pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 8/19/12
Date of Incident: 3/15/13
Date of Oral Report: 3/16/13

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

4/11/14

This report is confidential under the provisions of the Child Protective Services Law and cannot be released. (23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law. (23 Pa. C.S. 6349 (b))

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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 convened a review team in accordance with Act 33 of 2008 related to this report on April 5, 2013.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]*	Mother	[redacted]/90
[redacted]	Father	[redacted]/89
[redacted]	Child	8/19/12
[redacted]	Sibling	[redacted]/12
[redacted]*	Sibling	[redacted]/07

*Signifies that the individual does not reside with the child. [redacted]

Notification of Fatality / Near Fatality:

On 3/16/13, the Philadelphia Department of Human Services received a call [redacted] concerning [redacted], age 7 months. [redacted] allegedly had [redacted]. It was determined that these injuries were consistent with [redacted] had been at the home of [redacted], who were babysitting while her father, [redacted], was working. Mr. [redacted] reported that she was stiff and that she was not breathing. [redacted] was asked to bring [redacted] twin sister [redacted] in for examination, and it was found that she also had [redacted], though her injuries were not as serious as [redacted] injuries. [redacted] was placed in foster care on 3/18/13 as a plan of safety.

Documents Reviewed and Individuals Interviewed:
The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past records pertaining to the [redacted] family, including the [redacted]. Follow-up interviews were conducted with the Social Work Services Manager, [redacted], on 6/13/13, as well as [redacted]. staff on 6/12/13, the ongoing Social Work Services Manager, [redacted] on 1/8/14, and the Family Empowerment Services (FES) supervisor, [redacted] on 1/10/14. Two Incident Reports, posted on the Home and Community Services Information System (HCSIS), were reviewed regarding [redacted] recent hospitalizations.

Summary of Services to Family:

Previous Children and Youth involvement:

12/31/07

The family, including mother, who was a minor child in foster care, was accepted for Services on the day that [redacted] was born. She lived with her mother in a [redacted]. foster home, and then placed in a mother-baby Supervised Independent Living (SIL) program. On 4/4/10, DHS visited the home unannounced and found that [redacted] had moved her paramour into the SIL apartment, [redacted] was under the influence of alcohol, and [redacted] had left [redacted] in the care of an aunt, who was not cleared to supervise children. On 4/12/10, DHS removed [redacted] from her care and placed with a relative temporarily. [redacted]

8/19/12

[redacted] were born.

10/5/12

11/14/12 General Protective Services Report Screened Out

DHS received a GPS report that [redacted] was hospitalized for [redacted]. The mother was not visiting the child often and the father was in Baltimore with the twin, [redacted]. The mother had missed five appointments related to [redacted], and the mother was not cooperative in obtaining required training. This report was screened out by the DHS hotline, because the report did not meet the Hotline-Guided Decision Making criteria, for lack of information. This report was rejected by the DHS hotline for lack of information.

11/15/12 General Protective Services No Findings Present-Invalidated

DHS received a second GPS report about the same allegations that were rejected the previous day. [redacted] was not possible until one of her parents completed training to care for her. The case was assessed and the [redacted] concerns were not validated. The family was given Family Empowerment Services through [redacted].

1/30/13 to 3/5/13

[redacted] provided Family Empowerment Services (FES) to the family. The father, [redacted], was living in a 10x8 room with his daughters, who slept in a single Pack n Play and he shared a bathroom and kitchen with other individuals in the house. The [redacted] worker and supervisor made

numerous visits to the home, [redacted] the father stated that he had these items at the mother's house. He had not retrieved the crib and the refrigerator during the time he received services. [redacted] also found a home where he could rent 2 rooms and have free childcare from an individual who had received clearances but he refused. [redacted] staff encouraged him to change the recipient of the children's cash and food stamps from the mother to him but he was reluctant to sever his relationship with the mother. He stated frequently that the mother was caring for the children while he was out looking for a job, but it was later revealed that he left the children with various caregivers. After a report was made to DHS on 2/28/13 about [redacted], he became extremely defensive, missed or would not schedule visits, and was not available by phone, when [redacted] staff were [redacted]. This service is voluntary and the agency is not expected to file a report of child abuse or neglect if the family is not cooperating with services.

2/28/13 General Protective Services Validated
DHS received a GPS report stating that [redacted] had marks on their faces, and bruises on the sides of their knees, and [redacted] allegedly had [redacted]. The father stated that he placed the children in their playpen when he went to the bathroom. While in the bathroom he heard a scream. He was not able to explain the girls' injuries. At the time, the father was the sole caregiver to the children. [redacted]

Circumstances of Child's Near Fatality:
On 3/15/13, [redacted] had been at the home of [redacted], who were babysitting while her father, [redacted], was working. Mr. [redacted] reported that [redacted] was stiff and that she was not breathing. He did chest compressions and a rescue breath, and [redacted] began breathing. He brought [redacted] to the St. Christopher's Hospital Emergency Room, where she had [redacted] and other tests. [redacted] father, [redacted], was asked to bring [redacted] twin sister [redacted] in for examination. It was found that [redacted] also had [redacted], though her injuries were not as serious as [redacted] injuries. On 3/16/13, the Department of Human Services received a call [redacted] stating that [redacted] was in critical condition for a [redacted]. It was determined that these injuries were consistent with [redacted].

