pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/20/2012
Date of Incident: 1/28/2013
Date of Oral Report: 1/28/2013

FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY

REPORT FINALIZED ON:

August 14, 2013

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. The Philadelphia County Act 33 team met on February 15, 2013

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	12/20/2012
	Biological Mother	[redacted]/1992
	Biological Father	[redacted]/1990
	Maternal Grandmother	[redacted]/1953
	Biological Mother's Sibling	[redacted]/1976

Notification of Child Near Fatality:

On 01/28/13, the victim child arrived at Children's Hospital of Philadelphia (CHOP) Emergency Department with apnea; at the hospital she was examined and it was determined that she had posterior rib fractures, [redacted]. There were concerns for non-accidental trauma. The victim child was expected to survive with serious [redacted] as reported by Dr. [redacted] who certified the incident as a near fatality. The parents were not able to provide an explanation as to the cause of the child's injuries. Medical evidence indicated the injuries were the result of inflicted trauma.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current and past case records pertaining to the victim child. Contact has been made with the ongoing DHS social worker, foster parent, and the provider case manager to obtain current information on the victim child. The regional office also participated in the County Internal Fatality Review Team (Act 33) meeting on February 15, 2013 at the medical examiner's office.

Children and Youth Involvement Prior to Incident:

The family did not have prior involvement with The Philadelphia Department of Human Services and there were no prior reports.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child was transported by her mother and maternal grandmother to CHOP on 01/28/13 for difficulty breathing. Once examined, it was determined that there were injuries: posterior rib fractures, [redacted] She was expected to live but would have serious [redacted] Certification for the near fatality was completed by Dr. [redacted] and obtained by DHS. CHOP informed the DHS social worker of the presenting injuries and there was no known cause at the time. The physician also reported that the victim child had serious [redacted] that were healing. A full skeletal survey could not be done because the victim child was too fragile.

The DHS social worker followed up with notifying the Philadelphia Police Department, Special Victims Unit (SVU) and completed the [redacted]. There were no identified alleged perpetrators at the time the CY-104 was submitted. The case was investigated by SVU. The DHS social worker was instructed by their legal department to determine during further investigation if the victim child would remain in the hospital, and if so, there would not be a need to obtain Order of Protective Custody, (OPC). Continued assessment of the victim child's safety while she remained in the hospital was to ensure that visits from the biological mother and family were supervised, mainly because there was no identified alleged perpetrators and the nature of the injuries had not been determined. DHS and their legal department agreed to the hospital safety plan that the victim child would remain in a controlled environment and that she would not be released to the biological mother. On February 8, 2013, an OPC had to be obtained due to the biological mother threatening to remove the victim child from the hospital.

Conference calls were held in order to obtain the victim child's medical records. Parties involved were the MDT Supervisor and social worker; the DHS Nurse; [redacted] Supervisor and Visiting Nurse. Records reviewed by the DHS social worker summarized the number of visits to the home. There was no indication of trauma, bruises, physical abnormalities or respiratory issues. [redacted] were in the home to monitor feedings and stated that the victim child had gained weight. [redacted] has provided services in the home since the victim child's birth. There was constant communication between medical professionals, St. Christopher's Hospital for Children, CHOP and [redacted] in regards to the victim child's treatment. The child protective team at CHOP determined that there was no apparent congenital or underlying medical condition that would have led to the multiple injuries and trauma.

The maternal grandmother (MGM) reported to St Christopher's hospital that she has custody of the victim child. The DHS social worker initiated the request that the legal department provide assistance with finding out if the MGM has custody. Results were that the MGM does not have custody of the victim child, documentation confirmed by the Deputy City Solicitor.

[redacted]

According to the biological mother, she visited their home in Sharon Hill, PA in January 2013. She also stated that she believed the niece could have dropped the child; however, she could not provide any other information in regards to the victim child being dropped. The biological mother also stated that the biological father could have dropped the child because he was not good at taking care of the child. [redacted]

During the interview with SVU and the DHS social worker, the biological mother stated that the victim child was holding her breath which is something that the biological mother observed in the past. The mother stated she would give her own breath by breathing into the victim child's mouth. On the day of this incident, the biological mother observed the victim child holding her breath and thought it would be best to transport her to CHOP on public transportation (SEPTA). She felt that the bus would be faster than calling 911.

The biological mother did not take the victim child to St. Christopher's Hospital stating they were aware that the victim child had problems breathing but would not do anything about it. St. Christopher's physicians were not aware that the victim child had breathing problems and there is no documentation that it was ever reported by the biological mother to anyone at St. Christopher's.

The biological mother gave birth to the victim child at Temple Hospital; medical records were requested and reviewed by medical professionals at DHS to determine if there was documented medical information to show previous injuries or if the victim child was born with an injury that could have led to some of the injuries observed upon her admission to CHOP. There was also the need to determine and attempt to identify if the victim child's birth was a difficult one.

