pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/06/12
Date of Incident: 08/10/13
Date of Oral Report: 08/12/13

FAMILY NOT KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

06/22/2015

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. The Philadelphia County Department of Human Services convened a review team in accordance with Act 33 of 2008 on 9/6/13.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim child	01/06/12
	Mother	[redacted]/91
	Father	[redacted]/85
	Sibling	[redacted]/10
* [redacted]	Paternal Aunt	Adult
* [redacted]	Babysitter	[redacted]/75

Notification of Child Near Fatality:

On 08/10/13, the Philadelphia Department of Human Services (DHS) received a [redacted] report regarding twenty month old victim child. In the report, it was alleged the child had fallen out of her crib the day before, on 08/9/13, while playing with her sister who was about two weeks short of her third birthday. The parents were not present during the incident. A friend of the family was babysitting the two children. The babysitter said he was in the bathroom and he heard a thump. When he came out of the bathroom, he discovered the child; she was lying on an air mattress next to the crib and was not breathing. The child was transported to St. Christopher's Hospital for treatment. A report was not taken initially, because the child's injuries appeared to be consistent with the fall. Further examination revealed a [redacted]. Her injuries were then determined not to be consistent with falling out of her crib.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all records pertaining to the family upon receipt of the case record on August 21, 2013. Follow up interviews were conducted. SERO attended the DHS Act 33 review team meeting for this case on 9/6/13.

Children and Youth Involvement prior to Incident:

The family was not known to Children and Youth prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 8/10/13, Philadelphia DHS received a [redacted] report alleging that the child fell out of a crib on 08/9/13. The child was discovered by her babysitter and she was not breathing at 11:00 p.m. The child was transported to St. Christopher's Hospital for treatment 12:38 a.m. on 08/10/13. She arrived at the ER at about 1 hour and 38 minutes after the injury. An examination revealed a [redacted]. Her injuries were not consistent with falling out of her crib. The child was placed [redacted] in the hospital, [redacted]. The child went [redacted].

This case was assigned to a Hotline Social Work Services Manager (SWSM) to immediately assess the safety of the child and her sister. The Hotline SWSM reviewed the child's old and new injuries with St. Christopher's staff and with the mother. The father was not present at the hospital because he was removed by hospital security after throwing a chair in the waiting room. The mother provided explanations for the child's old injuries and reported that she was treating the diaper rash. The mother did not have an explanation for the new injuries, but denied that she or the father abused the children. She reported that the child was in the care of the babysitter at the time she was injured. The mother agreed to have her other daughter examined, and the examination did not reveal any signs of abuse or neglect. The St. Christopher's Hospital [redacted] allowed the oldest victim child [redacted] to her paternal aunt who lives in [redacted], Pennsylvania. This was an informal agreement, as a result of the child being Safe with a Plan, as per the Safety Plan dated 8/11/13. The aunt reported the girls had previously resided with her because the parents did not have appropriate housing.

Upon further examination, the victim child [redacted] resulting from blunt impact. She also had a [redacted]. The medical team determined that [redacted] were consistent with the force resulting from falling out of the crib.

[redacted] CUA assumed management of this case on 9/10/13.

[redacted]. Police did not pursue criminal charges.

The child was [redacted] from CHOP on 11/06/13 into the care of paternal aunt.

Current Case Status:

The children remain in the care of her paternal aunt in [redacted], PA. The parents have supervised visits at the aunt's home under her supervision. The oldest child attends a day care in

Chester County. The victim child attends [redacted] Day Care in Chester County. She receives [redacted] at the day care and also at home. [redacted] The child [redacted] is also able to eat by mouth. The caseworker reported that the child had a [redacted]. She was [redacted]. She has sight in her right eye, but only has peripheral vision in her left eye. She is unable to sit up or walk. [redacted] was discontinued, and she is able to talk.

The child remained at CHOP-[redacted] until 11/6/13. Upon [redacted] she began living with the paternal aunt. [redacted] has been in the custody of her paternal aunt also, since 8/10/13. [redacted] The father also had not fulfilled any of the recommendations [redacted], which include [redacted], attending parenting classes, and attending domestic violence classes. The mother has completed [redacted], her domestic violence classes, and parenting classes. The mother also attended medical training to help provide care for the child [redacted]. The father has not attended the medical training.

The parents also have a history of domestic violence. [redacted] The mother will continue to have supervised visits by the aunt at the aunt's house. The aunt was warned not to allow the father to have any visitation with the children. The mother and father no longer live together. The aunt has assured he will not be allowed around the children.

[redacted] The permanent placement goal is for the children to return to the mother.

[redacted] the perpetrator failed to seek medical attention for the child, which was reported to be one of the major causes of her injury. The significant time in the delay of medical attention was said to have worsened the child's injury.

There were no criminal charges filed against the babysitter.

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

<u>Strengths:</u>

- Philadelphia DHS did a good job investigating the case and sorting out the inconsistencies in the accounts of the events that occurred.
- The MDT SWSM documentation was thorough, citing all of the interactions with the supervisor, medical staff, and the [redacted] Police department.

Deficiencies:

- There were none identified.

Recommendations for Change at the Local Level:

- Since the family was not known to Children and Youth, there are no recommendations for change at the local level.

Recommendations for Change at the State Level:

- None

Department Review of County Internal Report:

The Department concurs with the county report's findings.

Department of Public Welfare Findings:

County Strengths:

- Philadelphia DHS was able to identify a family member who could provide care for the children.

County Weaknesses:

- There were none identified.

Statutory and Regulatory Areas of Non-Compliance:

- There were none identified.

Department of Public Welfare Recommendations:

The Department recommends that the county continue to conduct thorough investigations and continue to provide their standard of excellence with regard to their documentation.