pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF

[redacted]

Date of Birth: 12/31/2014
Date of Incident: 03/08/2017
Date of Report to ChildLine: 03/08/2017
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:
09/07/2017

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))

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 Child Line.

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 04/07/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	12/31/2014
	Mother	[redacted]1981
	Father	[redacted]1982
*	Half-Sibling	[redacted]1999
*	Half-Sibling's Father	[redacted]1977
	Sibling	[redacted]2011
	Sibling	[redacted]2012

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the victim child's family. The regional office also participated in the County Internal Fatality Review Team meetings on 04/07/2017 where history of the case and chronological documentations was presented by the Department of Human Services of [redacted] (DHS). The assigned OCYF Program Representative continued working with DHS staff and the [redacted] Police Special Victim Unit. Additional discussions regarding safety assessment of multiple children in a household will be held to make recommendations for changes at the State and local levels on abating incidents of near fatalities associated with child abuse. [redacted] is not a household member and was not living with the mother at the time of the incident.

Summary of Circumstances prior to Incident:

On 3/9/2011 a GPS report received by Philadelphia County, alleged that the mother tested positive for [redacted] at the birth of her child on 03/08/2011. It was noted that the mother [redacted] after suffering injuries in a couple of motor vehicle accidents. After the mother's [redacted] were depleted, she ingested one of the MGM's [redacted] pills for reportedly a severe headache. The baby was born without any medical concerns. The mother only had a car seat and was not prepared to take him home. [redacted] The report was investigated with a valid outcome. The family was then referred for Family Empowerment Services through [redacted] on 4/21/2011. These services includes [redacted] and life skills training for the family using the home as the primary learning environment, but the mother refused services [redacted] on 05/10/2011.

On 08/06/2012, there was a GPS report alleging that the mother and her newborn child tested positive for marijuana at the child's birth. It was reported that the mother abused cocaine during her pregnancy and that she had made numerous attempts to stop using drugs but was unsuccessful. [redacted] The family also had a history of domestic violence. When this baby was born, the mother reportedly had the necessary supplies to care for the infant. The father [redacted] but it was not determined whether he would be involved in the child's life. The mother had one other child in her care who was 17-months-old at the time. The mother's oldest child (age 13) resided with her father but the mother was unable to provide an address or telephone number. The report was investigated and determined as valid.

The family received in-home protective services [redacted] which included: Parenting skills, Family planning, Resource management, Meal Planning, Preventive health care and Vocational Planning from 10/10/2012 to 05/28/2013. On 05/28/2013, the two children were placed in kinship care, because mother had unresolved drug issues and domestic violence issues. [redacted]

[redacted] At this time mother was pregnant with the victim child. On 12/30/2014, NET CUA #7 began providing case management services to the mother. The services included: parenting skills, family planning and preventive health care.

Mother gave birth on 12/31/2014 to the victim child and mother and child continued to receive services until 01/10/2017 through NET CUA #7. Mother was not tested for drugs when the baby was born, because the victim child was negative for substance abuse exposure when tested at birth. Philadelphia Department of Human Services did the safety assessment and deemed the infant to be safe in the

care of the mother indicating that both were bonding well [redacted]

On 11/03/2015 a GPS report alleged that the mother had fallen behind on the victim child's medical appointments. The report indicated that the victim child, at this time, presented with developmental delays; he could not sit up or crawl and he had no facial responses. The report was investigated and the outcome was invalid on 01/02/2016. There was no indication that the child was exhibiting any delays in his milestones, therefore the case was not open for services.

A similar GPS report was reported in May 2016 and the investigator, at that time, determined the report valid. Mother had missed several appointments on: 12/08/2015, 12/15/2015, 12/21/2015, 12/29/2015, 01/11/2016, 01/19/2016, 04/05/2016 and 04/12/2016. Some of the appointments were rescheduled and there were others that were no-shows. The mother indicated that due to her poor health, being barely able to walk and needing a wheelchair, caused her to miss the appointments. At that time there were concerns about the mother's ability to properly care for a young child. The determination of the GPS was valid. The victim child and his mother received in-home safety services through NET CUA#7 beginning on 06/02/2016 and ending on 1/10/2017.

Circumstances of Child Near Fatality and Related Case Activity:

A 2-year-old male child nearly died on 03/08/2017, as a result of physical abuse. Philadelphia Department of Human Services indicated the case on 03/29/2017, naming the child's mother as the perpetrator. The mother jumped from a second story window while holding the child in her hands. It was reported that the mother was under the influence of Phencyclidine (PCP) at the time of the incident. The child was transported to St. Christopher's Hospital for Children and the mother was transported [redacted] The child is expected to live despite the head injuries and was classified in critical but stable condition. It was reported that mother was naked at the time of the incident and had not been cooperating with police or hospital staff. The mother has a history of [redacted] drug and alcohol issues. The mother was arrested on 03/08/2017 and charged with criminal attempted murder, aggravated assault, endangering the welfare of children, simple assault and recklessly endangering another person. The CPS Determination was indicated on 03/29/2017.

