pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/07/07
Date of Incident: 04/7/13
Date of Oral Report: 04/7/13

FAMILY NOT KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON:
01/17/14

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 convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 review team meeting was held on April 19, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/07/2007
[redacted]**	Mother	[redacted]/1986
[redacted]*	Father	[redacted]/1984
[redacted]	Maternal Grandmother	[redacted]/1966
[redacted]	Step Father	[redacted]/1985
[redacted]*	Paternal Grandmother	[redacted]/1951
[redacted]*	Step Mother	[redacted]/1982

*Designates the person is not a household member and did not live in the home at the time of the incident

** The Father of the victim child was not a household member but had partial custody at the time of the incident

Notification of Child Near Fatality:

Philadelphia Department of Human Services (DHS) received a referral for alleged child abuse on April 7, 2013 for [redacted], age 6. Child was in severe respiratory distress with swollen lips and face when he was seen at the Children's Hospital of Philadelphia (CHOP) on April 7, 2013. Child has known allergies to certain foods and also has a history of asthma. When the child was seen at CHOP by medical staff, it was determined that the child was in a critical condition due to medical neglect.

Summary of DPW Child Near Fatality Review Activities:

The Department of Public Welfare, Southeast Regional Office of Children Youth and Families obtained and reviewed documentation of the case of near fatality for the victim child. The Regional Office participated in the County Internal Fatality Review Team meeting on April 19, 2013. A follow-up conversation was conducted with the county caseworker on June 5, 2013.

Children and Youth Involvement prior to Incident:
There was no Children and Youth involvement with this family prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:
The date of the incident which began the Child Protective Service (CPS) Investigation was April 7, 2013. The investigation began after medical professionals at CHOP determined that the victim child was in a critical condition due to medical neglect on April 7, 2013. The near fatality CPS report was assigned on 11:35am on April 8, 2013 to begin the required investigation. The mother of the victim child was identified as the perpetrator in the [redacted] report and listed on the [redacted] document. The father was on the [redacted] but during the investigation, it was determined that the victim child's mother proved to be at fault [redacted]. After the [redacted] medical neglect was stated, a referral was made to ChildLine.

The victim child's condition started when he was in the care of his bio-father on the afternoon on April 7, 2013. The child's birth parents are married and living separately in their own households. The child visits the father every other weekend per court order. The child was picked up by the father from his mother's residence on Friday April 5, 2013 about 6pm. The child had a cold and had brought cold medicine and his inhaler with him. The child normally has an inhaler with him to remedy symptoms of asthma that flare up constantly. The child also has known allergies to certain foods if exposed to them. On Sunday April 7, 2013 around 2pm the father noticed the child was having difficulty breathing. The child was given a couple of puffs from the inhaler. The child was also given his cold medicine after using the inhaler. The child threw up about 20 minutes later after taking the medicines provided. The father then decided to take the child to Temple University Hospital Emergency Room. He then decided against it because he did not have the medical insurance information for the child. Father called the Maternal Grandmother (MGM) to find out about the medical insurance and where the child could be seen. The MGM lives in the home with the mother of the child and her husband. MGM told the father to bring the child home and they would take the child to CHOP. The father avoids talking directly to child's mother because they normally argue. The father reported that the child was playing basketball and believes the child's symptoms were asthma related. The father brought the child back home at about 4:20pm on April 7, 2013. The child's step father was at the home to receive the child. At that time, the father reports that the child appeared to be doing better and was asleep.

