pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT OF NEAR FATALITY OF:

[redacted]

Date of Birth: 01/21/2000
Date of Incident: 02/14/2017
Date of Report to ChildLine: 02/15/2017
CWIS Referral ID: [redacted]

FAMILY WAS KNOWN TO PHILADELPHIA COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services (DHS)

REPORT FINALIZED ON:
09/15/17

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 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 03/03/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/21/2000
	Paternal Cousin	[redacted]1984
	Paternal Niece	2009
	Paternal Nephew	2010
	Paternal Nephew	2015
* [redacted]	Biological Mother	[redacted]1972

* 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 Region Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the victim child. SERO staff reviewed various reports, assessments and case documentation provided by Philadelphia Department of Human Services and Delta Foster Care agency.

Summary of Circumstances Prior to Incident:
On 07/24/2009, Philadelphia Department of Human Services (DHS) received a General Protective Services (GPS) report in reference to children not being supervised and possible physical abuse. These concerns were investigated by Philadelphia DHS and determined to be invalid.

On 09/04/2009, Philadelphia DHS received a Child Protective Services (CPS) report in reference to the victim child being hospitalized [redacted] It was reported that the victim child had not received [redacted] for the past two days and this was the victim child's second admission to a hospital for the same reason. It was unclear as to why the victim child's biological mother was not giving the victim child [redacted] The victim child's biological mother participated in a refresher

course on 07/29/2009, in which she learned how to properly care for the victim child. [redacted] This report was investigated and indicated by Philadelphia DHS. The family was opened for services and received in-home protective services [redacted] from 09/15/2009 to 03/03/2010. Philadelphia DHS closed this case on 03/31/2010.

On 10/10/2010, Philadelphia DHS received a GPS report indicating that the victim child had been hanging out of the second floor window a few times in the last five months. The child was unsupervised and throwing things out of the window. It was reported that the mother and the reporting source had a conversation in which the reporting source was not totally satisfied with the mom's plan and/or her conduct. The reporter was instructed to call 911 if this occurred again and the GPS report was determined to be invalid by Philadelphia DHS.

On 02/25/2011, Philadelphia DHS received notification that a child in the home (victim child's brother) was attacked by a man wearing a mask. It was reported that the child had been raped and had a knife placed against his throat. The child was seen by medical professionals at the Children's Hospital of Philadelphia (CHOP). The report was rejected by Philadelphia DHS and referred to the [redacted] Police Department for criminal investigation.

On 01/29/2015, Philadelphia DHS received a GPS report indicating that the victim child [redacted] that has been poorly managed. It was reported that the victim child had been at Delaware County Memorial Hospital a day before this report complaining of belly and back pain. The victim child's [redacted], therefore, the victim child was transported to CHOP for medical services. The victim child had also been hospitalized [redacted] in November 2014. The victim child's biological mother stated the victim child was hanging around a bad crew, tried to stab her and was smoking marijuana. This report was investigated and was determined to be valid. [redacted]

On 01/29/2015, and 01/30/2015, Philadelphia DHS rejected two reports as they appeared to have the same information and allegation as received and accepted on a previously investigated report on 01/29/2015.

On 01/18/2016, Philadelphia DHS received a GPS report that the victim child was hospitalized [redacted] on 01/14/2016, after she confronted her mother with a knife. It was reported that the victim child was not in school, had a history of running away, using drugs and not was complying with her medication regime as it relates to her [redacted] The victim child's biological mother refused to pick up the child [redacted] due to her beliefs that the victim child needed [redacted] services. This report was investigated and determined as valid.

On 01/22/2016, Philadelphia DHS received a CPS report indicating a physical altercation occurred between the victim child and her biological mother in which the mother bit the child's hand. The victim child had marks on her hand including some that were healed, however the marks did not have a distinctive shape. The victim child refused to provide additional information about the incident in the investigation. The report was rendered as unfounded. The family case was accepted for services on 02/01/2016. The victim child was hospitalized [redacted] and the case was transferred to Wordsworth Community Umbrella Agency (CUA) on 02/11/2016. The victim child was [redacted] and placed into a [redacted] group home from 02/28/2016 to 02/07/2017.

