



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



BORN: 09/09/2014
Date of Incident: 10/29/2014
Date of Oral Report: 10/30/2014

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE:

REPORT FINALIZED ON:
July 16, 2015

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:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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 Act 33 of 2008 related to this report. The county review team was convened on November 21, 2014.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	09/09/2014
[REDACTED]	Biological Sibling	[REDACTED] 2013
[REDACTED]	Biological Mother	[REDACTED] 1994
[REDACTED]	Biological Father	[REDACTED] 1991
[REDACTED]	Maternal Grandfather	Adult
[REDACTED]	Paramour to maternal grandfather	Adult
[REDACTED]	Maternal uncle	[REDACTED] 1998
[REDACTED]	Maternal uncle	[REDACTED] 1999
[REDACTED]	Maternal uncle	[REDACTED] 2001
[REDACTED]	Maternal uncle	Adult
[REDACTED]	Maternal Uncle	Adult
* [REDACTED]	Maternal grandmother	Adult

*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.

Notification of Child Near Fatality:

On October 30, 2014, the Philadelphia Department of Human Services (DHS) received a Child Protective Services (CPS) report alleging that [REDACTED] was transported to Children's Hospital of Philadelphia (CHOP) by his parents. The mother reported that the child was crying and his left thigh was swollen. An x-ray revealed that [REDACTED] had suffered a [REDACTED] fracture (is a bone break that occurs along the shaft of a long bone, it may be caused by trauma) of his left femur (thigh). The cause of the injury was determined non-accidental. The parents were unable to explain how the child sustained the injury. The parents reported that they were the only caretakers for the child within the last 24 hours.

Summary of DHS Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the [REDACTED] family. SERO staff conducted interviews with the [REDACTED] foster care social worker [REDACTED]. SERO staff also conducted interviews with the Philadelphia Department of Human Services fatality administrator [REDACTED]. SERO staff participated in the Act 33 meeting that occurred on November 21, 2014 at which medical professionals and law enforcement were present and provided information regarding the incident as well as historical information.

Children and Youth Involvement prior to Incident:

The family had no prior children and youth involvement prior to the incident. The biological mother [REDACTED] has a history with the Philadelphia Department of Human Services (DHS) as a child. She was in foster care placement. [REDACTED] has a history as a child with Philadelphia Juvenile Probation, Philadelphia Department of Human Services (DHS) that includes [REDACTED] was adopted through foster care.

Circumstances of Child Near Fatality and Related Case Activity:

On October 30, 2014 the Philadelphia Department of Human Services (DHS) received a report regarding [REDACTED]. While at the Children's Hospital of Philadelphia (CHOP) [REDACTED] it was determined that the child had a [REDACTED] fracture, a [REDACTED] fracture and an [REDACTED]. It was noted that the child required critical care.

On October 31, 2013, the Philadelphia Department of Human Services received a supplemental report that [REDACTED] condition was certified as a near-fatality.

On October 30, 2014 around 3:30pm, the mother and father transported [REDACTED] to Children's Hospital of Philadelphia (CHOP) in response to the child crying and mother noticed that the child's left thigh was swollen. The child's x-ray showed a [REDACTED] [REDACTED] fracture of the left femur. It was determined that this injury was non-accidental. It would have occurred by a pulling motion and would cause [REDACTED] snapping sound. In addition [REDACTED]. The CAT scan to his head showed a new injury [REDACTED]. This was reported to be clearly the result of impact to the child's head. All of the injuries occurred around the same time. It was medically determined that the injuries that [REDACTED] sustained were non-accidental. Mother and father could not explain the injuries. The parents had been the only caretakers for their child within the past 24 hours. At that time the alleged perpetrators were unknown. [REDACTED] received a full skeletal and she was cleared medically, there was no evidence of any abuse or neglect.

The mother, [REDACTED] explained that the family was out shopping on October 30, 2014 at the [REDACTED] mall) and she was carrying [REDACTED] in a sling type carrier. She further

reported that when the family arrived back home she pulled the baby out of the sling and she noticed that his leg was swollen while changing his diaper. She reported that she thought the baby's leg was swollen because he was in the sling wrong. The mother stated that [REDACTED] was crying and he was really cranky. She called the father to look at the child's leg. Both of the parents took [REDACTED] to Children's Hospital of Philadelphia (CHOP) [REDACTED] and the child was admitted into the hospital. The medical documentation determined that the child's injuries were recent and could not have been the result of the child being taken out of the sling carrier. It was reported that the femur is a difficult bone to break. [REDACTED]

The father, [REDACTED], reported that the family was out shopping on October 30, 2014 at [REDACTED]. Both mother and father and the two children went shopping. Mother carried [REDACTED] in the sling the entire time while shopping. He further reported that when they returned home mother noticed the child's leg was swollen. Both he and mother transported [REDACTED] to the Children's Hospital of Philadelphia (CHOP).

All of the household members were interviewed regarding the injuries of [REDACTED]. The five maternal uncles ranging from the ages of 10 to 18 were interviewed. All of maternal uncles reported that they do not provide care for [REDACTED]. All of the maternal uncles reported that they do not know how he received the injuries. The maternal grandfather and his paramour reported that the parents provide the care for their children. They were unaware of how [REDACTED] sustained the injuries.

