pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/05/2015
Date of Incident: 10/02/2016
Date of Report to ChildLine: 10/02/2016
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:
03/28/2017

Office of Children, Youth, and Families/Southeast Region
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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 10/21/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/05/2015
	Biological Mother	[redacted]1993
	Biological Father	1991
	Sibling-Paternal Half	2013
	Sibling-Paternal Half	2016
	Father's Paramour	1996
	Sibling-Maternal Half	2009
	Sibling-Maternal Half	2010
	Sibling-Maternal Half	2011

Summary of OCYF Child Near 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. Follow up interviews were conducted with the county caseworker and the county supervisor. OCYF also participated in the county internal near fatality review team meeting on 10/21/2016 where the history of the case and chronological documentation was presented by Philadelphia Department of Human Services (DHS). 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 family was known to the Philadelphia Department of Human Services. Victim child has three maternal half siblings who are being serviced by Philadelphia DHS/Community Umbrella Agency (CUA) #6 (Tabor Community Partners) at this time. These children have been open since 01/24/2014. [redacted]

[redacted] Victim child's female paternal half sibling was also opened on 01/24/2014 but was closed on 06/04/2016.

Victim child's maternal half siblings were all in foster care services through [redacted] from 01/24/2014 to 05/28/2015. From 05/29/2015 to the present, they have been receiving foster care services through [redacted] Victim child's female paternal half sibling also received foster care services through [redacted] from 01/24/2015 to 05/15/2015. It is unknown if services were in place from 05/16/2015 to 11/24/2015 for the victim child's female paternal half sibling. From 11/25/2015 to 03/30/2016, victim child's female paternal half sibling received In-Home Non-Safety services through Tabor Community Partners.

Prior reports include:

04/21/2012–Child Protective Services (CPS) report (Indicated); Subdural Hematoma to victim child's youngest female maternal half sibling. The perpetrator was the subject child's father.

10/24/2013–General Protective Services (GPS) report (Invalid); allegation of "unsafe shelter" for victim child's maternal half siblings and victim child's female paternal half sibling; alleged perpetrator was the mother of the children.

01/20/2014–GPS report (Valid); allegation of "unsafe shelter" and "failure to provide supervision" for victim child's maternal half siblings and victim child's female paternal half sibling; alleged perpetrator was the mother of the children.

02/10/2015–GPS report (Valid); allegation of "inappropriate discipline" for victim child's maternal half siblings; alleged perpetrator was a foster parent.

Circumstances of Child Near Fatality and Related Case Activity:

A CPS referral was received at ChildLine on 10/02/2016. Philadelphia DHS was made the investigating agency. The CPS referral was with regard to concerns of serious physical neglect and causing bodily injury to the victim child. The identified alleged perpetrators were the father and the father's paramour. The CPS referral was processed as a near fatality.

One year old female victim child was transported by emergency medical services (EMS) to Albert Einstein Hospital on 10/01/2016 for multiple facial bruises on her forehead, the bridge of her nose, and under her eyes. The victim child was unstable and unresponsive. She was also having breathing difficulties [redacted] All of these injuries occurred while she was in the care of her father and his paramour. The father's paramour stated that the victim child fell from their bed and, prior to the fall, she had a fever

the previous day. The father's paramour administered Tylenol, for the fever, to the child. The doctors reported that the injuries were inconsistent with the explanation of the victim child falling from a bed; there were suspicions that her injuries were the result of abuse and neglect. It was further reported that even if she had suffered from a seizure and fallen from a bed, the injuries were inconsistent with falling off the bed. It was reported that her condition was certified to be serious and critical. Additionally, the child was transported to Children's Hospital of Philadelphia (CHOP) [redacted] Her prognosis was uncertain; however, she was stable enough to be transported to CHOP.

[redacted] This report met the criteria to be processed as a near fatality. Philadelphia DHS and the Philadelphia police are investigating the case.

The county conducted an Act 33 meeting on 10/21/2016 with all involved parties present. The victim child's father was arrested and charged on 10/02/2016 with aggravated assault, conspiracy, endangering the welfare of children, simple assault, and recklessly endangering another person. The father was released on bail and his whereabouts are currently unknown. The father's paramour, at the time of the incident, was arrested on 10/02/2016 and charged with aggravated assault, conspiracy, endangering the welfare of children, simple assault, and recklessly endangering another person. The father's paramour was incarcerated at the [redacted] Correctional Facility.

On 11/21/2016, Philadelphia DHS indicated the CPS investigation identifying the father and the father's paramour as perpetrators for serious physical neglect and causing bodily injury to the victim child. Philadelphia DHS upgraded the decision from indicated to founded on 01/31/2017 [redacted]

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 was upset to learn that the 10/24/2016 report was not assigned to a DHS worker until 12/02/2016. The delay of almost six weeks before efforts were made to meet with the family and assess the victim children is in violation of the State's regulations governing timeframes for making initial contact with the subjects of a report. DHS First Deputy Commissioner stated that the delay was totally unacceptable. She also noted that the presence of four tender-aged children in the home should have warranted a more immediate assignment.

