



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: October 18, 2013
Date of Incident: June 1, 2014
Date of Oral Report: June 1, 2014

The Family was not known to:

Philadelphia County Department of Human Services

REPORT FINALIZED ON:
June 23, 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. 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, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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 child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	10/18/2013
██████████	Biological Sibling	██████████/2012
██████████	Maternal Aunt	██████████/2000
██████████	Biological Mother	██████████/1993
██████████	Biological Father	██████████/1993

Notification of Child Fatality:

On June 1, 2014, the Philadelphia Department of Human Services (DHS) received a report concerning ██████████. On June 1, 2014 ██████████ was transported to Einstein Hospital in a state of near-drowning. It was reported that ██████████ would be transported to St. Christopher's ██████████. It was stated that the risk of death is high in the first 24 hours after a near-drowning. There were no other issues or concerns reported.

At this time, mother was asking the reporting source if there was any way to stop the ██████████ from visiting the child ██████████ and in the hospital. The mother was upset that the ██████████ had been responsible for the child at the time of the incident. Mother was further asking the reporting source about filing for full custody of the child.

On June 11, 2014, the Philadelphia Department of Human Services (DHS) received a supplemental report concerning ██████████. The report stated that the child had been certified as a near fatality. It was determined that the child did meet the criteria of a near fatality. The child suffered injuries from an act that meets the definition of a near fatality. It was determined that the near drowning placed the child in a serious or critical condition. Therefore, the report was certified as a near fatality.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the ██████████ family. The regional office participated in the Act 33 meeting on June 20, 2014.

Children and Youth Involvement prior to Incident:

There is no prior children and youth involvement for ██████████ are the biological children of ██████████.

At the time of this report [REDACTED] and her sister [REDACTED] were receiving [REDACTED] services through [REDACTED] to support [REDACTED] (mother) with the care of her 13 year old sister [REDACTED] to address her medical condition [REDACTED]. On April 10, 2014, DHS implemented [REDACTED] through [REDACTED]. These services remain in the home.

There was a GPS (general protective services) report regarding [REDACTED] for safety and medical issues while living with her biological mother. This report was substantiated through Philadelphia Department of Human Services. The family was accepted for services regarding [REDACTED] on November 18, 2013. On July 8, 2013 [REDACTED] was granted legal custody of her sister [REDACTED] in New Jersey. [REDACTED]

On May 6, 2014, the Philadelphia Department of Human Services received a GPS (general protective services) report alleging that loud music was frequently playing from the home. It was reported that [REDACTED] who was the paramour of [REDACTED], often smoked marijuana with his adult friends on the porch of the home. It was reported that there were concerns regarding [REDACTED] who was 12 years old at the time because she [REDACTED]. It was reported that [REDACTED] did not smoke the marijuana. The allegations of this report did not meet the Child Protective Services Law (CPSL) and/or neglect criteria and the report was rejected.

Circumstances of Child Near Fatality and Related Case Activity:

On June 1, 2014 the father, [REDACTED], was bathing [REDACTED] and his sibling, [REDACTED]. The father left the bathroom for 2 minutes leaving the children unsupervised. When the father returned to the bathroom he observed that [REDACTED] was blue and floating on his back in the bathtub. Father took [REDACTED] out of the bathtub and took him downstairs and he performed CPR on [REDACTED] for 5 minutes. The child then vomited water and opened his eyes. After about 5 minutes, [REDACTED] regained consciousness. When father thought [REDACTED] was having trouble breathing, he gave him [REDACTED].

The mother was on the porch at the time of the incident of the near drowning. When the mother came inside of the home she witnessed father patting [REDACTED] back and informed mother that [REDACTED] was congested and may have swallowed some water during the bathing. Mother had concerns for [REDACTED] breathing and she immediately called 911. Mother reported that she was not made aware until later that the father had to perform CPR on [REDACTED].

When the emergency medics arrived at the home, it was reported in medical documentation that they were not given an accurate account of incident. It was reported by the hospital physician that if the parents would have given the emergency medics the correct account of the incident, the child would have received the proper treatment immediately from the emergency medics. The emergency medics were initially told by father that [REDACTED] had a cold for a few days and that he had swallowed some bath water while taking a bath. The emergency medics were not told that [REDACTED] lost consciousness as a result of this. As a result, [REDACTED] did not receive appropriate medical intervention for his condition.

On June 1, 2014, [REDACTED] was transported to Einstein Hospital via ambulance and later transported to St. Christopher's Hospital for Children in a state of a near drowning. It was reported that the risk of drowning is high for the first 24 hours after a near drowning. The child required to be closely monitored for more than 24 hours.

██████████ did admit that he had left ██████████ and his sibling ██████████ alone in the bathtub unsupervised for approximately 2 minutes. He admitted that he should not have left the children in the bathtub unsupervised. ██████████ reported that he filled the bathtub up with water and then went to get a diaper and a towel. When he returned to the bathroom he found ██████████ unresponsive face down in the bathtub. ██████████ checked for ██████████ heartbeat, he did not hear his son's heart beating so he performed CPR. ██████████ further reported ██████████ opened his eyes and started to vomit, ██████████. He stated that ██████████ seemed to be having difficulty breathing ██████████. ██████████ reported that during the incident the mother was on the front porch braiding her sister's hair. When the mother came into the house and saw that ██████████ was having trouble breathing she called 911 and then ██████████ was transported to Einstein Hospital.

On June 2, 2014, a safety assessment was completed and a safety plan was developed. It was determined that mother is capable of parenting her children. ██████████ was examined and determined to be a healthy child with no signs of abuse or trauma. ██████████ was also evaluated and it was determined that she is receiving proper care.

██████████ was interviewed regarding the near drowning incident. ██████████ reported that her sister was braiding her hair at the time of the incident. She reported that she did not see anything. ██████████ reported that she overheard what happened to ██████████. She overheard that ██████████ was giving the children a bath and ██████████ almost drowned. She stated that he left them to get a diaper and some clothes. She further stated that she heard that ██████████ gave him CPR and he was floating in the tub. She further stated that she thinks her sister called the ambulance.

██████████ do not have any history as minors with Children and Youth Agencies.

Current Case Status:

On June 2, 2014, the Special Victims Unit (law enforcement) reported that the incident was an accident and no arrest will be made.

On June 13, 2014, the ██████████ began providing ██████████ and the family continues to receive the services.

██████████ continues not to reside in the home. He is cooperating with ██████████ services. ██████████ is involved in his children's lives.

██████████ has not displayed any signs of effects from the near drowning incident.

On June 30, 2014, the CPS report was indicated naming ██████████ as perpetrator.

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

Strengths: The Team felt that the MDT Social Work Services Manager (SWSM) did an excellent job investigating the case and conferencing with her chain of command.

Deficiencies: There were no deficiencies identified

Recommendations for Change at the Local and State Levels: There were no recommendations.

Department Review of County Internal Report:

The Department received the Act 33 Fatality Report from the County on September 18, 2014.

Department of Human Services Findings:

County Strengths:

The county completed a timely and thorough investigation.
The county collaborated effectively with the hospitals with obtaining medical documentation.

County Weaknesses:

There are none identified

Statutory and Regulatory Areas of Non-Compliance:

There are none identified

Department of Human Services Recommendations:

None identified.