Pediatric well baby appointments were maintained by St. Christopher's Hospital, who reported concerns regarding the victim child's slow weight gain and possible "failure to thrive".

The victim child's injuries are consistent with abuse; however the biological mother denies ever using any form of physical discipline. DHS has identified a medical foster family through [redacted] for the victim child. The family resides in Richfield, PA. The foster mother visited the child several times at CHOP. Upon discharge from CHOP, a plan was made for the child to be transferred to the Gersengen Medical Center near the foster family's home where she would then be transferred to the medical foster home.

The [redacted] investigation was [redacted] against the biological mother on February 26, 2013 as a result of the medical evidence.

Current Case Status:

This case has been transferred to the Ongoing Department at DHS and the victim child is placed in medical foster care with provider; [redacted]. Social workers from DHS and the provider agency have been

assigned to make home visits and to monitor the victim child and the medical foster care home. The foster home is in Richfield Pa, Snyder County. The victim child receives [redacted] and is receiving [redacted]. Medical appointments are at the Gersengen Medical Center near the foster home. The medical foster parent reports that the child is cooing, lifting her head when lying on her stomach, responding to sounds and is familiar with her caregiver. The victim child has [redacted]. She has received [redacted] and according to the [redacted].
According to the foster parent and DHS worker, the biological mother has made very few visits. The transportation expenses would be paid by [redacted].

The biological mother and maternal grandmother were both arrested and are incarcerated at the [redacted] Prison. They were charged with criminal conspiracy, aggravated assault, endangering welfare and simple assault. No other court hearing has been arranged at this time.

Interviews were conducted by the Special Victims Unit. According to the detective, the biological mother continues to state that she does not know how the victim child obtained her injuries. The biological mother said she has never dropped, hit, shaken or handled the victim child in any way that would cause harm, and that the victim child did not appear to be in pain. The biological mother cared for the victim child including changing her diapers, bathing and feeding but never noticed any injuries.

During the interview, the biological mother also stated that she received pre and post natal care which was provided by St. Christopher's Hospital. The post natal care consisted of visiting home nurses, who were in the home to monitor the victim child's weight, as there have been signs of slow weight gain since birth. The victim child was released from the hospital several days before the biological mother was released due to the mother's high blood pressure. The victim child was with the maternal grandmother until the mother's discharge.

There was some discrepancy in statements between the biological mother and maternal grandmother when they were interviewed by the detective. The police report indicated that the maternal grandmother stated that the victim child fell off of the bed before going to the hospital on 1/28; however, the biological mother stated that the victim child did not fall from the bed. An interview was conducted with the sister of the biological mother. She stated that her mother and sister "are sneaky and manipulative and have called DHS on her numerous times because she does not go along with their schemes".

The biological father was incarcerated at the time of the incident. He was incarcerated for robbery and arrested on 01/18/13. Notification of the incident was sent to him by mail. According to DHS documentation, the biological father is no longer incarcerated and has not had contact with the family or with DHS. His whereabouts are unknown.

The biological father was interviewed while incarcerated on 2/8/13; he stated that he cared for the victim child in the company of the biological mother and maternal grandmother. He also resided in the home before being arrested. The biological father stated that he noticed that the victim child had lost weight and was insisting that

she should get her feedings. He also stated that he did not notice that the victim child had problems with her breathing.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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. The Act 33 team met on February 15, 2013

Strengths:
None identified

Deficiencies:
None identified

Recommendations for Change at the Local Level:
Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect

- The Act 33 Team felt the social work department at Temple University should be counseled regarding their failure to act as a mandated reporter despite their concerns regarding the mother's parenting capacity.

Monitoring and Inspection of County Agencies

- The team recommended that DHS create a mechanism to track CPS reports in which abuse occurred but a perpetrator could not be indicated. Under the Child Protective Services Law, these cases are unfounded, resulting in an undercount of children who are abused.

Recommendations for Change at the State Level: NA

Department Review of County Internal Report:

DPW/OCYF is in agreement with the fatality review team recommendations related to the Temple University Hospital; the Department of Social Work at Temple University should receive updated in-service trainings on their role as mandated reporters, and the failure to act.

Department of Public Welfare Findings:

- **County Strengths:** The County conducted an exceptional interview with the biological mother, was able to obtain pertinent information that allowed for direct follow through with medical professionals who had provided previous medical treatment to the mother and baby.

This case involved intensive medical background. The county was able to collaborate with other professionals and performed good teaming in order to gather necessary documentation related to the case.

- County Weaknesses: **None Identified**

- Statutory and Regulatory Areas of Non-Compliance: **NA**

Department of Public Welfare Recommendations:

The Department recommends that the Act 33 team implement a process that will assist Temple Hospital, Social Work Department with obtaining appropriate training specific to mandated reporting regarding mothers' parenting capacity.