



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 1/24/13
Date of Incident: 1/18/15
Date of Report to ChildLine: 1/20/15

[REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

7/17/15

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 convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 2/6/15.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	1/24/13
[REDACTED]	Half sibling	[REDACTED]/09
[REDACTED]	Mother	[REDACTED]/93
[REDACTED]	Maternal Grandmother	[REDACTED]/72
[REDACTED]	Great M. Grandmother	Age 74

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (OCYF) obtained and reviewed current child protective services (CPS) investigative information, including the form CY-48, as well as written case documentation from the Philadelphia Department of Human Services (DHS). Included in the packet of information were medical records from the Children's Hospital of Philadelphia (CHOP) as well as criminal investigative information from the [REDACTED] Police Special Victim's Unit. The Southeast Regional Program Representative also reviewed information from the Act 33 meeting which was held on 2/6/15 where a thorough case presentation was given. The Program Representative also received periodic case updates (telephone calls) from the Philadelphia DHS supervisor, [REDACTED] and the Private Provider Agency, [REDACTED] case manager, [REDACTED].

Children and Youth Involvement Prior to the Incident:

Mother has had extensive Philadelphia DHS involvement as a child, including a substantial placement history, and was opened with the agency at the time of the incident. Information gained from the Act 33 meeting and from supporting written documentation revealed that the mother and a male sibling have a history with DHS as children dating back to 2005. These

reports involve CPS and general protective services (GPS) investigations with both "indicated" and "substantiated" finding with regards to physical abuse, neglect, and adolescent issues. Philadelphia DHS provided in-home and/or placement services almost continually from 2005 to 2011 [REDACTED]

[REDACTED] In August of 2006, [REDACTED] after being arrested and charged with aggravated assault, simple assault and recklessly endangering another person. The matter was closed on 11/29/06. Despite that, [REDACTED] from 1/07 to 3/08.

As an adult, [REDACTED] became involved with Philadelphia DHS as a parent in May of 2014. At that point [REDACTED] was the mother of 2 children, [REDACTED] (age 4) and [REDACTED] (age 16 months). Neither father has been identified by mother or involved with the children. [REDACTED] is reportedly a product of a rape. Prior to the incident there were three referrals made to the agency with concerns for [REDACTED] care of her own children. One call was screened out, and two reports were referred for GPS investigations. The first call was received on 5/5/14. [REDACTED] (age 4) was attending [REDACTED] program and came to school with an apparent injury to his penis which was described as raw and swollen, with pain upon urination. The school staff also stated that the child was walking funny. Staff questioned the child as to how he received the injury. The child made no disclosure of sexual or physical abuse and attributed the cause to an accidental fall. At the time of the report (5/5/14), a risk screening assessment was completed by the Philadelphia DHS screener, which indicated some concerns about mother regarding her adult functioning, however there did not appear to be any concerns related to her general parenting of the child. The mother and child appeared to be bonded, the facility reported no parenting concerns and the child was taken for prompt medical care at which time the mother brought a note to the school verifying that the child had received medical attention with only minor concerns. As a result the case was screened out on 5/6/14. This was the first referral made involving the family with [REDACTED] as the parent.

On 7/28/14 a second call was placed [REDACTED] which was referred for a GPS investigation. The report appeared to have come from [REDACTED]. This report also included the victim child, [REDACTED], who was age 2 at the time. The home was reported to be dirty and cluttered with the mother and children sharing the same bedroom. At that time there were no concerns regarding the children's functioning, however there was a concern for mother in that she was described as "mentally delayed." An initial visit was made to the home on 8/6/14 and there were no concerns at all regarding the quality of the home. The mother denied the allegations and stated that the referral came from her brother who was asked to leave the home and as a result threatened to place a call to the agency. The maternal grandmother confirmed the mother's story and had no concerns about the care of the children. The children were also observed and seemed well, but did not give additional information despite being asked. The caseworker felt

that the needs of the children were being met by the parent and that the allegations appeared "unsubstantiated."

As there did not appear to be any safety threats on the visit conducted by the caseworker on 8/6/14, there was no record of contact by the agency again until 11/8/14 when another visit was made to the home. The caseworker again found no safety threats, issues or changes regarding the family. The case worker stated that he observed the children who seemed fine, and spoke with the grandmother who appeared to be supportive of the mother. Subsequent to that visit, the caseworker contacted the school and medical provider on 11/19/14. Neither contact presented with concerning issues related to the children. The record indicated that the case was closed on 11/19/14 with no safety threats or [REDACTED] issues at the time. The risk assessment completed on 11/19/14 was rated low risk overall, however there were high risk ratings in the area of vulnerability (due to age) for both children.

The third referral for the family was made to Philadelphia DHS on 12/11/14. The referral source stated that [REDACTED] (age 5) reported that his mother hit him with a bathroom plunger. The child later gave a different account and had no apparent pain, injury or impairment. The report was assigned for further assessment given that the family had recently been closed on 11/24/14.