Philadelphia DHS received notifications of incidents that occurred while the victim child was a resident in [redacted] Group home. On 10/24/2016, Philadelphia DHS received notification that on 10/23/2016, a male staff at the group home where the victim child was residing smacked the child near her left eye. It was reported that another male staff also smacked the victim child. The victim child complained of blurred vision to the school nurse. This report was rejected but referred to the local police for investigation. On 12/12/2016, Philadelphia DHS received notification on 11/29/2016, that a group home staff witnessed a police officer kicking the victim child on the legs and ribs while she was hand-cuffed and seated on the ground. It was reported that the victim child set a hairbrush on fire and was a danger to herself and others. It was also reported that one of the police officers apologized for the other officer's treatment to the victim child. However, the victim child did not suffer a severe injury but stated that her back and ribs area was sore. This report was rejected and referred to local police for investigation.

Circumstances of Child Near Fatality and Related Case Activity:

It was reported by the victim child during the CPS investigation on 02/16/2017, that the victim child had begun experiencing discomfort and stomach pains on 02/10/2017. It was stated that the caregiver checked the child's condition and the next day, 02/11/2017, the victim child stated she was feeling better. On 02/13/2017, the caregiver stated she worked most of the day but communicated with the victim child via her cellphone. Around midnight the victim child informed her paternal cousin that her stomach was hurting and she did not feel well. It was reported that the caregiver's daughter was battling a stomach virus and the caregiver stated that she thought the victim child was experiencing the same virus. The caregiver stated that she gave both children ginger ale to settle their stomach and the victim child did not alert her that she needed emergency services. About an hour later the paternal cousin stated the paramedics were at her door and they transported the victim child to CHOP.

On 02/15/2017, a CPS report was made indicating that the victim child was transported to the Children's Hospital of Philadelphia (CHOP) [redacted]

Moreover, the victim child reported having symptoms of vomiting and diarrhea over the past seven days. The victim child's caregiver did not recognize that the victim

child's condition was deteriorating in the days before being brought to the emergency room at CHOP. It was reported that the victim child called 911 herself and she was transported alone to CHOP. The victim child was in serious/critical condition thus generating a near fatality certification by the hospital doctor.

The victim child [redacted] to CHOP on 02/14/2017, and [redacted] 04/11/2017. During that period, the child received excellent medical care [redacted] Moreover, this time was used by the Philadelphia DHS in securing a medical foster home that would be instrumental in closely monitoring the victim child to ensure compliance with her medical needs. The foster parent working with the victim child participated in [redacted] educational training through CHOP, [redacted]

The CPS investigation was unfounded on 04/15/2017, citing that the caregiver did not knowingly, recklessly or intentionally contribute to the victim child's unfortunate health breakdown. The investigation revealed that the caregiver requested and did not receive the necessary medical educational training to adequately provide support to meet the victim child's medical needs. Moreover, the lack of appropriate formal training and reasonable understanding of the victim child's medical needs prior to placing the victim child in the care of the alleged perpetrator was not a lack of responsibility of the caretaker. Also, the [redacted] Police Department did their independent investigation and it was concluded that no criminal charges would be pursued.

The Philadelphia DHS validated their GPS assessment. This case was already open for services with Wordsworth CUA-10 at the time of this near fatality. The victim child is currently receiving foster care services [redacted] and receiving case management services with Wordsworth CUA-10. The child receives follow-up [redacted]
There are no other children involved in this case.

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 Act 33 Team reviewed the Intake SWSM's efforts to locate.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  The Act 33 Team was very upset to hear about the extensive lack of communication and miscommunication that occurred on the case. Team members felt that the communication issues placed the child in danger and contributed to the neglect of her medical condition.

