pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON NEAR FATALITY OF:

[redacted]

DOB: 10/29/12

Date of Incident: 02/26/2013

Date of Oral Report: 02/27/2013

NOT KNOWN TO:
The Philadelphia Department of Human Services

REPORT FINALIZED ON: 11/04/2013

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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 Department of Human Services has convened a review team in accordance with Act 33 of 2008 related to this report on March 15, 2013

1. Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	10/29/2012
	Sibling	[redacted]/2007
	Sibling	[redacted]/2010
	Mother	[redacted]/1987
	Father	[redacted]/1996

Notification of Near Fatality:

On 02/26/13 The Department of Human Services (DHS) received a call [redacted] concerning [redacted]. [redacted] reported the victim child, [redacted], was admitted to [redacted]. Following admission the victim child [redacted]. The mother and father denied allegations of abuse and were unable to explain the injuries sustained by [redacted] During the interview, the parents' explanations of the time frames and the events of the day were questionable and inconsistent. Based on the examination of [redacted] and interviews with parents, [redacted] determined the child's injuries were a result of a non-accidental injury and the police should investigate.

Documents Reviewed and Individuals Interviewed:

The Department reviewed the structured case notes provided by DHS. On 2/27/13 the Department interviewed [redacted] Performance Management Project Manager, regarding the initial near fatality CPS investigation. On 3/3/13 and 3/4/13 the Department conducted follow up interviews with [redacted] Multidisciplinary Team Social Worker. [redacted] was assigned the case on 02/27/13 to complete the CPS investigation. The Department and [redacted] reviewed and discussed in-home, home of origin safety assessments, interviews, criminal status and the well-being of all the children. The Department attended the ACT 33 Review Meeting on 3/5/13.

Summary of Services to Family:

Previous CY involvement:

The family had no prior history with the Philadelphia Department of Human Services

Circumstances of Child's Near Fatality:

On February 26, 2013 The Department of Human Services (DHS) received a CPS (Child Protective Services) report [redacted], reported that the Victim Child was admitted to CHOP after being transported to the hospital by ambulance. The Victim Child was diagnosed with an [redacted]. The mother reported she went down the street with the victim child's siblings and left the victim child with the father, [redacted]. The mother reported she returned with the sibling children later in the afternoon. According to the mother's report, when she returned home she placed the victim child in the infant swing. The mother stated the victim child played in the swing with his siblings. The mother reported she was supervising the children while they were playing. The mother reported eventually the victim child fell asleep for a couple of hours. The mother stated she attempted to awaken the victim child around 5pm and he didn't awaken. The mother reported she tried several times by tickling his feet for approximately 19 minutes. When the victim child didn't awaken the mother removed the victim child from the swing. The mother reported when she had taken the victim child out of the swing his body went totally limp and he wasn't responding. The mother reported she immediately became concerned and instructed the father to call 911. The ambulance arrived and the child was resuscitated and transported to CHOP. The child was [redacted]. The child was examined and evaluated by [redacted]. According to [redacted], the victim child suffered from an acute [redacted] with an unexplained large [redacted] injury. [redacted], signed the Near Fatality Certification. According to [redacted], the injuries were not accidental and were consistent with a child that was forcefully shaken. [redacted] determined that the incident warranted a police investigation.

On 2/26/13 when DHS received the Child Protective Service Report (CPS) [redacted] the DHS Social Worker conducted a safety visit to the hospital to ensure the safety of the victim child, and interviewed the mother and father. DHS reported that the mother and father were unable to explain the injuries to the victim child. According to the DHS investigation, the parents were inconsistent with their reported accounts of time and interaction with the victim child. During the interview, it was noted that there were two other children in the home. During the initial safety visit the sibling children were not interviewed by DHS SW and the attending physician. According to the DHS social worker, the sibling children refused to talk to anyone while at the Hospital. The sibling children are 2 yrs. and 5 yrs. old. During the second safety visit at the home, the five year old sibling was open and responsive. The 5 year old child reported that when she does something wrong, her mother and father will talk to her. The 5 year old child reported when her 2 year old sibling does something bad the father will hit her on the head. The 5 year old child stated she wasn't afraid of the father or the mother.

