



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 03/02/2014**

**Date of Incident: 10/19/2014**

**Date of Report to ChildLine: 10/20/2014**

**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. Section 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, the Department, through OCYF 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 substantiated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia has convened a review team on 11/21/2014 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

| <b><u>Name:</u></b> | <b><u>Relationship:</u></b> | <b><u>Date of Birth:</u></b> |
|---------------------|-----------------------------|------------------------------|
| ██████████          | Victim child                | 03/02/2014                   |
| ██████████          | Father                      | ██████████/1988              |
| ██████████          | Mother                      | ██████████/1993              |
| * ██████████        | Maternal Grandmother        | ██████████/1958              |

\*Maternal Grandmother does not reside in the home and did not live in the home at the time of the incident.

**Notification of Child Fatality:**

The Philadelphia Department of Human Services received a report ██████████ on 10/20/2014 with the following information: The 7-month-old child was brought to the Children's Hospital of Philadelphia (CHOP) by her parents on 10/19/2014. The child reportedly fell off of the bed while in the care of the father. The mother was at work at the time of the incident and father cares for the child in her absence. The child was examined ██████████ and had numerous injuries, old and new. The CHOP medical team suspected that the child's injuries were as a result of non-accidental trauma and that the injuries were not consistent with a fall as the father stated.

**Summary of OCYF Child Near Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current CPS investigative information including the CY-48 as well as written case documentation from the Philadelphia Department of Human Services. Included in the packet of information were medical records from the (CHOP) as well as criminal investigative information, from the ██████████ Police Special Victim's Unit. The Southeast Regional Program Representative also reviewed information from the Act 33 meeting which was held on November 7, 2014 where a thorough case presentation was given.

**Summary of Services to the Family:**

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

The family was never known to the Philadelphia Department of Human Services.

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

The child was seen in [REDACTED] at CHOP on 10/19/2014. The father reported being the sole caretaker for the child for most of the day while the mother worked. The father states that he left the child on the bed and went to take a shower. The father states that he heard the child fall from the bed. After returning to check on the child the father stated that he found the child on the floor and reported that the child was "breathing funny." At that point, the father gathered the child up, picked up mother from work and they both brought the child to [REDACTED] at CHOP.

During the child's medical exam at CHOP the child received an X-ray and a [REDACTED] which revealed [REDACTED] and [REDACTED], old and new. According to medical reports the child [REDACTED]

It was also discovered that the child had been seen in the CHOP [REDACTED] on 09/30/2014 for a [REDACTED] burn. This injury also occurred while the victim child was being cared for by the father. The couple reported that the child was burned while being bathed in the kitchen sink. The father reported that the knobs to turn the water on and off were switched and as a result the father accidentally turned on the hot water which burned the child. There were no concerns about the promptness for which the child was brought in for medical attention, however the parents failed to keep follow up appointments which was a major concern regarding the protective capacities of both parents. There were also concerns as to whether that incident was an accident. The CHOP medical staff viewed the incident as an accident and as a result it went unreported to the Philadelphia Department of Human Services.

A preliminary safety assessment completed on 10/20/14 found both parents to have both diminished and absence parental capacities. The child was determined to be "unsafe" however remained in the hospital out of the direct care of both parents until [REDACTED]

[REDACTED] The child was immediately [REDACTED] the hospital to a medical foster home through [REDACTED], a private provider agency. The foster parents at [REDACTED] were given appropriate medical information and instructions regarding the proper care of the child. The child was [REDACTED]

hospital with a [REDACTED] Since that time, the child has had numerous follow-up medical appointments as a result of her condition. The child has had several medical appointments through [REDACTED] at CHOP. The child continued to make progress. [REDACTED]

A CPS investigation was completed by the Philadelphia Department of Human Services on 11/05/2014, which resulted in an Indicated finding on both parents. A criminal investigation was conducted by the [REDACTED] Police Department Special Victim's Unit. The father admitted to the police that he struck the child after the child would not stop crying. As a result, the father was arrested, charged and incarcerated with crimes related to the extreme severity of the child's injuries. He is currently awaiting trial.

**Current Case Status:**

The child continues to reside in a medical foster home through [REDACTED]. The child has made steady progress and improved to the point where the child is now recommended to receive [REDACTED] through the child's pediatrician. The child was assessed for [REDACTED], however does not need them as the child does not have any [REDACTED] at this time.

The father continues to be held at the [REDACTED] Correctional Center and is awaiting trial. Due to the severe nature of the child abuse, [REDACTED]

The mother was found to not have followed through with medical appointments after the child suffered a [REDACTED] in September of 2014. She was not arrested. She remains in the home and is working on a plan of reunification at this time which includes [REDACTED] with appropriate follow through of recommendations as well as a parenting capacity evaluation and parent skills training. [REDACTED]

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

- **Strengths:** The Team felt that a competent investigation was completed by the Philadelphia Department of Human Services caseworker which included contacts with the family, medical information from the Children's Hospital of Philadelphia and a criminal investigation conducted by the [REDACTED] Police Department.

The Team felt that case documentation was thorough and that

the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

- **Deficiencies:** The following concerns were identified by the MDT members at the 11/07/2014 Act 33 meeting.

It should be noted that the family was not opened to the Philadelphia Department of Human Services at the time of the incident.

The team had some concerns as to whether the previous emergency room visit where the child suffered a burn should have precipitated the medical staff at CHOP to perform a skeletal survey on the child. Also a referral could have been made to the Child Protection Team at CHOP which would have created a more focused investigation as to whether concerns regarding child abuse were valid and a referral to Child Welfare authorities were warranted.

Given the above, the team was concerned as to whether evidence of child abuse goes unnoticed and/or missed during initial Emergency Room visits across the board and whether this is a systemic issue.

The Team also discussed whether a better job could be done to medically screen all children who are at high risk for CA/N (Skeletal surveys, recognizing pattern of injuries, etc.). Also the team felt that there should be clearer guidelines to medical professionals as to when a report needs to be called in.

There were also concerns as to whether the father had additional children who were not a part of the current investigation and whether Philadelphia DHS should ensure their safety as well. (Philadelphia DHS agreed to look into this and a contact and subsequent safety assessment was conducted.)

**Recommendations for Change at the State and Local Level:**

The team recommended that a letter be written to the Philadelphia Department of Public Health Commissioner and the Chairs of the Emergency Departments at St Christopher's Hospital and the Children's Hospital of Philadelphia to discuss standards of care to evaluate child for other possible injuries when they present with an injury. The Team cited cases that had been recently reviewed by the Act 33 Team that involved children who had older injuries that were not detected when they had been seen in the hospital prior to sustaining a fatal or near-fatal injury.

**Recommendations for Change at the State Level:**

There were no further recommendations for change at the state level.

**Department Review of County Internal Report:**

The Department has received the County's report dated 02/04/2015 and is in agreement with their findings. A written response from Department was submitted on 02/11/2015.

**Department of Human Services Findings:**

- County Strengths: The Philadelphia Department of Human Services conducted and completed an appropriate CPS investigation within 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.
- County Weaknesses: The Department is in agreement with the deficiencies discussed in the Act 33 meeting and has identified no further weaknesses.
- Statutory and Regulatory Areas of Non-Compliance: A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

**Department of Human Services Recommendations:**

The Department has no further observations or recommendations other than those already contained in the report.