pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/25/2016
Date of Incident: 06/01/2017
Date of Report to ChildLine: 06/01/2017
CWIS Referral ID: [redacted]

FAMILY UNKNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

12/29/2017

Unreacted 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.

On 06/29/2017, Philadelphia Department of Human Services convened a review team in accordance with the Child Protective Services Law related to this report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	12/25/2016
	Mother	[redacted]1990
	Father	1984
	Sibling	2011
* [redacted]	Household Member/ Babysitter	Unknown
* [redacted]	Mother's friend/ roommate	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.

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the family. The Regional Office participated in the County Fatality Review Team meeting on 06/29/2017.

Children and Youth Involvement prior to Incident:

The family was not known to Philadelphia Department of Human Services prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

The Department of Human Services (DHS) received a Child Protective Services (CPS) report on 06/01/2017 alleging that five-month-old victim child was brought to the Children's Hospital of Philadelphia (CHOP) with vomiting and increased

irritability. It was reported that the victim child had a history of failure to thrive and reflux with frequent vomiting. [redacted] The family could not provide an explanation for the victim child's injuries. At first, there was no alleged perpetrator identified due to the victim child being in the care of several adults before the incident. The victim child's injuries were suspicious for non-accidental trauma.

On 06/02/2017, the victim child remained hospitalized at CHOP and the report was assigned to an Intake Social Work Service's Manager (SWSM). It was reported that the victim child's sibling lived with her grandparents in [redacted], Pennsylvania via a family arrangement and that this arrangement was made because the mother does not like the schools in Philadelphia. The sibling's safety was assessed in her grandparents' home. After CHOP examined the sibling on 06/02/2017, it was determined that there were no concerns for abuse or neglect of the sibling.

At first, both parents did not believe that the victim child was injured. They reported that they believed that the victim child's condition was related to an undiagnosed medical issue. The father stated that the mother had been complaining since February 2017 that something was wrong with the victim child. The victim child had an appointment, with another medical provider, that was recently scheduled by the victim child's mother for a second opinion. The parents provided the Intake SWSM with the victim child's history of medical appointments and multiple hospitalizations due to feeding issues, vomiting, and poor weight gain. The mother also provided documentation regarding her ongoing communication with the victim child's medical providers.

It was reported by the parents that the mother's friend and the friend's mother would sometimes provide care to the victim child. It was noted that the victim child's mother and her friend had known each other since childhood. The mother's friend lived in the home and would babysit the victim child for short periods of time at night. The victim child's mother stated that the victim child and the friend would be asleep during these times. The friend's mother did not live in the home but would reside there periodically when she needed somewhere to stay and had provided care to the victim child several times during the prior month while the mother was at work. It was not clear how much the mother knew about the friend's mother before the mother decided to use the friend's mother as a caregiver.

The mother provided an account of events leading to the victim child's hospitalization. The mother stated that she left the victim child in the care of the friend's mother on 05/29/2017. The friend's mother told the mother that the victim child had slept for most of the day. The mother reported that it was unusual for the victim child to sleep that much so she left work early. The mother reported that the victim child was extremely irritable and was vomiting, crying, and arching as if he were in pain. The victim child only drank a small amount of formula and then refused to eat. The mother stated that she called the victim child's physician who reportedly stated that the victim child might have a stomach virus; however, the

victim child did not have a fever. The victim child slept through the night but appeared to be tired the next morning. The mother fed victim child but reported that he vomited after every feeding. The mother stated that she called the emergency number for the physician that evening as well. While she was on the telephone, the friend's mother reportedly told the victim child's mother that the parents should take the victim child to the hospital because something might be wrong with him. The parents decided to take the victim child to CHOP and the victim child was admitted to the hospital on 05/31/2017. The mother stated that they were initially told that test results were normal but then the victim child's heart rate increased and his head began to swell. [redacted] Both parents denied ever hitting or shaking the victim child and stated that the victim child had never hit his head.