[redacted] The victim child was placed in the care of his maternal uncle and his fiancée. There has been no contact between the victim child and his siblings. [redacted]

The mother is currently incarcerated, at [redacted] Correctional Facility. Her preliminary hearing was held on 07/26/2017. She is awaiting pre-trial conference. The last action date was 08/23/2017 and her next Court date will be 09/12/2017.

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;

It was clear to the Act 33 Team that the NET CUA Case Management Team did not follow DHS' policies and procedures or good social work practice. Proper supervision of the case was also severely lacking. There were multiple opportunities to recognize that the level of service provided to [redacted] was not appropriate. [redacted] should not have remained in the care of his mother. NET Chief Executive Officer [redacted] acknowledged that the family's case was severely mismanaged by the CUA case management team. [redacted] stated that there was no acceptable explanation for the poor social work practice on the case.

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

The Act 33 Team concluded that [redacted] safety and well-being were being assessed and managed independently of the safety and well-being of the mother's other two children throughout the life of the case. [redacted] The CUA CM ignored the case history and did not assess [redacted] within the context of the circumstances that were affecting his siblings.

The CUA CM reported to NET leadership that the mother presented well. The mother had convinced the CM that she wanted "redemption" with [redacted] The MGM was her support. The CM focused on the mother's strengths and did not look at her history, the level of risk, or the potential safety issues. [redacted] noted that the CM trusted the veracity of the mother's assertions and did not independently verify the mother's statements through collateral contacts.

The Act 33 Team stated that, if one child in a family is unsafe, CMs should assume that all children in the family are unsafe until there is proof otherwise. In this case, since the safety issues that had resulted in the removal of [redacted] siblings were due to the mother's inability to properly care for those children in the home, the same safety threats also existed for [redacted]

[redacted] safety was not appropriately assessed during the course of in-horne Services. The CUA CM failed to identify an active safety threat for [redacted] but had identified the older children as unsafe in the mother's care. In addition, the identified safety threats were used as confirmation that the older children could not be reunified with the mother.

The Act 33 Team questioned why no Law Department consultation occurred, [redacted] Rather than [redacted] remaining in his mother's care, a law consultation could have resulted in [redacted] subsequent placement for [redacted]

The Act 33 Team stated that that it was unacceptable that NET did not begin providing services to [redacted] until June 2016. NET should have been providing services to [redacted] immediately after his birth in December 2014. They had a responsibility to visit with [redacted] in the mother's home and complete regular safety assessments to determine the appropriate level of care.

During the course of the May 2016 GPS investigation, the Intake SWSM informed the CUA CM that a case needed to be opened as to [redacted] as no services had been provided to date. The CUA CM had informed the Intake SWSM that the mother was not in compliance with her Single Case Plan objectives.

Deputy Commissioner of Child Welfare Operations [redacted] questioned why, from DHS investigations to CUA case management, no one voiced concerns about keeping [redacted] in his mother's care. If the mother was not in compliance with her service objectives regarding her two older children, then there was no acceptable explanation for keeping [redacted] in her care.

In this case, it appeared that all of the workers compartmentalized their work and did not complete a comprehensive assessment of the mother's issues and how they impacted the safety and well-being of all of her children.

The Act 33 Team felt that this case should be used as a learning opportunity for all staff. DHS and the CUAs need to look at cases such as these and make system-wide changes regarding training issues, supervision, and staff accountability.

The DHS' training module "Charting the Course" is important but not sufficient for creating a competent and dedicated work force. Quality, timely supervision is paramount.

The Act 33 Team questioned why no consultation with an DHS Psychologist occurred given the mother's history of [redacted] substance abuse issues. The case met the criteria for a mandatory consultation.

At the meeting, [redacted], OHS psychologist, noted that, if the CUA CM had obtained a consultation, a recommendation for services would have been made. In addition, [redacted] would have also recommended a Law Department Consultation.

Case closure for [redacted] was discussed at the October 2016 Family Team Conference but no conference occurred prior to [redacted] actual case closure in January 2017. A Closing Conference would have provided another opportunity to assess the appropriateness of the level of service provided and to determine if it was appropriate to close [redacted] case.

At the October 2016 conference, the CM was directed to consult with the Case Management Director to determine if closing [redacted] case was an appropriate service decision. It was not clear if this consultation ever occurred. When [redacted] case closed, an alternate Case Management Director reportedly reviewed the decision prior to closing the case.

The Act 33 Team questioned if workers were mentally fatigued by their caseloads and by ongoing vicarious trauma, which can negatively impact performance and judgment. The Team felt that, at the time the CM [redacted] she and her Case Management Director should have immediately looked closer at [redacted] case and the services he was receiving.

The Team questioned what strategies could be implemented to guard against staff becoming immune to the signs of abuse and neglect of children. The Team tasked Deputy Commissioner [redacted] with examining this issue at both DHS and at the CUAs.

