



## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 12/11/2015**

**Date of Incident: 02/25/2016**

**Date of Report to ChildLine: 02/26/2016**

**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO CHILDREN AND YOUTH AGENCY AT TIME OF  
INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Philadelphia County

**REPORT FINALIZED ON:**

**8/16/16**

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:**

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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 the Child Protective Services Law related to this report. The county review team was convened on 04/01/2016.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	victim child	12/11/2015
[REDACTED]	mother	[REDACTED] 1990
[REDACTED]	father	[REDACTED] 1990
[REDACTED]	sibling	[REDACTED] 2015
[REDACTED]	half sibling	[REDACTED] 2007
[REDACTED]	half sibling	[REDACTED] 2010
[REDACTED]	maternal grandmother	adult
* [REDACTED]	father of half siblings	adult
* [REDACTED]	paternal grandmother of half siblings	adult

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

**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, siblings, and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the investigative social worker as well as the social worker from the community umbrella agency. SERO attended the Act 33 Review Team meeting held on 04/01/2016.

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

The family had no prior history.

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

On 02/26/2016, the county received a Child Protective Services report alleging that the two month old child suffered [REDACTED]. The father reported the child fell off a changing table in a restaurant bathroom and became unresponsive. The father rushed the child to the closest hospital on foot where the child required cardiopulmonary resuscitation (CPR). Upon examination, it was determined that the injury was not consistent with the father's explanation. The child was transferred to the Children's Hospital of Philadelphia (CHOP) for additional testing and care [REDACTED]

[REDACTED] The cause of these injuries is unknown but is concerning for abusive head trauma. The father's behavior was erratic and threatening so he was banned from the hospital.

The safety of the child and his siblings were immediately assessed. Safety threats were identified. The children were examined by a physician. The two older siblings had no signs of injury, however, the child's twin had several injuries including a [REDACTED]. Both the victim child and the twin were seen for a well child visit with their pediatrician 3 days prior to the near fatality incident. The twin was [REDACTED] she was placed in foster care. The mother stated that she allows the maternal grandmother to care for the children even though she has a history of mental health issues and is [REDACTED]. The mother also assisted the father with access to the victim child although he had been banned from the hospital with no contact with the children. The older half-siblings were moved to their paternal grandmother's home with their biological father who has filed for custody with in-home safety services in place. Eventually, the victim child was [REDACTED] [REDACTED] for several weeks before being placed in foster care with his twin. Paternal relatives were ruled out due to concerns they would allow the father access to the children. The mother and father were married on 03/05/2016.

Interviews with all relevant parties occurred. The county indicated reports on both the father and mother for both the victim child and the twin on 03/28/2016, for causing serious physical neglect of a child by repeated, prolonged and egregious failure to supervise. The mother is a perpetrator by omission due to her inappropriate response to the incidents. The father is a perpetrator by commission due to his statement not being consistent with the injuries sustained. The father was arrested on 05/11/2016 charged with aggravated assault, endangering the welfare of a child, simple assault and endangering the welfare of another person,

and remains incarcerated at this time. He has no contact with the children. The mother has supervised visits. She continues to deny any form of domestic violence.

The family was accepted for service on 02/29/2016. Services include case management, foster care placement, [REDACTED]

[REDACTED] The mother has been minimally compliant with the service plan goals. She has declined parenting classes, has yet to pursue [REDACTED] and has not had a substance abuse screening.

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

- Strengths in compliance with statutes, regulations and services to children and families;  
The team felt the SW did a great job investigating the report.
- Deficiencies in compliance with statutes, regulations and services to children and families;  
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; and  
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 06/28/2016. We are in agreement with the county's findings.

**Department of Human Services Findings:**

- County Strengths:  
There was clear documentation in the case notes and investigation report. File documentation appeared up to date. All parties were interviewed. Timely safety assessments were made on the other children residing in the home. Assessments resulted in relevant services for the family. The children were

placed together in the same [REDACTED] foster home ensuring family connections. Medical needs are being addressed appropriately.

- 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 support needed to ensure safety for victims and children.