significant efforts made to locate the family. The county implemented Accurint and [redacted] searches.

On 10/21/2016, DHS received a 24 hour response CPS report. The report stated that maternal aunt was inappropriately disciplining [redacted] It was reported that maternal aunt cut [redacted] on his finger because he asked people for money. In addition, it was reported that two weeks prior, [redacted] had a bump over his eye. It was reported that maternal aunt had custody of [redacted] This report was unfounded and there were no services put in the home. There were no safety threats identified in the home. It was determined that biological mother and maternal aunt were in a custody battle over [redacted] There were no safety threats present and the child was determined to be safe. The case was closed on 11/14/2016.

On 01/24/2017, DHS received a 24 hour response CPS report alleging that [redacted] had cuts on his face. It was reported that biological father cut him on his face with scissors. It was noted that [redacted] was in the care of his maternal uncle at an unknown address. It was reported that biological father smoked marijuana and

consumed alcohol. It was reported that biological father had a criminal history. It was further reported that biological father, his paramour and his paramour's two children resided at [redacted] Hotel. [redacted] Hotel denied that the family was living in the hotel. It was reported that a custody hearing concerning [redacted] was scheduled for 04/28/2017. DHS interviewed biological mother and it reported [redacted] appeared to be clean and safe. Biological mother and [redacted] father resided in the same home. Mother reported at this time that her siblings were conspiring against her to keep her children from her. She also reported that she did not have any information as to [redacted] because his father was keeping him away from her. [redacted] father reported during this visit that his family supports him and his family. It was determined that there were no safety threats in the home of [redacted] and her child [redacted]

At this time, DHS was unable to locate [redacted] and his biological father. The child was not located until receiving the near fatality on 02/18/2017. The county made several attempts to locate [redacted] and his father. The county traveled to the various addresses they had for the family. [redacted] and his father were not living in any of the addresses. This investigation was determined unfounded. The case was closed on 3/21/2017 with the determination that the incident did not occur.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/18/2017, DHS received a 24 hour CPS report that alleged father had [redacted] in a stroller and it was observed that he had burns on his hands, feet and buttocks. It was stated that father reported that something happened while he was in the home of the maternal uncle. The biological father reported that maternal uncle was attempting to bathe the child and that the water was too hot causing the burns. It was reported that biological father stated that this happened four days ago. It was stated that the explanation of the child's burns was not plausible. The child was living in the home with maternal uncle and paramour at the time of the near fatality. The maternal uncle was listed as the alleged perpetrator as to the burning and scalding of [redacted]

On 02/18/2017, DHS received another 24 hour CPS report. This was the same information from the previous report. This report named both biological mother and father as alleged perpetrators for failing to provide medical treatment and care for the child in response to the burns.

On 02/18/2017, DHS received a supplemental report stating that [redacted] arrived at a hospital via ambulance. It was reported that the child suffered from third and fourth degree burns to his body. [redacted] The biological father reported that either on 02/13/2017 or 02/14/2017, he took the child to maternal uncle. The maternal uncle would provide care for the child while father went to work. Biological father stated that he received a telephone call from maternal uncle reporting that [redacted] was hurt. Biological father reported that, when he picked up [redacted], he (biological father) observed burns on the child's feet and hands. It was reported that, earlier that week, the maternal uncle placed the child in the bathtub and that the hot

water tank was set high. It was stated that maternal uncle left the child in the tub not knowing that the water was extremely hot. At this time, it was reported that the police had to persuade biological mother to go to the hospital to see the victim child. The police had to transport mother to the hospital. Biological father reported that, when he saw the child on 02/17/2017, the victim child was covered with gauze bandages. Biological mother reported that she had not visited with the child since 01/20/2017. She stated that she had no knowledge of how [redacted] was burned.

Medical reports indicate that the child's burns are second degree burns which covered 24 percent of his body. There were no splash patterns to the burns which indicated that someone held the child down in the water. The areas of the injury are consistent with the injuries being inflicted.

On 02/18/2017, A CPS report was generated for Failure to provide medical treatment/care for [redacted] naming biological mother and father as the alleged perpetrators.

On 02/22/2017, DHS received a supplemental reported that [redacted] medical condition was certified as a near fatality naming maternal uncle as the perpetrator.

On 03/09/2017, Bethanna Community Umbrella Agency assumed case management services. The agency began providing [redacted] service to each sibling in their respective homes.