When the child was brought back home the mother reported that the child was in severe respiratory distress and had facial swelling. The child was then taken to the hospital per statement from the mother. The mother made a video asking the child leading questions about his condition instead of taking the child immediately to the hospital. The video that was reviewed by the DHS caseworker shows the child in a very drowsy state and appearing to have difficulty breathing. The severe condition reported by the mother seemed to be in question by the DHS caseworker after reviewing the video. In the video the child is drowsy responding to the mother's leading questions, there is difficulty breathing but there was no swelling noticed. The video was made at 4:35 pm after the child's father brought him back home. The child's mother stated she made the video because she wanted the hospital to see the condition the child was in. The mother

was also questioned as to why she didn't take the child to a closer medical facility. Mother stated she wasn't "thinking straight" and was just used to going to CHOP. Victim Child's mother did not bother to call an ambulance because she believed the ambulance would have taken too long. Another concern about the mother's activities was that she did not provide the father with medical insurance information and did not [redacted]. The child needed [redacted] because the old one broke after the child had [redacted]. Mother has also admitted that she had not been giving the child [redacted]. Child had been referred for allergic testing by his pediatrician but the mother failed to do follow up with this. Also the investigation revealed that the mother did not arrive at CHOP until 6:45pm per hospital records.

When the child did arrive at CHOP the medical team realized his condition was severe and near fatal. Hospital staff also stated that if the child had been further delayed in his arrival it would have been a fatality. [redacted] that the child did suffer neglect for the delay of necessary treatment that would have remedied the child's condition much sooner. The report was indicated with the mother as the perpetrator on May 9, 2013. During the investigation and by the mother's own statements it revealed that the mother withheld medical insurance information from the child's father, did not take the child to seek medical professional help prior to his condition becoming severe, did not get allergy testing as required by the child's pediatrician, and did not timely [redacted] for the child when the old one broke.

Current Case Status:

Victim child [redacted] on April 8, 2013 and returned to his mother's home. On April 9, 2013 the home of child's mother where child was residing was visited and the home was found to be safe and suitable. On April 16, 2013 a Safety Assessment was completed in the home of the child's mother and on May 3, 2016 a Safety Assessment was completed at the residence of the child's father. [redacted] A safety plan was prepared and signed by the child's parents for their respective homes. The child was then determined to be safe with a plan. However on April 18, 2013 information from CHOP was received by DHS concerning the severity of the child's condition on April 7, 2013. The key point provided by CHOP was that it was highly unlikely the child's respiratory distress and facial swelling had occurred more than one hour before he was examined at CHOP. [redacted] for the victim child and he was placed in a foster home through [redacted]; the child is currently in foster care. The Placement goal is Reunification. [redacted]

On April 30, 2013, [redacted] was re-unified with his father [redacted]

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

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ChildLine. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 review team meeting was held on April 19, 2013.

- Strengths:
  Investigation was well done, including thorough documentation.
  Social worker utilized the chain of command to assist with decision making and in the assessment of the family dynamics.
  Social work documentation was thorough.

- Deficiencies:
  None identified

- Recommendations for Change at the Local Level:
  No Recommendations at this time

- Recommendations for Change at the State Level:
  No Recommendations at this time

Department Review of County Internal Report:
The county provided reports to the department in timely manner, all reports reviewed were complete and the content was consistent. Required documents were completed within the correct time line. The county social worker made initial contacts with all other services, departments, and individuals.

Department of Public Welfare Findings:

- County Strengths: Notes in the file demonstrate an extensive and thorough interview process with the family. Case file documents a careful review process of family members and caretakers involved with the victim child.

- County Weaknesses: The child was returned home to his mother's care on April 8, 2013 prior to a Home Safety Assessment being completed. The Home Assessments were completed on April 16, 2013. Also the County worker did receive important information from CHOP regarding the child's care and their assessment of illness/injury on April 11, 2013 after the child was returned home. The information that the County received from CHOP regarding the medical treatment and assessment led to the decision the County made to [redacted]. This could have been done sooner to avoid having the child return to and remain in an environment where questions of safety were still unanswered.
- Coordination with hospital staff could have been conducted better to avoid delaying the safety assessment and receiving facts that the hospital staff had regarding the mother's role in facilitating proper medical care for the victim child.

- Statutory and Regulatory Areas of Non-Compliance:
  No areas of non-compliance cited

Department of Public Welfare Recommendations:

Pediatricians should ensure that parents are fully aware of the child's medical needs and treatment.