A DHS Unexplained Injury teaming occurred on 06/12/2017. There was no medical explanation for the victim child's condition and his injuries were consistent with non-accidental trauma. The mother remained concerned about the victim child's health but seemed to be focused on what she believed was the mishandling of the victim child's medical care. [redacted] The mother and maternal grandmother (MGM) initially struggled to understand that the victim child had been physically abused and that victim child's prior medical problems had nothing to do with his injuries. [redacted] nurse further explained to the mother and the MGM that the victim child's injuries were non-accidental. The perpetrator of the victim child's injuries was still unknown. Due to the ongoing investigation, the mother identified a maternal aunt (MAU) and her wife as potential caregivers for the victim child. Philadelphia DHS completed an assessment of the identified caregivers. Their home was appropriate and they would be able to meet the victim child's ongoing medical needs.

The Intake SWSM spoke with [redacted] who had been identified as the [redacted]. She stated that, in early May, [redacted] so the mother allowed the friend's mother to provide care for the victim child. [redacted] stated that she never observed the friend's mother babysitting but stated that "if I had a child, I wouldn't leave my child with a woman like the friend's mother." [redacted] alleged that the friend's mother did not have custody of her own children. [redacted] did not know if the parents were aware of the friend's mother's DHS history. [redacted] described the friend's mother as always stressed because she did not have her life together. [redacted] also stated that she was surprised to learn that the friend's mother had abruptly moved from [redacted] following the victim child's hospitalization. The mother's friend also confirmed that her mother provided care for the victim child before his hospitalization. The mother's friend reported that, prior to his hospitalization, the victim child was whimpering as if he were in pain.

[redacted] The sibling remained in the care of her maternal grandparents. The victim child [redacted] the care of the MAU

and her wife. They received the necessary training [redacted]

The Intake SWSM was unable to interview the friend's mother in person. She reportedly had moved to [redacted] Pennsylvania the day after the victim child was hospitalized. The friend's mother moving raised suspicions as she had just obtained a new job in [redacted] and no one had any indication that she was planning to move. The Intake SWSM was able to speak with the friend's mother via telephone. The friend's mother confirmed that she had provided care for the victim child prior to his hospitalization.

The friend's mother noted that the victim child had been sleeping more than usual and the mother was concerned so she returned home from work. The friend's mother reported that the victim child never cried while he was in her care. The friend's mother's statement was not consistent with the parents' report that the victim child cried often. When the Intake SWSM informed the friend's mother of the victim child's injuries, the friend's mother started babbling and the Intake SWSM could not understand what she was saying.

[redacted] was able to obtain the friend's mother's statement via telephone. It was noted that the friend's mother had a prior criminal record; which included assault charges. Additionally, after the incident, the victim child's mother obtained a Protection from Abuse Order against the friend's mother. The order has not yet been served as the friend's mother's whereabouts remain unknown.

On 07/13/2017, the CPS report was indicated with the mother's friend's mother named as a perpetrator. The police investigation is ongoing.

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, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations:

1-Compliance with statutes and regulations:

• The Act 33 Team felt that the Intake team was effective in coordinating with CHOP and with the [redacted]. All parties were patient with the parents and took the time to help the mother understand that the victim child's injuries were inflicted abuse. They also challenged the mother's belief that the victim child's injuries were evidence of medical malpractice.

• During the meeting, it was reported that there was a history of the perpetrator providing care for the victim child just prior to the onset of each of his most recent health crises and that, afterwards, the perpetrator would disappear for a period of time. Following the victim child's hospitalization on 05/31/2017, [redacted]

[redacted] In light of this information, CHOP representatives announced that they would formally review the victim child's case. CHOP would take a closer look at the victim child's prior medical care and hospitalizations to ensure that they had not missed any previous signs of physical abuse.

2. Services to the VC and the extended family:

• At the time of the report, the family did not have an open case with DHS and was therefore not receiving any services.

• On 06/13/2017, Catholic Community Services (CCS), a Community Umbrella Agency (CUA), assumed case management services for the family.

• The victim child remains in the care of the MAU and her wife. Kinship care services will be implemented.

• The victim child's sibling remains in the care of her maternal grandparents. CCS CUA provides in-home safety,

- 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.

  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 Department received the county's report dated 09/27/2017 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

DHS/OCYF felt that a competent CPS investigation was completed by Philadelphia Department of Human Services. DHS/OCYF felt that the caseworker informed and

consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

County Weaknesses:

None

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

A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:

None