[redacted] and placed in a [redacted] foster home. This was following a GPS report received on 03/17/2017 alleging that mother and father had [redacted] issues that were a threat to the child's safety. The report was investigated and determined to be valid.

[redacted] He was removed from his father's care and place in the care of a paternal uncle. The child's father tested positive for cocaine [redacted] during screen on 03/21/2017. The GPS report was determined as valid.

On 03/17/2017, [redacted] father and his maternal uncle and the paramour of the maternal uncle were arrested and charged with aggravated assault, endangering the welfare of a child, simple assault and recklessly endangering another person related to the child's injuries.

On 04/21/2017, [redacted] father was released on bail. The maternal uncle remains incarcerated at [redacted] Corrections and the paramour of the maternal uncle remains incarcerated at [redacted] Correctional Facility. They are all scheduled for a pre-trial hearing in August 2017.

On 04/04/2017, the near fatality report as to the maternal uncle was indicated. The CPS report for failure to provide medical treatment/care naming biological mother and father as alleged perpetrators was determined unfounded for both parents. The reason for the determination was due to lack of substantial evidence. The case was closed on 03/06/2017.

[redacted]

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 Act 33 Team reviewed the Intake SWSM's efforts to locate [redacted] and his father prior to the incident. The narrative from the 01/24/2017 referral alleged that [redacted] and his father were staying at [redacted] Hotel. The Intake SWSM made a visit to the hotel on the day of the report. Staff denied that [redacted] and his father were staying at the hotel.

  *The Intake SWSM was unsuccessful in her attempts to obtain an address for the father from the Pennsylvania Department of Human Service (PA-DHS). The mother [redacted]; thus, it appeared that [redacted] was still in her care. [redacted]

  *The Intake SWSM completed a Parent Locator Search, however this did not provide any information as to where the father might be living. The Intake SWSM met with the mother several times but she was unable to provide information as to where the father was living with [redacted] The mother alleged that the father was conspiring with her siblings to keep [redacted] and the other children from her.

  *It was not until 01/30/2017 that the mother provided a telephone number for [redacted] father. The mother also provided a telephone number for the MUN and noted that the MUN sometimes provided care for [redacted] The Intake SWSM completed outreach using both telephone numbers but there was no response.

  *On 02/06/2017, DHS received supplemental information that [redacted] father might be living with the paternal grandmother. A possible address was provided and confirmed through a [redacted] search. The Intake SWSM attempted a visit but there was not answer at the door. The Intake SWSM

left a notification letter at the door stating that failure to respond would result in court action.

*The Intake SWSM consulted twice with the City of Philadelphia Law Department.

*Following receipt of the 02/18/2017 reports, the father's whereabouts became known to DHS as he was with [redacted] at [redacted] The father admitted to the Intake SWSM that he had previously been hiding from DHS. He also stated that he had been leaving [redacted] in the care of the MUN to further avoid DHS investigation.

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

The Act 33 Team questioned if the Intake SWSM's efforts were sufficient or if more could have been done to locate [redacted] prior to the near fatality incident.

Deputy Commissioner [redacted] reviewed the DHS' procedures to locate missing children and families. She noted that the Intake SWSM's efforts were consistent with current protocols. Deputy Commissioner [redacted] stated that the Intake SWSM could have also engaged the services of a private investigator; however the private investigator would have used many of the same search techniques that the Intake SWSM employed. As such, this additional step of hiring a private investigator was unlikely to have located the father.

*The Intake SWSM and Philadelphia Police Department-Special Victim's Unit shared information regarding their respective investigation. It was noted that the MUN had two paramours and lived between both homes. It was not initially clear in which paramour's home the NUM had been staying when [redacted] was injured. The Intake SWSM assessed the safety of [redacted] siblings in their respective homes. [redacted]

After reviewing the above information, the Act 33 Team concluded that the Intake SWSM did a good job investigating the reports.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  There were none noted.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  There were none noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  There were none noted.

Department Review of County Internal Report:

In review of the county report, the Department has determined that the report is comprehensive.

Department of Human Services Findings:

- County Strengths: The county children and youth completed an extensive search for the child and father during the 01/24/2017 CPS investigation. This report was under investigation when the near fatality report was received on 02/18/2017. The family was not located until [redacted] was hospitalized in response to the near fatality.

- County Weaknesses: There are none noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There are none noted.

Department of Human Services Recommendations:

The county should implement additional protocols when attempting to locate families during a CPS investigation. Two investigations were closed due to county unable to locate the family. The county did extensive searches in an attempt to locate the family. The county can include searches through private investigators.