REPORT ON THE FATALITY OF:

MUHKTAR PAIGE

Date of Birth: 12/07/2015
Date of Death: 02/10/2016
Date of Report to ChildLine: 05/17/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:
Philadelphia Department of Human Services

REPORT FINALIZED ON:
05/12/2017

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))

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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 06/03/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Muhktar Paige	Victim Child	12/07/2015
	Mother	1987
	Father	1990

Summary of OCYF Child Fatality Review Activities

The Southeast Regional Office of Children, Youth and Families (OCYF) obtained and reviewed all current and past case records pertaining to the family; conducted follow up interviews with the Caseworker and the Supervisor. And participated in the County Internal Near Fatality Review Team meeting on 06/03/2016, where history of the case and chronological documentations were presented by Philadelphia Department of Human Services. In addition, the assigned OCYF Program Representative continued working with the County Team and the Philadelphia Police Special Victims Unit.

Children and Youth involvement prior to Incident:

The mother's family was known to Philadelphia DHS when she was a child. She was never identified as a victim of abuse or neglect. The family received Services from 01/25/2001 to 05/28/2002. The family also received from 08/10/2005 to 02/15/2006 and from 10/11/2006 to 02/27/2007.

A report was received on 12/08/2015 alleging that Muhktar was born the previous day with exposure to drugs, the report alleged that the mother tested positive for cocaine, and marijuana at the time of Muhktar's birth. The mother denied using cocaine or

any medication that would provide a false positive screen. The mother reported that she used marijuana to increase her appetite and to control her nausea. The victim child was born healthy even though the mother did not receive prenatal care and reported that she did not know she was pregnant until the month prior to giving birth. The report was investigated and determined valid. The case however was not accepted for services but was referred for community services. The mother was referred to who provided services from 01/26/2016 to 02/10/2016, the date of Muhktar's death. The family was referred for services on 1/15/2016 however, the family did not avail themselves to the worker until 1/27/16. The worker attempted to open the case on 1/16/16 and the mother was not available. The worker tried again on 1/19/16 and 1/22/16 without success. The family was available on 1/27/16. The worker opened the case and met with the family twice on 2/8/16 and 2/9/16. On 2/10/16, the worker received a telephone call that the child had passed away.

Circumstances of Child Fatality and Related Case Activity:

Muhktar was taken to the Children's Hospital of Philadelphia (CHOP) by ambulance on 02/10/2016. Upon arrival, he was already deceased and the cause of death was unknown. stated that on the day of the incident, woke the victim child up around 6:30 am and gave him a bottle. At 8:30 am stated gave the victim child a bath and placed him in his bassinet before going downstairs to wash his baby bottles. reported that Muhktar was not exhibiting any trouble breathing while in his bassinet. also stated that after 15 minutes, returned to check on him and found him having difficulties breathing at that time. stated picked him up and was screaming and shaking him. called 911 and the operator walked through the Cardiopulmonary Resuscitation (CPR) Process, while the Emergency Medical Technicians (EMTs) were on their way. When the EMTs arrived they took and the baby to CHOP where the child was pronounced dead. Special Victim's Unit is currently investigating this incident and the District Attorney's office is also aware of this incident.

This report was initially categorized as a report when referred to the county. Philadelphia Department of Human Services assessed the case and determined it During the investigation, it was determined that there were no signs of abuse or neglect however, there was evidence of drug activity in the household. The home also had major environmental issues. There were exposed wires and falling ceilings. These conditions created an unsafe environment for the child. On 2/10/16 Philadelphia DHS determined that the but did not deem it necessary to open the case for Services.

However, when the autopsy results were received, it was determined that the child had a minute trace of cocaine in his system. The case was referred to Philadelphia DHS for a report on 05/17/2016. Even though the autopsy revealed that the victim child had a minute trace of cocaine in his system, the medical examiner stated that the amount of cocaine found in the victim child's

system cannot be the cause of death of the child. On 06/04/2016 the ███ report was ██████ for co-sleeping. The ███ determination was based on information the investigators gathered during the investigation which indicated that ██████ regularly slept with the child in ███ bed. ██████ was not forthright with the investigators however, ███ friend who was at the home ██████ informed the investigators that ███ slept with the baby in ███ bed regularly. In addition there was information about ██████ drug use the day of the child's death.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child 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 investigating the report and documenting her interviews.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  - SHS Leadership admitted that mistakes were made in assessing the family's need for services during the investigation of the December 2015 report. The decision to make a referral to the ██████ ██████ program and then close the family's case was not the appropriate service decision. ██████ drug use was a safety threat and the case should have been accepted for service.
    - DHS Leadership reported that an Executive Teaming of the case was held shortly after Muhktar's death. The meeting found that the Intake team was not familiar with the type of services that are available to the families. These services should be put in place during the course of an investigation. The service providers' work with the family can inform the investigation process and the assessment of safety and risk.
    - ███ Additionally, DHS Leadership announced that they had recently expanded their contracts with ██████ program and with the ██████ Both of these service programs are resources that workers can use to assist with assessing a family's need for services and with supporting caretakers that have a ██████
  - The Team had questions regarding DHS's process for responding to reports involving children that have been exposed in utero to illegal substances. These types of reports were previously investigated by a specialty unit at DHS. Due to recent changes in the child abuse laws, however, the unit was dissolved and the reports are now assigned throughout all general Intake sections.
    - The Team expressed concerns about how the assignment of such reports across all general Intake sections could potentially be problematic based upon some workers' lack of experience with such cases. These types of reports involve a uniquely targeted assessment to delineate between high and low risk

cases. The Team suggested that DHS explore a mean of assisting workers with a more structured protocol to guide the investigations.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse: There were no recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and There were no recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse; There were no recommendations.

Department Review of County Internal Report:

The Department agrees with the findings of the County and agrees with the County's decision.

Department of Human Services Findings:

- County Strengths: The caseworker and the Multi-Disciplinary team (MDT) team conducted a thorough CPS investigation in collaboration with Children's Hospital of Philadelphia staff.

- County Weaknesses: NONE

- Statutory and Regulatory Areas of Non-Compliance by the County Agency: NONE

Department of Human Services Recommendations:

The County should partner with other organizations to:

- inform and sensitize the public on the causes and rate of increase of child death due to co-sleeping and exposure of infants to drugs; and how to reduce the occurrences.