pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/23/2017
Date of Death or Date of Incident: 11/2/2017
Date of Report to ChildLine: 11/02/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO Montgomery COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT.

REPORT FINALIZED ON:
6/1/2018

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))

DOffice of Children, Youth, and Families, Southeast Regional Office
801 Market Street, Suite 6112, Philadelphia, PA 19107 | 215.560.2249 | Fax: 215.560.6893 | www.dhs.pa.gov

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.

Montgomery County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on December 4, 2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Biological Father	[redacted]1988
	Biological Mother	[redacted]1988
	Full Sibling	[redacted]2016
	Victim Child	07/23/2017

Summary of OCYF Child Near Fatality Review Activities:

Human Service Representative attended the Act 33 review on December 4, 2017. Initial referral and doctor's reports were reviewed. Southeast Regional Office staff attended the Act 33 meeting, Montgomery County involved staff interviewed and the investigation materials analysis completed.

Children and Youth Involvement prior to Incident:

There was no Children and Youth Involvement prior to the incident on November 2, 2017.

Circumstances of Child Near Fatality and Related Case Activity:

[redacted] was taken to [redacted] after Mother found the infant on the bed unresponsive. Mother reports she immediately called 911 and began CPR. Emergency Medical Services immediately transported the infant to [redacted] transferred to [redacted] then transferred to [redacted]. The infant remains there as the date of this report.

There was a discrepancy as to whether the child became unresponsive in the tub as a result of drowning or whether the infant became unresponsive while on the bed. Mother reported giving a bath to the infant and putting the infant on the bed to

clean out the baby tub after the infant defecated in the tub during the bath. She does not report leaving the baby in the baby tub or that the infant became unresponsive while in the baby tub.

According to case file documents, a report of abuse was made while the infant was at [redacted] and the incident was certified a “Near Fatality”. However, upon further investigation it was determined while infant was at [redacted] that the infant has [redacted]. Further investigation also revealed that the infant has an older sibling (now one year and eleven months old) that [redacted]. According to case file, end of life discussions have been discussed with parents. The parents have not wanted to move forward. It has been determined [redacted]

The Montgomery County Children and Youth made a determination of Unfounded for Causing Serious Physical Neglect on December 27, 2017 not finding any evidence of mistreatment or neglect. The police have an open investigation but to date, taken no criminal action.

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:

  County appears to be in compliance with investigating and making sure the children involved were safe.

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

  There were no deficiencies noted.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

  Recommended criteria for reports and certification of Near Fatalities be expanded to cover unexplained respiratory and heart failure. Hospitals and County Agency could have identified [redacted] reducing the likelihood of child fatality or near fatality.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

  Recommended hospitals and medical teams consult their in-house abuse teams routinely for complex medical cases without diagnosis.

Recommended continued and increased use of community-based home visiting programs for purposes of prevention and education.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

  Recommended that in instances where police respond, and conditions are deplorable, OCY should be called for a dual response to address the home conditions.

Department Review of County Internal Report:

The review consisted of case documents and information from Cheltenham Police and the Children's Hospital of Philadelphia.

Department of Human Services Findings:

- County Strengths:

  Information gathered was sufficient for the determination of the findings.

  Montgomery County Children and Youth complied with completion of the investigation and review.

- County Weaknesses:

  No weaknesses were noted.

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

  The County provided service within the regulatory guidelines.

Department of Human Services Recommendations:

- Recommends a more thorough investigation and exam before doctors call ChildLine.
- Recommends a database for unexplained or undiagnosed disease or illness for doctors and county agencies to use to include symptomology. This could possibly reduce the likelihood of fatalities or near fatalities. In this case the infant could have been monitored more closely [redacted].