DHS reported the 2 year old child refused to talk on the second home visit. [redacted] On 2/26/13 DHS completed a present danger assessment that identified the nature of the present danger; the victim child had unexplained non- accidental injuries due to trauma. On 2/26/13 DHS initiated an in-home, home of origin safety plan for the victim child and the sibling children. The victim child was not being released from the hospital until this case was cleared by [redacted] The parents were not allowed to visit during the investigation. During interviews with the DHS SW and the Special Victims Unit, the parent's explanations for the victim child's injuries were inconsistent. DHS and the Special Victims Unit had concerns with the safety of the children; [redacted]. There are still criminal charges pending against the parents. Initially on 2/26/13 the sibling children were placed with a family friend. The family friend was cleared by DHS and a safety visit to the family friend's home was completed. According to the paternal grandmother, the family friend was a relatively new acquaintance and she wasn't familiar with the sibling children. On 2/27/13 DHS social worker and the paternal grandmother agreed that her home would be more suitable for the sibling children. The paternal grandmother was cleared by DHS and the safety plan was revised and the sibling children were placed with the paternal grandmother. The victim child was [redacted] on 3/19/13. The victim child was placed in a [redacted] foster home through [redacted] The victim child was diagnosed with an [redacted] The child needs will be met in the present [redacted] home.

Current / most recent status of case:

- [redacted]. The victim child was [redacted] on 3/19/13 and placed in a medical foster home through [redacted] The victim child is adjusting and the foster family will follow-up with the victim child's medical treatment.
- The sibling children were placed with the paternal grandmother and receive kinship care through [redacted] The sibling children have supervised visits with the mother and the father at the paternal grandmother's home.
- Initially there was a plan for the siblings and the victim child to visit. The victim child recently received a [redacted]. During a visit the siblings were unintentionally playing with the victim child. The agency and the grandmother decided the victim child is not [redacted] for visits. The visits will resume when the victim child is [redacted].
- Criminal charges are still pending.
- The mother and father are not allowed to visit with the victim child; [redacted].

[redacted] On 3/27/13 DHS completed the CY48 and the report was filed with an Indicated status. According to the medical professionals, the victim child suffered a significant head trauma including [redacted]. The victim child sustained unexplained non-accidental physical abuse. Based on the injuries sustained by the victim and the parents' inability to explain these injuries, both parents were identified as the Perpetrators.

County Strengths and Deficiencies as identified by the County's 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. The Department of Human Services convened a review team in accordance with Act 33 of 2008 related to this report on March 15, 2013.

- Strengths:
  All the children's safety and well being were addressed by DHS in a timely manner and DHS was in compliance with statutes and regulations.

- Deficiencies:
  There were no deficiencies identified.

- Recommendations for Change at the Local Level:
  There were no recommendations.

- Recommendations for Change at the State Level:
  There were no recommendations.

Department Review of County Internal Report:

The Department agrees with the findings of the Act 33 review. DHS conducted the review timely and the Child fatality team consisted of individuals who had the expertise in prevention and treatment of Child Abuse. DHS staff collaborated with the medical team to ensure the appropriate treatment for the victim child upon hospital discharge. The resource family for the victim child will be able to meet the special medical needs for the victim child. On March 19, 2013 the victim child was [redacted]

Department of Public Welfare Findings:

- County Strengths: The victim child and the sibling children's safety were addressed by the Hotline Social Work Services Manager and the Multidisciplinary Team Social Worker in a timely manner. DHS was in compliance with the statutes and regulations. Initially the sibling children were placed with a family friend. The Multidisciplinary Team Social Worker (MDT SWSM) interviewed all relevant family members. Based on the interview with the paternal grandmother, the family friend was identified as a casual acquaintance of the mother and she was not familiar with the sibling children. MDTSW immediately revised the safety plan and removed the children; the children were placed in the paternal grandmother's home. According to MDT SW, the paternal grandmother's home was more suitable to meet the needs of the children. The MDT SW conducted a thorough Child Protective Service Investigation.

- County Weaknesses:
  There were no areas of concern identified.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of concern identified.

Department of Public Welfare Recommendations:

The Department did not have any recommendations regarding the monitoring and inspection of the Department of Human Services. This case was not the result of services not provided by The Department of Human Services. DHS completed the safety visits, risk assessments and safety plan timely. DHS interviewed and made collateral contacts with all relevant individuals. DHS completed a thorough investigation.