A home visit was made by the DHS caseworker on 12/15/14. According to the case notes, the mother denied the allegations, the maternal grandmother supported the mother's claim and the child made no further disclosure to support the allegations nor appeared fearful of his mother. A preliminary safety assessment was completed on 12/16/14, which determined both children to be safe.

The next visit occurred on 1/15/15, three days before the incident. This visit was labeled a closing visit. The children were observed and the caseworker interacted with both children. They appeared to be happy, "well groomed, well cared for, in good health and appeared to be developing appropriately" according to a note written about the contact. The case worker spoke with the parent, who again denied that she uses corporal punishment with the children. [REDACTED]

[REDACTED] There did not appear to be any concerns on that visit and the caseworker was planning to close the case. A safety assessment at the conclusion of the case was completed on 1/15/15 with no safety/parental capacity concerns. A Pennsylvania risk assessment was completed on 12/16/14 after the initial visit which rated the overall severity and risk to be low. A check with the child's pediatrician and school on 12/22/14 found no concerns or issues with the children's health or medical care and the school reported that [REDACTED] had good behavior [REDACTED]. The GPS case was closed on 1/28/15, as the issues in the report were

determined to be "invalid." The near fatality report was known to the agency at that time and the report was subsequently accepted for CPS investigation on 1/20/15.

Circumstances of the Near Fatality and Related Case Activity:

On 1/18/15 the victim child ([REDACTED] age 2) was transported by ambulance to [REDACTED] CHOP after being found unresponsive by her mother. The child presented [REDACTED] with shallow breathing, a decreased heart rate and low blood pressure. There were concerns that the child ingested [REDACTED] which was a medication [REDACTED]. The child was given [REDACTED], and after multiple administrations, stabilized. The mother admitted to the hospital that her son was taking the medication, but gave an inconsistent story as to how the incident could have occurred and denied DHS involvement. The victim child was admitted [REDACTED] and after a few days improved, and was able to [REDACTED]. The mother threatened to take the child from the hospital after she was informed that a report would be filed with the Philadelphia DHS. [REDACTED] (CHOP) classified the report as a near fatality and stated that the child's symptoms were consistent with [REDACTED] ingestion. As a result a CPS/near fatality report was [REDACTED] on 1/20/15. Philadelphia DHS intervened and began a CPS investigation on 1/20/15. The child continued to improve and was ready for [REDACTED] on 1/22/15. An assessment of the mother's home was completed at that time to see if the victim child and a sibling could remain in the home. Although [REDACTED] cooperated with the investigation, she was unable to demonstrate "protective capacities and adequate decision making skills" necessary to keep the children safe. As a result both children were placed with [REDACTED], a maternal aunt living in [REDACTED], (Delaware County) by a safety plan agreement 1/21/15 [REDACTED] on 1/22/15, pending the outcome of the CPS investigation. [REDACTED] was removed and placed in the aunt's home on 1/21/15. [REDACTED] was placed with the aunt upon [REDACTED] on 1/22/15. Both children appeared to be acquainted with their aunt and comfortable in the home. Currently both children remain in kinship foster care with a goal of reunification and a concurrent goal of adoption.

The CPS investigation was completed on 2/26/15 and the mother was indicated as a perpetrator for lack of supervision. The mother reported that she went to the store and upon her return to the home, found the child in an unresponsive state. The mother denied allegations that she left medication unattended for the children to have access to. The mother admitted that she gave [REDACTED] the medication but denies that she left it out after that and believed [REDACTED] may have "cheeked" his medication. During the course of the investigation, [REDACTED] received a forensic interview [REDACTED] and gave conflicting information making it difficult to determine how the victim child accessed the medication. One of the statements made by [REDACTED] reported that the mother left the

medication on the table where the victim child was able to access it. A CPS investigation determined that the "cognitive, emotional, and behavioral protective capacities of [REDACTED] (mother) were limited and that she failed to provide adequate supervision of the children".

The [REDACTED] Police Department determined that although the incident was attributed to a lack of adequate supervision, it was not a crime and declined to press charges.

Current Case Status:

The victim child and a sibling are receiving case-management services through the private provider, [REDACTED], which began on 1/23/15 shortly after the children entered placement. [REDACTED]

[REDACTED] The child does not currently take any medication other than [REDACTED] symptoms which appear well under control. [REDACTED] last medical appointment was on 2/11/15. There were no medical concerns. The child has another well check on 5/22/15. [REDACTED]

The victim child, [REDACTED], is also on the same medical appointment schedule as her brother and appears to have suffered no ill effects from the incident. Both children seem to be doing physically, emotionally and medically well and appear comfortable in the kinship home. [REDACTED] was living at [REDACTED] and was participating in the [REDACTED]

[REDACTED]. She is reportedly residing between her mother's home and with friends and does not appear to have a stable residence. She is in the midst of completing [REDACTED]. Her current level of emotional and cognitive functioning is not known at this time, but efforts are being made to rectify that and [REDACTED] does have a [REDACTED]. She attends bi weekly parenting classes [REDACTED]. The placement goal is reunification with a concurrent plan of adoption. Mother has semi-weekly supervised visitation with her children which she keeps. With respect to progress in the last 90 days, the agency feels that [REDACTED] has made marginal progress. Primarily, it was reported that [REDACTED] needs to complete a [REDACTED], cooperate and make herself more available to the agency to get tasks completed and to discuss progress towards achieving her goals.