The Act 33 Team questioned the quality of supervision that the CUA case manager received. The documentation in the case file reflected the CUA CM's incorrect perspective of the case. Additionally, there was a lack of documentation in the case file to support the conclusions that were being made by the case management team.

NET leadership reported that the CUA CM thought that she was providing in-home non-safety services to the family but, at minimum, she should have provided in-home safety services. As a result, the CUA CM was not visiting weekly nor was she assessing [redacted] safety at the intervals required by DHS policy.

Rather than addressing the mother's capacity to safely parent [redacted], the CUA CM focused her attention on [redacted] medical care and

developmental delays. In addition, the CUA CM's attention to these issues was superficial as she did not seek appropriate collateral documentation that [redacted] needs were being met. It was noted that the CUA CM did seek [redacted] services for [redacted]

NET leadership reported that, during subsequent internal interviews with the CUA CM, she stated that she saw no evidence of the mother's [redacted] or substance abuse issues. The CUA CM did not seek collateral information to confirm the mother's compliance with services or random drug screens, however. Better supervision is needed to address any issues that may arise on a case. Supervisors should not be promoted just because they have been with the agency for a certain period of time. Promotions should be based on performance.

The Act 33 Team questioned how NET leadership could have promoted the supervisor to a Case Management Director position given the identified supervisory concerns on this case. NET needs to ensure that they are hiring the best people who are dedicated and capable of providing quality services to families.

CUA Director [redacted] noted that the supervisor's documentation and compliance with policy was reviewed prior to the promotion and there were no concerns at that time. The supervisor completed the interview process and demonstrated that he could develop a team environment. As a result, it was determined that the supervisor was the best available candidate for the case management director position.

It was noted that, after the promotion in May or June 2016, the unit was without a supervisor. As a result, the newly promoted Case Management Director continued to provide direct supervision to the CMs.

[redacted] reported that he had ongoing supervision with the Case Management Director. He stated that they would discuss policy and procedures. They did not review specific cases unless they came to [redacted] attention. Subsequent to [redacted] near-fatal injury, NET's Quality Assurance (QA) unit completed a review of the CUA CM and Case Management Director's caseloads. Insufficient documentation and collateral information were common issues across all cases. Plans of action were developed for each case in which issues were identified. Alternate staff persons were assigned to the cases to ensure that the identified concerns were addressed.

NET leadership provided information regarding changes that were being made to their internal QA procedures. Under the existing QA procedures, [redacted] would not have been subject to a review because his case was closed.

NET revised its QA process to include a review of compliance and service delivery on each case. These processes will encompass all children in the family's case, not just those children that are accepted for services. In addition, audits and internal reviews of cases will occur at regular intervals.

NET has also issued a Request for Proposals to incorporate the "Signs of Safety" model of practice into the agency's existing casework. NET would like to create an environment for learning to improve training and further develop workers' skills. Another goal is to align supervision and leadership to address identified organizational issues.

The Act 33 Team questioned if DHS could develop a fail-safe method to red flag cases similar to this one. There seems to be a gap in service provision when some children are in foster care and other children remain at home.

Deputy Commissioner [redacted] noted that DHS should flag cases when a mother gives birth and her older children are in foster care. [redacted]

- 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 separate than what is contained in the strengths/deficiencies section.

- 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 separate than what is contained in the strengths/deficiencies section.

Department Review of County Internal Report:

The Department is in agreement with the content and findings of the County Report.

Department of Human Services Findings:

- County Strengths:
  The county agency collaborated well with the hospital social worker and physicians and collected all medical reports to ascertain the mother and Child's health condition. The County met with the [redacted] Police Department (Special Victims unit) to share information regarding the investigative process. The County also met with family members on several

occasions to ascertain who was going to be the appropriate discharge resource for the child.

- County Weaknesses:
  The County's safety assessment of the family was not properly completed in identifying the safety threats that led to the removal of her two older children from her home and placed into foster care due to mother's her inability to care for the children.
  A thorough assessment should have been completed when the infant child was born. Mother's [redacted] and her ability to care for her child should have been more carefully assessed.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  The County's safety assessment of the family was not properly completed in identifying the safety threats that led to [redacted] her two older children [redacted] placed into foster care. Even though her older children were removed the infant child was not removed from her custody leaving the child in an unsafe environment. This and the mother's condition culminated in the child's near fatality. An LIS was not issued as the county already has an acceptable correction action plan that they have been implementing to improve their Safety Assessment practices in response to findings of the annual inspections.

Department of Human Services Recommendations:

It is recommended that a family engagement meeting be convened in cases when a new child is born into a family where siblings are in out of home placement due to safety concerns. The county knew the mother suffered from [redacted] substance abuse challenges but little was done to encourage her to get treatment. While at the time of the victim child's birth, the child was tested and found to have no drugs in his system, [redacted] and level of usage should have been considered related to the intensity of services and monitoring.