



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 04/21/2015
Date of Incident: 09/02/2015
Date of Report to ChildLine: 09/02/2015
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN
THE PRECEDING 16 MONTHS:**

Philadelphia Department of Human Services

REPORT FINALIZED ON:
04/20/2016

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 10/02/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	04/21/2015
[REDACTED]	Biological Mother	[REDACTED] 1992
[REDACTED]	Biological Father	[REDACTED] 1990

Summary of OCYF Child Near-Fatality Review Activities:

OCYF attended the Act 33 meeting for this case. OCYF has reviewed case records, medical records, and spoken with caseworkers involved with the case. OCYF spoke with [REDACTED] Community Umbrella Agency (CUA) 5 Supervisor, on 03/29/2016.

Children and Youth Involvement prior to Incident:

The family had no Children and Youth involvement prior to the incident.

Circumstances of Child Near-Fatality and Related Case Activity:

On 09/02/2015, Philadelphia DHS received a Child Protective Services report stating that [REDACTED], age 4 months, had suffered head trauma. It was alleged that the father had shaken the child. The child was in the father's care when the mother left the house. The mother returned to the home, and she noted that the child was unresponsive. When she asked father what had happened, he became violent towards her and stated that he "doesn't care what happens to the child." The mother took the child to a neighbor's house and called 911. When medics arrived, the mother and the child were outside of the apartment complex.

The child was taken to Albert Einstein Medical Center for evaluation. [REDACTED]

After the child was stabilized, he was transferred to St. Christopher's Hospital for Children.

On 09/03/2015, [REDACTED] reported to the DHS social work services manager (SWSM) that the mother had a black eye. It was reported that the child had [REDACTED]

[REDACTED] Medical staff also reported that the child was likely to survive, but that he would likely have a brain deficit. [REDACTED]

On 09/03/2015, a Safety Assessment was completed. No threats were found, and it was stated in the Safety Assessment that the child did not have injuries.

On 10/13/2015, the county investigation worker met with the father by telephone in the prison. The father stated that he had been swinging the child around in his arms, when he lost his grip on the child. The child flew into the wall, and hit the floor. The child sat on the floor, looking dazed. The child had a dirty diaper, so the father changed the child's diaper. The mother returned home, asked him what happened, and they started arguing. She attacked him, and he went for a walk.

[REDACTED]

On 10/29/2015, the county indicated the report for the father, for Engaging in Per Se Acts of Forcefully Shaking Child Under 1, and Causing Bodily Injury to Child Through Recent Act/Failure to Act.

[REDACTED]

On 11/15/2015, the child was returned to the mother. The mother began receiving in-home services. [REDACTED] The mother and grandmother were trained to care for the child's [REDACTED]

On 02/08/2016, the case was closed. The mother refused aftercare services. The CUA case work staff assured the mother that she can contact them if she needs support in the next year, without the necessity of a child abuse report being made.

[REDACTED]

Criminal charges were filed against the father, for Criminal Attempt - Murder, Aggravated assault, Endangering the Welfare of Children/Parent/Guardian/Other Commits Offense, Simple Assault of Victim Under 12, and Recklessly Endangering

Another Person. Bail was set at \$1,500,000. The father remains incarcerated at the ██████████ Correctional Facility.

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 that the MDT SWSM did a good job of investigating the report and commended her thorough documentation.

- Deficiencies in compliance with statutes, regulations and services to children and families;

The Team noted that the safety assessment document completed by the Hotline SWSM on 09/03/2015, identified ██████████ as being "safe" in spite of the overwhelming evidence to the contrary. Representatives from DHS agreed that ██████████ was not safe at that time and stated that the practice issue would be explored further with the Hotline SWSM's supervisor.

- 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 identified

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None identified

Department Review of County Internal Report:

The Department concurs with the County Internal Report. However, there are additional concerns and recommendations noted by the Department that were not discussed in the County Internal Report.

Department of Human Services Findings:

- County Strengths:

The county's investigation was thorough, and the worker collaborated well with the police. The investigator interviewed the father in prison.

- County Weaknesses: and

The child was placed in foster care for 10 days, and the foster parent reported that she believed he was supposed to be [REDACTED] only while sleeping, [REDACTED]

[REDACTED] There was no documentation of communication with the foster mother regarding [REDACTED]

There is no documentation that domestic violence-related services were considered as a possible need for the mother, who experienced domestic violence on discovering the child's medical state. The supervisor reported that the focus in the case was on stabilizing the family, and domestic violence services were not considered.

There is no documentation of any engagement with the incarcerated father, despite the inclusion of his prison number ("PP number") in a letter scanned into the electronic case management system during the investigation.

It is unclear if the information regarding the father's whereabouts was shared with the ongoing caseworker from the CUA.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

The county did not include the incarcerated father in service planning meetings or provide a copy of the service plan to the father, despite the fact that the father's prison number was included in a letter that was scanned into the electronic system by the investigator.

The Safety Assessment dated 09/03/2015 states that the child was safe, and a box was marked saying that the child had no injuries.

Department of Human Services Recommendations:

All social work staff at the county and CUAs should be documenting the use of medical equipment to ensure that medical equipment is used [REDACTED]
[REDACTED]

In cases where a reported domestic violence incident has occurred, case managers should consider the provision of domestic violence services to the family to ensure the safety of children and families in the future.

County intake workers should meet with the ongoing CUA worker to discuss the case, detail what tasks need to be completed, and exchange information, prior to the 20-day safety teaming.

All CUA workers and supervisors should be trained on the importance and methods of engaging incarcerated parents of child receiving child welfare services, including facilitating the involvement of incarcerated parents in service planning.

County children and youth staff should work with the [REDACTED] Prison System and Pennsylvania Department of Corrections to ensure that any equipment needed to facilitate the engagement of incarcerated parents is provided for social workers at the county children and youth agency, the CUAs, and in the corrections systems.

All CUA workers and supervisors should be trained and receive support in understanding the larger picture of the case, to avoid losing focus on the general case work issues.

All county and CUA workers and supervisors should be trained to include the child's injuries in the safety assessment.