REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/17/2004
Date of Incident: 05/22/2017
Date of Report to ChildLine: 05/22/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Children and Youth Agency

REPORT FINALIZED ON:
11/27/2017

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 06/16/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	02/17/2004
[redacted]	Biological Mother	[redacted]1970
* [redacted]	Biological Father	[redacted]1977
* [redacted]	Biological Half Sibling	[redacted]1988
* [redacted]	Biological Half Sibling	[redacted]1991
[redacted]	Biological Sibling	[redacted]1997
[redacted]	Biological Sibling	[redacted]2002
[redacted]	Biological Sibling	[redacted]2010

* 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 records pertaining to the [redacted] family. SERO staff reviewed various reports, assessments and case documentation provided by the Philadelphia Department of Human Services. SERO staff attended the Act 33 meeting.

Children and Youth Involvement prior to Incident:

On 01/15/2003, the family became known to the Philadelphia Department of Human Services (DHS) regarding the child [redacted] was five years old at that time and reporting that she had been beaten with a belt by her mother. The child sustained bruises on her arms and legs. The report was determined indicated. The family received [redacted] services [redacted] [redacted] from 03/03/2003 to 08/16/2004.

Circumstances of Child Near Fatality and Related Case Activity:

On 05/22/2017, DHS received a Child Protective Services (CPS) report alleging that [redacted] was taken to the Children's Hospital of Philadelphia (CHOP) emergency after being found unresponsive and incontinent. The child was in [redacted] It was reported that the parents failed to recognize the child's deteriorating condition. The child's mother did report that she noticed that he was not himself for three to four days prior to the incident. The family did not seek medical care for the child knowing that the child was not feeling well [redacted] The mother reported that she felt the child is old enough to care for his condition without parental supervision. [redacted]

Upon arrival to the hospital the child was found [redacted] The other children in the home were medically evaluated at Children's Hospital of Philadelphia (CHOP). All of the children were medically cleared.

On 05/23/2017, the mother fled the hospital with the child against medical advice [redacted] and their whereabouts were unknown. She was upset because she did not agree with [redacted] so she removed the child from the hospital. The police were contacted and informed that a parent has the right to take their child out of the hospital. The police informed that it is not a criminal for a parent to take their child out of the hospital without medical clearance. The child was not in DHS custody at the time mother took child from the hospital.

On 05/24/2017, DHS was able to convince the parents to return the child to the hospital. Mother returned the child to the hospital. A visitation and safety plan was implemented and parents had restricted visitation. The investigation determined that the mother provided two addresses and both appeared to be abandoned houses. It was determined that mother and children were living in a one bedroom apartment with subject child's adult sibling [redacted]

On 05/06/2017, [redacted] it was determined that the child would not be returning to his mother's care in response to safety concerns. The child was placed in his adult half-sister's home with her and her husband. [redacted]

The family is receiving case management services through Wordsworth CUA-5. The siblings [redacted] are receiving non-safety in home services. The children do not have any medical needs and their needs are being met. The subject child remains in kinship care with his adult sister [redacted]

On 06/22/2017, the CPS report was indicated. There was no criminal investigation in process.

Summary of 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 felt that the MDT SWSM did a good job with the investigation. The MDT SWSM used good social work skills to locate the mother and to engage the family. The Team also acknowledged the MDT SWSM's successful efforts to convince the parents to return [redacted] to CHOP so that he could receive appropriate medical care. The Team noted that through her efforts, the MDT SWSM likely saved [redacted] life.

- Deficiencies in compliance with statutes, regulations and services to children and families; The Team discussed the police response when the mother removed [redacted] from CHOP. CHOP and DHS had contacted the local district, but were reportedly informed that parents had a right to remove children from hospitals against medical advice and that no crime had occurred. The Team felt that the parents had endangered [redacted] welfare and noted that, if the Special Victims Unit (SVU) had been notified of the situation, they may have been more receptive to assisting the DHS investigation. [redacted] of SVU agreed to check with his staff to determine if SVU had received notification when the mother took [redacted] from CHOP.

- 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:

In review of the county report the Department has determined that the report has provided the documentation that addresses the near fatality in a comprehensive manner. The County report was received on 09/14/2017.

Department of Human Services Findings:

- County Strengths: The County completed an extensive investigation. The County worked effectively with the Children's Hospital for Children (CHOP). The County worked effectively with the parents to return the child to the hospital.

- County Weaknesses: There were none noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were none noted.

Department of Human Services Recommendations:
Children that are diabetic require intensive support around diabetic management. The Department recommends that pediatricians and schools (nursing and social services) provide these youth with educational workshops and specialized groups to address their complicated medical needs. In addition the parents of these youth also need support and education regarding diabetes. According to medical documentation children with diabetes present with depression and non-compliance with medication.