pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/16/2013
Date of Incident: 11/21/2013
Date of Oral Report: 11/22/2013

FAMILY NOT KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
06/16/2015

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 convened a review team in accordance with Act 33 of 2008 related to this report on March 11, 2014.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/16/2013
	Mother	[redacted]/1990
	Father	[redacted]/1984
	Sibling	[redacted]2010
	Non-case Adult	Adult Male

Notification of Child (Near) Fatality:

On November 22, 2013, the Department of Human Services, (DHS), received a [redacted] report alleging that the six month old victim child, (VC), was brought to the emergency room at Children's Hospital of Philadelphia, (CHOP), with seizure- like activity. [redacted] The VC was in critical condition and his injuries were concerning for non-accidental trauma. The VC was admitted [redacted] The family was unable to provide an explanation for the VC's injuries. The mother reported that she was home alone with the VC prior to his hospitalization.

The parents spoke only Spanish and an interpreter [redacted] was used.

The VC's mother and father denied that they had done anything to harm him. The parents were unable to recall any recent trauma that might explain the VC's injuries. They did report that the VC's two-year old cousin had pulled the VC off the bed two months ago, and that the VC had hit his head on the hardwood floor. The mother stated that she contacted the VC's primary care doctor when the fall occurred and she was told that she did not need to seek any further care for him. [redacted]
Efforts were made to have the VC's sibling placed with relatives, but the DHS Hotline was

unable to complete criminal and child abuse clearances due to immigration issues and a lack of social security numbers. Neither parent is a United States citizen [redacted]

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Region Office of Children Youth and Families obtained and reviewed records pertaining to the [redacted] family. The regional office participated in the County Internal Fatality Review Team meeting on 12/20/2013.

Children and Youth Involvement prior to Incident:

The family had no prior history with DHS.

Circumstances of Child (Near) Fatality and Related Case Activity:

On November 22, 2013 the Department of Human Services received a [redacted] report alleging that the six month old VC was brought to [redacted], at CHOP, with seizure-like activity.

The mother stated that on November 21, 2013 she was home alone with the VC. The mother stated, through an interpreter, that she found the VC to be a little fussy. The mother states she changed the VC's diaper, laid him down in the middle of the bed and went to make a bottle. The mother stated when she returned to the VC with the bottle, his eyes were closed and he was not moving. The mother stated she picked the VC up and his body was stiff. The mother stated she took the VC for some fresh air and he opened his eyes slightly. The mother states she called the father. When the Father arrived home, they ran outside to the corner to get a taxi to take the VC to CHOP [redacted] The VC was brought to the CHOP with seizure-like activity. [redacted] The VC was in critical condition and his injuries were concerning for non-accidental trauma. The VC was admitted [redacted] The family was unable to provide an explanation for the VC's injuries.

The mother reported that she was home alone with the VC prior to his hospitalization. The mother stated that the other three other adults who live in the home work and were not present at the time the VC's incident occurred. The mother denied that any of these people provide care for the VC.

The mother stated that the VC's two year old cousin pulled him off the bed two months ago. The mother did not have any explanation for the recent trauma.

During a visit to the family's home, the [redacted] Manager noted that the VC's and his sibling's bedroom could not be easily accessed by anyone other than the mother and the father.

The VC's older sibling, was interviewed at the Philadelphia Children's Alliance on November 29, 2013, however he was unable to provide information about the cause of the VC's injuries.

On January 17, the [redacted] CY 48 was completed as [redacted] based on medical evidence that the injury was non-accidental in nature.

Current Case Status:

At the time of the report the family did not have an open case with DHS and therefore was not receiving DHS services.

On November 23, 2013, the VC's Sibling was placed in a general foster home with [redacted] On November 26, 2013, the VC [redacted] and placed in the same foster home with his sibling. [redacted] Staff reported that the parents have been interacting well with their children.

The mother attends all the children's appointments. [redacted]

The [redacted] Police Department has closed its investigation and will not be pressing charges.

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

Strengths:
The team felt that the [redacted] did an excellent job investigating the case and conferencing with his chain of command.
The team noted that the [redacted]s documentation was thorough, citing all of his interactions with his supervisor, medical staff, and the [redacted] Police Department.

Deficiencies:
The team recommended that the [redacted] re-interview the family, including grandparents and other relatives, in the event that they might be withholding information due to their fear of immigration issues.

Recommendations for Change at the Local Level:
There were no recommendations in this area.

Recommendations for Change at the State Level:
There were no recommendations in this area.

Department Review of County Internal Report:

The Department reviewed the county's report on 03/14/2014. The Department concurs with the Counties findings.

Department Of Public Welfare Findings:

County Strengths:

Thorough documentation of the investigation was done by the county.

County Weaknesses:
None Noted

Statutory and Regulatory Areas of Non-Compliance:
None Noted

Department Of Public Welfare Recommendations:
The county should establish a relationship with the immigration department to be able to secure a resource person within their department who would be able to help them maneuver within the immigration system to help families.

Spanish-speaking staff should be utilized with families who are not primarily English-speaking. While this may be difficult with the 24 hour contacts, it would benefit the families and the investigation if the worker was Spanish-speaking. Use of [redacted] may hinder open communication with the families who are already mistrustful of the system because of their immigration.