pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 7/4/11
Date of Incident: 4/10/13
Date of Oral Report: 4/11/13

FAMILY NOT KNOWN TO:

Philadelphia DHS

REPORT FINALIZED ON: 10/24/13

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 has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

AT TIME OF INCIDENT

Name:	Relationship:	Date of Birth:
[redacted]	Victim child	7/4/11
	Sibling	[redacted]/09
	Mother	[redacted]/94
	MGM	[redacted]/70
	MGU	adult
** [redacted]	Mother's paramour	[redacted]/95
** [redacted]	Paramour's brother	[redacted]/85

**Please note not residing in the family home, but acted as a caretaker for the child.

AT PRESENT

[redacted]	Victim child	[redacted]/11
	Sibling	[redacted]/09
	Father	[redacted]/92
	PGM	adult
	Step PGF	adult
	PAU	adult
	PAU	adult
	PUN	age 16

Notification of Child (Near) Fatality:

On 4/11/13, Philadelphia Department of Human Services (DHS) received a [redacted] report alleging the victim child was taken to Einstein Hospital where she was diagnosed with a [redacted]. She was then transferred to St. Christopher's Hospital and upon further examination was diagnosed with [redacted]. The child was listed in critical condition and it was unknown how the injuries occurred. [redacted]

The mother's paramour and his brother were the caregivers for the child over the days preceding hospitalization and family observed the child as not acting as herself and seeming unwell. The mother was advised by the family to take the child to the doctor; however, she failed to seek medical treatment for the child. On the date of incident, the child was found on the floor by the paramour with her eyes rolling to the back of her head. He attempted CPR. Child was transported by MGM and MGU and arrived at the hospital cold and unresponsive.

Summary of DPW Child (Near) Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation. SERO reviewed the county's investigation/assessment, structured case notes, safety assessments, safety plans and risk assessments. Interviews were completed with the investigative social worker and supervisor, as well as the On-going social worker. SERO attended the Act 33 Review Team meeting held on May 3, 2013.

Children and Youth Involvement prior to Incident:

This family had no prior history with the agency; however, the mother's paramour was active with DHS as a minor in the past. In 2002, DHS identified his mother as a [redacted]. He is reported to have a history of drug abuse and [redacted], as well as inappropriate sexual contact with a sibling at the age of 8.

It should also be noted that the victim child's mother has a juvenile criminal history.

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

DHS received the referral regarding the child on 4/11/13. The case was assigned to the Multidisciplinary Team (MDT) for investigation. The child's sibling was [redacted] to be examined. There were no injuries noted. A [redacted] was scheduled for the sibling for the following day, 4/12/13.

The county then coordinated with law enforcement (Philadelphia SVU) for the investigation. The county social worker saw the child in the hospital and obtained information pertaining to her medical status. A safety plan was developed by the county to ensure the safety of the child and

her sibling. Both children would reside with their father once discharged from the hospital. The mother, MGM, mother's paramour and his brother would have no unsupervised contact with either child. The father, PGM and step PGF were included and in agreement with the safety plan. An assessment was completed on their home. The child's sibling was released to the father that day.

The county social worker then met with the MGM and MGU. They reported when they returned to the home they found the child naked, limp and her eyes rolled back. The MGU got into an altercation with the paramour because he assumed he had harmed the child. They took the child to the hospital themselves.

The mother was then interviewed. She reported she worked and allowed the paramour to care for the children at times. She stated she was unaware the paramour's brother also cared for the children until recently and she never gave consent for him to care for them. She further stated that a few days prior she noticed the child favoring her left side and had difficulty breathing. She did not feel this was urgent enough to seek medical treatment.

When the county social worker next interviewed the paramour, he denied injuring the child. He admitted leaving the child in his brother's care on several occasions. He also noticed she was having breathing problems but felt it wasn't serious. On the date of the incident he thought she was having a seizure. He tried to revive her with CPR. The MGU came home and took the child to the hospital.

The social worker met with the paramour's brother who denied hurting the child while he cared for the children several times that week. He also admitted to leaving them unsupervised at times.

In addition to those stated above, the social worker made many collateral contacts with extended family members of both the victim child and paramour. He additionally interviewed community members in order to obtain information relevant to the investigation.

On 5/10/13 the report of abuse related to the near fatality was submitted [redacted]. Ongoing services have been opened to assist the father with ensuring the children's medical needs are met; affording him support in obtaining [redacted], and enhancing his parenting skills.

Current Case Status:

The child [redacted] on 4/27/13, with no outstanding medical issues. She and her sibling continue to reside with their father. He will pursue full custody of the children via Domestic Relations Court. In Home Protective Services (IHPS) through [redacted] are being provided to assist the father with medical appointments, employment services and parent education. The child is receiving [redacted] and has been referred to [redacted] The mother continues to have supervised visits with the children at the father's home. The Philadelphia Police are still investigating the

events leading to the child's near fatality; to date police have not been able to identify a perpetrator.

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

- Strengths: The agency noted that the MDT social worker did a remarkable job investigating the case and conferencing with the chain of command. The documentation was thorough and detailed all aspects of the investigation including the interviews with everyone involved.

- Deficiencies: None identified

- Recommendations for Change at the Local Level: None identified

- Recommendations for Change at the State Level: None identified

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county. We are in agreement with the county's findings as per letter dated July 31, 2013.

Department of Public Welfare Findings:

- County Strengths: The county provided clear documentation in the case notes and investigation report. All relevant parties were interviewed. The subject child and her sibling were seen in a timely manner. Safety assessments and plans were made for both children. The county collaborated with the local police department and hospitals. The family was referred for appropriate services. The county has a positive adherence to the Act 33 guidelines and the provision of services.

- County Weaknesses: None identified

- Statutory and Regulatory Areas of Non-Compliance:

Department of Public Welfare Recommendations:

The county worker's extensive, thorough investigation resulted in positive outcomes. The county should strive to ensure all social workers have the level of skill and expertise demonstrated by the worker who conducted the investigation pertaining to this near fatality. The county agency and the social worker are to be commended for the dedication demonstrated to the subject child and her family.