The Team was also concerned to learn that the delays in assigning reports for investigation had been ongoing for some time before it was successfully

addressed. Deputy Commissioner stated that the issue was addressed when it came to the attention of DHS management; however, the problem was not being monitored on a consistent basis.

First Deputy Commissioner stated that an examination into the issue revealed concerns about insufficient staffing. Currently, there are 80 worker vacancies in the DHS Intake divisions alone.

First Deputy Commissioner also noted that this staffing issue occurred simultaneously with an increase in the number of reports being investigated by DHS. The increase occurred predominantly as a result of the changes made to Pennsylvania's Child Protective Services Law and the subsequent effects those changes had on the requirements for mandated reporting of suspected child abuse and neglect.

DHS management also reported that since the time of the October 2016 report, a number of changes had been enacted to facilitate a timely response to reports as follows:

The responsibilities of the DHS Hotline have been expanded to include making initial assessments on all cases that cannot be responded to by investigation staff following normal assignment protocols. In addition, new specialized units within the Hotline have been created to conduct initial visits and complete preliminary assessments of safety for these families.

At certain points in time, staff who are properly qualified to perform field work but who are not in case-carrying positions have been assigned to complete investigations.

Lastly, when there are reports that remain unassigned at the end of a shift, notification is sent to DHS management so that additional actions can be taken as needed.

As a result of these changes, Deputy Commissioner announced that, currently, 100% of reports are being responded to in a timely manner.

Services to the victim child and the extended family:

At the time of the report, the victim child's three oldest half siblings had been receiving case management services through Tabor Community Partners (TCP), a community umbrella agency (CUA). The half siblings have been freed for adoption. They remain in foster care through [redacted] pending the finalization of their adoptions. Victim child, victim child's female paternal half sibling, and male paternal half sibling were not open for services with TCP at the time of the incident.

On 10/02/2016, TCP extended their case management services to include the paternal half siblings of the victim child. The children were placed in a [redacted] foster home on that date.

On 10/04/2016, TCP began providing case management services to the victim child. The victim child remained hospitalized.

On 11/21/2016, the victim child [redacted] CHOP and placed in a medical group home through [redacted] The victim child receives all necessary medical care. Her developmental needs will also be assessed [redacted]

The victim child's female paternal half sibling will receive [redacted] The victim child's male paternal half sibling's development will also be assessed to determine if he is in need of services.

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

There was a delay in the initial assessment of the family and children. The report was not assigned from 10/24/2016 until 12/02/2016.

The team was confused as to why the victim child's safety had never been formally assessed prior to the October '16 investigation. DHS Deputy Commissioner acknowledged that the efforts made by DHS to locate the victim child and assess her safety prior to transferring the case to TCP were inadequate. In addition, when DHS learned that the victim child was in the father's care, an assessment was not completed.

TCP representatives stated that their agency had not been aware that the victim child was in the father's care. However, the victim child was mentioned in the narrative information contained in the November '15 service referral that was made to TCP. The victim child should have also been entered into the family composition in the electronic records for the case.

The team was concerned about discrepancies in the TCP case manager's notes. During the investigation of the CPS reports, the father stated that he began caring for the victim child in November '15. Though structured progress notes indicated that visits with the victim child's female paternal half sibling and the father were occurring in the father's residence on a regular basis, there was not documentation that the victim child had ever been seen or assessed.

TCP CUA Director reported that when the case manager would visit with the victim child's female paternal half sibling and the father, she would call ahead to arrange the visits with the paternal grandmother

(PGM). The PGM would then contact the father and ensure that he and the victim child's female paternal half sibling were present in her home at the appointed time.

TCP CUA Director also reported that TCP representatives had interviewed the PGM regarding the case manager's visitation. The PGM was able to recall having seen the case manager visit the home and meet with the father and the victim child's female paternal half sibling on at least two occasions. The PGM also noted that she was not present for all of the visits that had been scheduled.

The PGM also reported that the victim child had never resided in her home. She stated that the father had been residing for a time in a hotel with his children. When the case manager would call to arrange a visit, the father would continue to appear at the PGM's residence but with the victim child's female paternal half sibling only.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

No recommendations.

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

No recommendations.

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

No recommendations.

Department Review of County Internal Report:

The county report was received on 01/19/2017. The Department is in agreement with the county report.

Department of Human Services Findings:

County Strengths:

The county collaborated very well with the hospital personnel. The county collected all medical records and continued to maintain contact with the detectives until the alleged perpetrators were arrested.

County Weaknesses:

None identified.

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

There were statutory violations by the county as the case was not assigned for six weeks by Philadelphia DHS.

Department of Human Services Recommendations:

The Department recommends that internal policies and procedures at the county level be assessed regarding assignment of investigations. Investigations into fatalities and near fatalities should be appropriately assigned in a timely manner by the investigating agency to ensure the safety and security of children involved.