Following the referral for kinship services, the foster care agency began the process to certify the Paternal Cousin's (PCO) home. Although staff at the foster care agency were aware that the child had [redacted], they mistakenly thought that the CUA case-manager (CUA CM) had the responsibility to identify a provider for the PCO's [redacted] training. The CUA CM, however, stated that it was the responsibility of the foster care agency to ensure that the PCO had received all the necessary training. This confusion of responsibilities was not resolved prior to the child's placement and thus the PCO did not receive the necessary [redacted] training.

During the investigation, the kinship caregiver stated that the foster care agency told her that [redacted] training from her aunt was sufficient when the aunt's only experience was [redacted] herself. The foster care agency, however, denied that they were in agreement with this arrangement.

Agencies should never approve any medical training that is provided by someone who is not appropriately credentialed. In this case, the alleged approved training was deficient and presented a conflict of interest because of the blood relationship. The foster care agency should address any lack of familiarity with the requirements for adequate medical training of its licensed caregivers.

On January 31, 2017, the foster care agency Certification Specialist sent an email stating the PCO had completed all the required training when in fact the PCO had only completed the basic kinship care training. As a result of this miscommunication, the CUA CM was under the impression that it was okay for her to move the child into the PCO's home.

At the Act 33 meeting, the foster care agency reported that the PCO's home had, in fact, not yet been certified. Although kinship care training had occurred, the PCO's home could not be certified as a medical foster home until the PCO received [redacted] training. In addition, the criminal, child abuse, and FBI fingerprint clearances were not completed. The child should not have been placed in the home until all of these requirements were satisfied.

DHS leadership noted that a review of the kinship care process would occur. The practice on this case was unacceptable.

Prior to making a referral for kinship care services, DHS must assess the potential kinship caregiver. A complete review of the case history should have occurred prior to the kinship assessment but it did not happen for this case. When the DHS Practice Coach conducted the assessment with the PCO, she had failed to acquaint herself with the child's medical condition and [redacted] needs. As a result, the child's specific service needs were not incorporated into the DHS kinship care evaluation.

Additionally, prior to moving the child to the PCO's home, a Family Court-Ordered meeting should have occurred between all of the case parties so that the move could be discussed. The CUA CM stated that she had sent an email to the Child Advocate Attorney but a response had not been received. None of the other parties on the case received notice of the meeting and thus the meeting did not occur.

The Act 33 Team was upset by the lack of response by the CUA CM once she became aware that the PCO had not received training on how to care for the child's health condition. The child was placed and remained in the care of an individual who was not adequately trained to safely manage her condition, which the Team felt directly contributed to her hospitalization. The CUA CM should have made outreach to the CHOP [redacted] and the DHS nurses, both of whom would have made efforts to ensure that the PCO receive immediate [redacted] training. The CUA team could have also consulted with the DHS Practice Coaches and Senior Learning Specialist who are embedded at the CUA office.

The Act 33 Team did not understand why the CUA team failed to consult with a DHS nurse. The DHS nurses are available via email and telephone, and they are also on-site at the Wordsworth CUA location one day per week.

The CUA Team failed to follow the DHS policy requiring mandatory consultations with a DHS nurse. Per the policy, a consultation should have occurred because the child has a chronic health care issue. In addition, another consultation should have occurred in preparation of the child's move to the PCO's home.

The CUA leadership acknowledged that the policy had not been followed. As a result, the CUA's Quality Improvement would conduct an audit on all cases involving medically fragile children to ensure that children were receiving the necessary services and to prompt consultations with the DHS nurses.

DHS leadership announced that starting in May 2017, all placements would be handled by the DHS Central Referral Unit (CRU). The CRU staff will have the ability to trigger a mandatory nursing consult to occur on cases that involve children who have special medical needs.

The Act 33 Team was concerned about the gaps in medical care for the child's [redacted] The child's last appointment with [redacted] occurred in July 2016. Appointments that were scheduled to occur in November 2016 and February 2017 were missed.

The Act 33 Team stressed that the lack of urgency on both the part of the Group home where the child was placed and the CUA was unacceptable and contributed to the neglect of the child. Staff should have been fully aware that the child needed to be seen in a timely manner especially since she missed so many appointments.