DHS Social Worker, [redacted], interviewed all relevant family members, including father, mother, the babysitters [redacted], the father's paramour, police personnel from the Special Victims' Unit (SVU), and all relevant medical professionals. The DHS investigator conferenced with the DHS supervisor as required for guidance. DHS also reviewed all relevant medical documentation for both [redacted].

On 3/18/13, [redacted] was placed in foster care with [redacted]. On 3/27/13, [redacted] was [redacted] and placed in [redacted] foster home with [redacted].

On 3/19/13, the family was accepted for services.

On 5/10/13, DHS submitted the CY48 for the near-fatality, determining that the case would be unfounded, as the identity of the perpetrator was unknown.

Current/most recent status of case:

- The family has been accepted for services and both children are now placed in foster care.
- No criminal charges have been filed, as there is no clear perpetrator who caused the injuries.
- The permanency goal is reunification. [redacted] older sister [redacted] was adopted by her foster parents on 9/9/13.
- [redacted] was placed in a foster home through [redacted]. She was moved to the same foster home as her sister on 1/4/14.
- [redacted] has been placed in [redacted] foster home through [redacted], where she is progressing remarkably well, according to medical professionals. She is [redacted]. She is diagnosed with [redacted], which the foster parent has been managing well, as the foster mother has the same diagnosis.
- [redacted] has been in the hospital twice, once on 4/8/13 for [redacted] and again on 6/25/13 for weight loss.
- [redacted], because it was unknown who caused the injury.
- Both girls are allowed visits with their parents but visits have been inconsistent. Father, [redacted] has moved to [redacted], North Carolina and he was stating that he would return some weeks for visits with the children. DHS has [redacted] for some visits and now he and his new wife drive to Philadelphia periodically to visit with [redacted].
- Family Group Decision Making services have been implemented. The paternal grandparents have been involved in meetings over the phone, as they reside in [redacted], MD.
- Team members are planning for reunification with the father and his new wife. Clearances have been completed for his wife and her mother, who will also reside in the home as a support for the father. He will need to take [redacted]. He has been attending parenting classes in North Carolina.
- The father is reportedly working as a chef in [redacted], North Carolina.
- The mother's whereabouts are unknown. DHS has visited her last known address, left a letter, and no response has been received.
- [redacted] receives [redacted] services in the home and at [redacted], and doctors report that she is progressing extremely well.
- [redacted] is not receiving [redacted] services because she is not eligible for services and the [redacted] is continuing to monitor her development.
- The concurrent plan for both girls is adoption by the foster parents.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

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.

- Strengths: None identified in the Act 33 report.

- Deficiencies: The team agreed that the GPS dated 11/15/12 should have been validated or had findings present because the allegations were true and the father did not comply until after DHS had begun the investigation.

  Team members felt that Family Empowerment Services, a voluntary service, was not appropriate for the father, as he did not follow through with referrals and refused assistance to locate more suitable housing. If the parent's refusal of voluntary services necessitates a child abuse referral, voluntary services may not be appropriate for that parent. When [redacted] closed the case and reported that the father's objectives were met and it seemed that all appropriate referrals were made for the family, the objectives were not truly satisfied because he had not achieved the goals of the service.

  The team believed that DHS should have discussed with father how to obtain sole legal custody of the children at the time of the 11/15/12 GPS report. DHS should have examined mother's parenting skills more thoroughly, [redacted].

- Recommendations for Change at the Local Level: The team recommended that DHS establish a mechanism for prevention service providers to follow up with DHS when goals are not fully met or if there are concerns that do not rise to the level of a child abuse or neglect report.

- Recommendations for Change at the State Level: None identified in the Act 33 report.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county. In the Act 33 report, the county addressed the concern that the case was referred for a service, Family Empowerment Services that did not match the family's needs, as that service is voluntary. The county also highlighted some concerns with a prior report in November 2012.
The Department agrees with the Act 33 report.

Department of Public Welfare Findings:

- County Strengths: None

- County Weaknesses: The father was referred for voluntary in-home services at the conclusion of a previous case and discussions indicated that a different, non-voluntary service would have been more appropriate to support this father, and that these services were discharged when it was determined that the appropriate referrals had been made.

- The County CPSL investigation was closed as unfounded because the county investigation could not identify a perpetrator.

- Statutory and Regulatory Areas of Non-Compliance: None

Department of Public Welfare Recommendations:

- It is recommended that DHS staff require that all in-home services be maintained until the achievement of a goal, such as achievement of housing, rather than allowing agencies to discharge services based on referrals made.

- It is recommended that, while DHS social workers are working to reunify children with their parents, family finding be implemented to evaluate if other family members could be visiting or permanency resources for the children. (Fostering Connections, Act 115 of 2010, Concurrent Planning).

- It is recommended that siblings be placed in the same foster home if at all possible, unless there is a logical reason to separate them, even if a move would require another foster home move. Particular care should be taken with siblings who are multiples, to preserve the special bond that exists between multiples.

- It is recommended that a parent locator search be completed for the mother.