



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## REPORT ON THE NEAR FATALITY OF:



**Date of Birth: 2/12/15**  
**Date of Incident: 4/17/15**  
**Date of Report to ChildLine: 4/17/15**

## FAMILY KNOWN TO COUNTY CHILD WELFARE:

Philadelphia Department of Human Services

**REPORT FINALIZED ON:**  
**09/28/2015**

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 5/15/15.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
	victim child	2/12/15
	mother	 /77
	father	 /77
	sister	 /11

**Summary of OCYF Child Near Fatality Review Activities:**

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, sibling and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the mother and investigative social worker, as well as the social worker and director from the contracted placement provider. SERO attended the Act 33 Review Team meeting held on 5/15/15.

**Children and Youth Involvement prior to Incident:**

In June 2011 the county received a report alleging that the electricity had been turned off for several days. The family was storing food at a neighbor's home. In addition it was reported the father had an anger management problem. The newborn was sleeping in a car seat. The investigation was determined that there were no findings present. No services were provided.

**Circumstances of Child Near Fatality and Related Case Activity:**

On 4/17/15 the county received a CPS report alleging that the two month old child [REDACTED] [REDACTED] When EMTs responded to the home for a report that the child had fallen, the mother denied them access to the home and instead brought the child outside to them in a car seat. Mother stated she and the father had been arguing and that when he hit her she dropped the child on the bed to protect him. She then fell on top of the child after being hit by the father. As per hospital staff, the mother's explanation was inconsistent with the child's extensive injuries. The child would have to have fallen from waist high height onto a hard surface for the injuries received. St. Christopher's Hospital tests revealed [REDACTED] [REDACTED] Mother stated there had been a prior incident in which the child had been injured, but gave no specifics at that time. She stated that the child received medical attention for this injury on 3/28/15 at Children's Hospital (CHOP).

The safety of the child and his sibling was immediately assessed. Safety threats were identified. Initially a family friend was identified as a placement resource for the sibling while the child remained in the hospital. After several days this resource contacted the assigned Multi-Disciplinary Team (MDT) social worker and informed her she could no longer care for the sibling. [REDACTED] The sibling was placed in foster care. [REDACTED] the victim child was placed in a medical foster home.

The county has not yet been able to interview the father. He refuses to speak with the investigator or police at the advice of his attorney. However, the county Indicated the report on both the mother and father on 6/5/15. The criminal investigation continues at this time.

As per the [REDACTED] case manager from [REDACTED], the parents continue to reside in the same household. The parents are resistant to meet in their home and insist that meetings are held in the community. [REDACTED]

[REDACTED] One resource parent even had to file a police report on the father for safety concerns.

The children continue to reside in separate foster homes, but have weekly visits with one another. An attempt to place the sibling in the same home as the victim child was made, however, the sibling had a fear of the resource home's dog and was returned to her former foster home. She is now in a respite foster home due to the caregiver's [REDACTED] and statement that she no longer wanted to care for the child. [REDACTED]

The victim child has continued to receive follow-up medical care at St. Christopher's hospital.

[REDACTED]  
[REDACTED] as a result of the injuries. Otherwise he is showing improvements and has been referred [REDACTED].

As per the mother the sibling [REDACTED]. However, she will be evaluated to determine the extent or to confirm [REDACTED]  
[REDACTED]

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

- Strengths

The team felt the MDT social worker did a thorough investigation. The team felt the county and provider agency worked well in developing a plan to include both parents in case planning while ensuring the safety of those involved. The provider held separate meetings with the parents so that [REDACTED] could be included at the mother's meeting so as to engage her in a safe and confidential environment. The father will be referred [REDACTED].

- Deficiencies

None 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

None noted

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

None noted

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

None noted

### **Department Review of County Internal Report:**

The Department has received and reviewed the report provided by the county dated 8/10/15. We are in agreement with the county's findings.

### **Department of Human Services Findings:**

- County Strengths:

The county and provider agency provided clear documentation in the case notes and investigation report. All parties were interviewed. The county collaborated with law enforcement and the hospitals during the investigation.

- County Weaknesses:

None noted.

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

None noted.

### **Department of Human Services Recommendations:**

The county should continue to enhance all social workers skill levels in working with potential victims of domestic violence to provide any support needed to ensure safety for victims and children.