The CUA CM reported that the child was unable to attend the November 2016 appointment as she was detained by police on the day of the appointment.

Regarding the February 2017 appointment, the CUA CM reported that the child should have been transported to the PCO's home on February 6, 2017. This did not occur, however, as the group home did not have anyone who could facilitate the transport that day. Then on 02/07/2017, hazardous weather conditions delayed the child's departure from the group home which resulted in the child not arriving back in time for her medical appointment.

A discussion occurred between the group home and the CUA CM and the result was that both parties were in agreement that the appointment would be rescheduled. In spite of indications that the child needed to have her medical care and condition reviewed [redacted], no additional appointments were scheduled until after the child's hospitalization.

The Act 33 Team members expressed that more aggressive on site monitoring was necessary to ensure that policies and practices are being followed by the CUAs. CUA responsibilities need to be clearer to their case managers. CUA leadership must strengthens its internal Quality Improvement processes. Poor practice needs to be addressed as it occurs and before a case becomes a crisis situation.

DHS is in the process of developing CUA Scorecards which will assist with monitoring compliance and ensuring healthy outcomes for children. In addition, the Scorecards, which will be made public, will result in consequences for poor practices at the CUA agencies.

The ACT 33 Team was concerned that there were no [redacted] services set up for the child prior to her move to the PCO's home. [redacted] was not made until the child was moved, and a [redacted] was not made until after the child was hospitalized.

The CUA CM reported being under the impression that the child needed to be in her new placement location before she could obtain a letter to document her whereabouts. This letter, however, would have been written by the CUA CM herself and could have been provided prior to the child move so that services could be initiated.

- 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 none noted.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
There were none noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  There were none noted.

Department Review of County Internal Report:
In review of the county report the Department has determined that this report is comprehensive, yet extremely concerning. This case is riddled with miscommunications between all parties which allowed this child suffering with [redacted] to fall between the proverbial cracks. However, the department recognizes that in the county report they acknowledged all short-comings that occurred in this case and has vowed to make the necessary adjustments to ensure that the CUAs will follow the protocols that are already in place.

Department of Human Services Findings:

- County Strengths:
  Once the county gained an understanding of how the case was initially handled they were very diligent in ensuring the case received the appropriate attention it deserved. The Department was not pleased with the initial communication efforts between the CUA and the foster care agency as it relates to the licensing of the foster home and the discharging of the victim child into a home that lacked the appropriate medical training necessary to properly monitor a child [redacted]

- County Weaknesses:
  The lack of communication and/or miscommunication that occurred in this case has contributed to the victim child's near fatality incident. This is rendered as unacceptable. The county must have better monitoring practices moving forward to ensure that this never happens again.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  First the Department will be looking into the licensing process timetable as it relates to providing kinship care resource home certifications. Next, the county has protocols and procedures in place for the CUAs to follow yet Philadelphia DHS has failed to provide the monitoring necessary to ensure the CUAs are kept in compliance. If Philadelphia DHS had been providing proper monitoring practices the impact of miscommunication could have been reduced. As a result of Philadelphia DHS' failure to monitor their own plan for how the CUAs operate, and the Department will need a plan of correction.

Department of Human Services Recommendations:
It is recommended that Philadelphia DHS take a more active leadership role when working with CUAs to ensure the proper protocols and/or procedures are followed. For example, the DHS nurses could have been very instrumental in getting the training completed and follow up appointments scheduled before the victim child could be [redacted] on 02/07/2017. Moreover, the Department must also take a more active role in meetings between Philadelphia DHS and the

CUAs to ensure that the policies and/or procedures that are already in place are adhered to. The Department has concerns that Philadelphia DHS is not effectively or efficiently monitoring the CUA adequately which resulted in this near fatality. Equally importantly, all county agencies must ensure that they be influential in the discharge planning of the children they serve; for, counties are ultimately responsible for the monitoring of the services that are provided to children from the intake process to discharge planning. The Regional Offices must ensure that this occurs.