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

The Philadelphia DHS Child Fatality Team convened on 2/6/15 for a review.

Strengths:

The Act 33 team felt that the Philadelphia DHS worker did a good job investigating the case and conferencing with his chain of command. The case work documentation was also noted to be clear and thorough.

Additional strengths discussed by the team:

The child is expected to make a full recovery.

The parent was not criminally charged and the incident, although a lapse in supervision was considered accidental and not a crime.

Deficiencies as identified by the fatality report:

The team was concerned that the Philadelphia DHS worker was unable to obtain [REDACTED] information [REDACTED] in a timely manner because the [REDACTED] computer system was inaccessible for a period of time during December and January. The caseworker was able to access information concerning mother's [REDACTED] history at the end of January, 2015.

Specifically:

It was felt that [REDACTED] and Philadelphia DHS case management services were not sufficiently linked.

It was not clear why [REDACTED] was [REDACTED]. From the information available, the team could not determine the child's exact diagnosis and why [REDACTED].

It was not clear whether [REDACTED] was being given his medication [REDACTED] properly and/or consistently by the parent.

There was a concern as to whether the school was adequately informed of [REDACTED] needs and recommendations so that proper placement, support and monitoring could continue in the school setting.

Additionally:

██████████ is a very dangerous drug which should be closely monitored ██████████, and should not be around other children. The team discussed whether ██████████ of the drug cautioned the parent about the drug as well as the danger that it could cause to other children.

The team discussed general reporting practices among hospitals to county children and youth agencies - for incidents of accidental ingestion of lethal substances. The group felt that this might not be fairly and/or consistently reported along class and socioeconomic lines.

The team felt that the developmental level of toddlers, who tend to pick up things and explore them with their mouths, makes supervision a very critical issue for children in this age group. The team discussed whether this information is generally being adequately communicated to parents of young children.

The team discussed whether there were consistent protocols (questions) when the initial assessment was conducted by the Philadelphia DHS caseworker, which requested information about the kinds of medications that were present in the home and their accessibility to children and adolescents.

Additional deficiencies regarding the parent which were discussed by the team:

It was felt that the seriousness of mother's ██████████ history was minimized as to its impact on her current parenting abilities and the future risk of the children in her care, which seemed considerable.

Recommendations for change at the local level discussed by the team:

The team felt that there should be protocols provided by the Philadelphia Department of Human Services to consistently inform families that all medication needs to be kept in a locked cabinet or box and away from children.

The Act 33 team felt that Philadelphia DHS should assist mother in obtaining an updated ██████████ to clearly ██████████ address any ██████████ issues, cognitive and learning difficulties.

The Act 33 team felt that Philadelphia DHS should assist mother in obtaining a parental capacity evaluation to clearly define her functioning as a parent.

The Act 33 team felt that the Philadelphia Department of Human Service should obtain an [REDACTED] and a thorough medical examination [REDACTED] to determine the need for medication such as [REDACTED] and/or any other medication.

Philadelphia DHS needs to contact the child's pediatrician to discuss all aspects of the child's medical picture including [REDACTED] medication.

Philadelphia DHS needs to gain an understanding as to how these medications are administered by the parent.

Philadelphia DHS needs to contact [REDACTED] to facilitate a multi-disciplinary team approach to better address [REDACTED] needs.

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 received the County's report dated 5/5/15 and is in agreement with their findings. Additional information discussed at the Act 33 meeting was also included. A written response from the Department was submitted on 5/8/15.

Department of Human Services Findings:

All indications regarding the county's CPS investigation, medical reports from the Children's Hospital of Philadelphia and a police investigation conducted by the [REDACTED] Police Department Special Victim's Unit, state that the victim child's medical condition occurred as a result of the mother's lack of supervision, which caused a dangerous situation to occur. As parents are ultimately responsible for the safety and well-being of their children, even in the presence of other adults, the result of the CPS investigation was determined to be "indicated" on the mother.

Strengths:

Philadelphia DHS conducted and completed an appropriate CPS investigation within 30 days fulfilling all regulatory requirements of the Child Protective Services Law (CPSL) and Chapter 3490.

Deficiencies:

The Department is in agreement with the deficiencies discussed in the Act 33 and has included additional information (above) which was discussed during that meeting.

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

A case record review was completed and 1 statutory and/or regulatory area of non-compliance was noted. The Program Representative could not locate any casework contacts in August, September and October 2014, during the period of Philadelphia DHS involvement beginning from 7/28/14 to 11/15/14. The Agency has had previous citations regarding this requirement and recently submitted a Plan of Correction as part of their annual licensing review.

Department of Human Services Recommendations:

The Department has no further recommendations other than what has already been contained in this report.