[REDACTED] was born in the home and transferred to Pennsylvania Hospital via ambulance. Mother delivered [REDACTED] prematurely and initially [REDACTED] and he was not gaining appropriate amounts of weight. In November 2014, during a pediatric examination it was determined that [REDACTED] was not gaining much weight and he was spitting up. The pediatrician recommended that additional rice cereal be added. This has been resolved and he was gaining weight. [REDACTED]

Current Case Status

[REDACTED] They were initially placed in the paternal aunt's home, [REDACTED]. The paternal aunt was not meeting the needs of the children. In addition, she was not meeting the medical needs of [REDACTED]. It was determined during a pediatrician visit that [REDACTED] was exhibiting slow weight gain. He was [REDACTED] and a set feeding schedule. Other family members were explored to provide kinship care for the children. The maternal grandmother [REDACTED] as well as other family members could not be cleared. [REDACTED] was not a resource as she has a history with her children through DHS. [REDACTED], the children's biological mother was in placement as a child through DHS. [REDACTED] is exploring family finding and planning a Family Group Decision Making meeting.

- On December 1, 2014 [REDACTED] cast was taken off. Overall [REDACTED] is healing from the injuries. The [REDACTED] doctor reported that his healing is good.
- On December 19, 2014 the investigation was determined indicated naming the father, [REDACTED], as the perpetrator. The investigation determined that on October 29, 2014 the father provided the only care for the children for several hours from 12:00pm to 2:00pm while the mother was at work. Mother had just started a new job as a Certified Nursing Assistant (CNA) and left the children at the home for the father to care for them. When she returned she had not noticed any changes in [REDACTED]. The police investigation has been completed and the case has been closed.
- On January 29, 2015 at the bar of the court it was determined that [REDACTED] had a bench warrant out for his arrest for marijuana charges. The father was incarcerated at the [REDACTED] Correction Facility. [REDACTED] is no longer incarcerated. He was released from prison in March 2015.

[REDACTED] On January 29, 2015, [REDACTED] were moved into [REDACTED] foster home. On February 15, 2015 under the care of the new foster home [REDACTED] feeding condition had improved and he was gaining weight. Both of the children are doing well. The parents have weekly two hour supervised visits with [REDACTED]. The children remain in this foster home. The parents are receiving parenting education and case management services through the [REDACTED]

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

During the Act 33 Team meeting the medical professionals discussed that [REDACTED] condition was not a near fatality. They did not agree that he should have been certified as near fatality. The child came in with femur swelling to left leg and increased fussiness. There was discussion on interpretation and identifying and certifying near fatality.

Strengths:

- The Team noted that the Intake Social Worker did a good job investigating the case, but noted that the Intake Social Worker needed to more thoroughly document her work. The decision-making process was not clearly documented.
- The team expressed concerns regarding the length of time that the children were hospitalized as they awaited a placement resource. There was no medical necessity for [REDACTED] hospitalization or [REDACTED] continued hospitalization. The Intake

Social Worker described her difficulties locating an appropriate caretaker for the children. Several family members were explored, but they did not pass clearances.

Deficiencies:

- The Team noted that [REDACTED] remained in the hospital for an unnecessary extended period of time. Once [REDACTED] was medically cleared, a plan should have been made for her discharge.
- Both [REDACTED] stayed in the hospital for a week and they did not have any medical needs. Due to this unnecessary stay, it had been reported that CHOP was frustrated that they were not able [REDACTED] the children.

Recommendations for change at the Local Level:

- Steps should be taken to ensure that proper monitoring of hospital stays are not longer than medically necessary
- The Team recommended that the DHS Commissioner appoint a representative from Community Behavioral Health to the Act 33 Team.
- The Team recommended that the DHS medical Director convene a meeting with DHS, CHOP and the St. Christopher's Hospital to promote consistency as to the definition of a near fatality case.

Recommendations for Changes at the State Level:

No recommendations were noted

Department Review of County Internal Report:

- PA Department of Human Services is in receipt of the County Internal report. The Department received the report on June 27, 2015,
- The County report stated that the children remain in the care of their paternal aunt (PAU). This is an incorrect statement. The children were removed from the PAU on January 29, 2015 [REDACTED]. The reason for the removal was PAU was not following the medical instructions for [REDACTED]. SERO spoke with the county fatality administrator who reported that at the time when the report was written the children were in the home with paternal aunt. There is a notation in the memo portion of the report which indicates that the children were moved to foster care due to ongoing concerns about their care in the aunt's home.

Department of Human Services Findings:

- County Strengths:
The social worker completed a thorough investigation regarding the incident. All of the household members were interviewed and appropriate information was obtained.
- County Weaknesses:

The County had a difficult time finding family resources [REDACTED] when the children were ready [REDACTED] the hospital.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
There are no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

- The Department recommends state wide public service announcements through social media that presents safety for young children and when parents feel overwhelmed with infant care making positive choices and responses to age appropriate infant behavior and development.