pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/28/2017
Date of Report to Child Line: 10/26/2017
CWIS Referral ID: [redacted]

FAMILY 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:

9/10/2018

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 convened a review team in accordance with the Child Protective Services Law related to this report. The Act 33 Meeting occurred on 01/19/2018.

Family Constellation:

First and Last Name	Relationship	Date of Birth
[redacted]	Biological Mother	[redacted]1982
	Biological Father	1986
	Full Sibling	2001
	Full Sibling	2002
	Full Sibling	2005
	Victim Child	02/28/2017

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documentation, and documents pertaining to the Family. Contact was made with the county case worker to obtain the documents listed; Structured Case Notes, Safety Assessment, Risk Assessment, Medical Records, County Report , CY47, and CY48. A representative from the Southeast Regional Office attended the Act 33 meeting held on 01/19/2018.

Children and Youth Involvement Prior to Incident:

On 01/17/2007 a General Protective Services (GPS) report was received alleging that the biological mother lived in a crowded apartment with her four children. The report was investigated and determined to be invalid.

On 02/02/2007, a GPS report was received alleging that the biological mother would lock herself in the bathroom for long periods of time, leaving the children

unsupervised. The family lived in a shelter at the time of the report. The report was investigated and determined as invalid.

On 03/10/2014, a GPS report was received alleging that one of the siblings was truant and the biological mother refused truancy services. The report was investigated and determined to be valid.

On 06/19/2014, a GPS report was received alleging that another sibling to the victim child was also truant and the family refused truancy services. The report was investigated and determined to be valid.

On 07/22/2014, the case was accepted for services. A Community Umbrella Agency, (CUA) [redacted] provided case management services through 11/30/2014.

On 11/25/2014, a GPS report was received notifying DHS that 3 of the siblings needed [redacted] due to inappropriate housing conditions. The siblings [redacted]. The family received [redacted] services from [redacted] through 12/01/2014.

On 03/02/2017, DHS received a GPS report alleging that the biological mother gave birth to the VC and mother admitted that [redacted]. The biological mother [redacted] the victim child was born healthy. The biological mother reported having a history of [redacted] services. The report was investigated and determined to be invalid. The victim child was discharged from the hospital to the biological father; no services were provided to the father to assist with the care of the victim child.

Circumstances of Child Near Fatality and Related Case Activity:

It was reported to Childline on 10/27/2018 that the victim child sustained second and third degree burns to her shoulder and backside. The referral source stated that the father disclosed that the victim child was laying against a radiator for an extended amount of time and didn't cry at all. The referral source stated that the father disclosed that he found the victim child laying against the heater last night but the victim child was not crying so he did not think anything of it. The father found the burns in the morning and transported the victim child to the hospital immediately. The referral source stated there were concerns about the father's story due to the fact that the victim child would have been crying due to the extent of the burns sustained.

The case was assigned to the Multi-Disciplinary Team Social Work Services' Manager (MDT SWSM) for investigation. The biological father was interviewed; he stated that the victim child was laying on his chest while he was trying to put her to sleep. The biological father admitted to falling asleep and when he awakened, he noticed that the victim child had rolled off the bed, and was wedged in between the heater and the bed. The biological father stated that he woke up sometime between

1am and 2am and placed the victim child into her pack 'n play. At 8am, when he checked on the victim child, he noticed something on her leg. When he went to wipe the victim child's leg, nothing came off; however, there were burn blisters on the victim child's leg and back. The biological father said that the victim child did not cry at any time. When he turned on the light, he could see that the victim child's skin had been burned. The victim child was transported to the hospital by ambulance. The biological father demonstrated appropriate parenting, as observed during the hospital visit at the time of the interview. He was concerned about the victim child's wellbeing, and has a bond with both of his children.

The biological father's 14 year- old daughter lives in the home and was also interviewed. She stated that she recently came to live with her father. She stated that she felt safe living with her father. She shared that she lived with her stepmother prior to living with her father and that she does not know the whereabouts of her biological mother.

The biological father lives in a two bedroom apartment. The 14-year-old has her own room and the victim child's pack 'n play was in the biological father's room. The biological father has cared for the victim child since she was 3 days old.

It was reported by the Dr. at [redacted] that the father's explanation of the how the injury occurred was feasible and the burn could have been accidental. However, the father's report of not hearing the baby cry is concerning and unlikely. The victim child obtained 2nd and 3rd degree burns that required surgery for skin grafting for treatment due to the extent of the victim child's burns to her buttocks, ear, back, and shoulder. She was discharged from the hospital on 11/08/2017.

The victim child [redacted] was received on 11/08/2017. The victim child [redacted] at discharge from hospital. Services provided to the family include case management, daycare services, family support services, home based services and parenting education. The parents have supervised visits with the victim child.

The investigation was concluded on 12/01/2017; the biological father was indicated. The biological father's statement that the victim child "did not cry" was not credible or consistent considering the severity of the victim child's injuries to her ear, neck, shoulder, back and thigh. Appropriate supervision of the victim child is questionable at the time of the injury. There were no criminal charges filed.

Summary of 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;

This CPS was generated on 10/27/2017. It reported that the near fatality certification form, signed by a [redacted] physician, was faxed to the DHS Hotline on 10/31/2017. This form was not received, and there was no record of the telephone call to the DHS Hotline or the PA-DHS Child Line. The MDT team at DHS was not aware that the child's condition had been certified, and the case had not been registered with Child Line as a near fatality.

When the MDT team submitted the CPS determination to Child Line on 12/1/2017, the near fatality indicator had been checked. Child Line requested additional information regarding the certification. On 12/6/2017, the necessary near fatality paperwork was obtained from [redacted] and the case was formally registered with Child Line as a near fatality.

DHS is currently revising the internal Act 33 policy that provides guidance to DHS staff regarding their roles and responsibilities when investigating CPS fatality and near fatality cases. The policy will direct DHS staff to refer physicians to Child Line when a case is to be certified as a near fatality so that the cases can be properly registered.

- Deficiencies in compliance with statutes, regulations and services to children and families; None

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and None

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

Department Review of County Internal Report:

The Southeast Region concurs with the County's Report, the report was received in a timely manner.

Department of Human Services Findings:

- **County Strengths:** None

- **County Weaknesses:** None

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

Department of Human Services Recommendations: None