pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Brianna Costello

Date of Birth: 05/08/2002
Date of Death: 12/21/2016
Date of Report to ChildLine: 05/16/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO PHILADELPHIA DEPARTMENT OF HUMAN SERVICES AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

REPORT FINALIZED ON:
01/12/2018

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 06/06/2017 [redacted]

Family Constellation:

First and Last Name	Relationship	Date of Birth
Brianna Costello	Victim Child	05/08/2002
[redacted]	Mother	[redacted]1984
	Father	1982
	Sibling	2006
	Sibling	2008
	Adopted Sibling	2012

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. SERO conducted the [redacted] Investigation in conjunction with Philadelphia-Department of Human Services (Philadelphia-DHS) evaluating their [redacted] Assessment. Both agencies had several telephone conversations discussing findings as well as participation in the ACT 33 Review, County Fatality Review Team meeting on Friday 06/06/2017 where copies of the medical examiner's reports as well as where [redacted] information were presented.

Children and Youth Involvement prior to Incident:

The Family was known to Philadelphia-Department of Human Services within the preceding 16 months: The timeline follows:

On 04/19/2016, Philadelphia-DHS received a [redacted] report alleging physical abuse was occurring in the home. The reported read that the victim child's (VC) father had punched the child resulting in a bruise on her side. However, the alleged incident occurred three weeks prior to this report and the

bruises were no longer noticeable on the VC. Moreover, it was reported that the father had threatened to kill the child the day the report was made; however, the child did not reside with her father. This report was investigated and determined to be [redacted]

On 05/20/2016, Philadelphia-DHS received a [redacted] report claiming that the VC's father was still physically disciplining her. It is reported that the VC told a friend that if she did not come to school then her father was hurting her and to tell someone. It was reported that the VC's mother had taken her phone away because the child was going to call Philadelphia-DHS. It was reported that the VC was not doing well (academically) and her attendance was a concern [redacted] The report was investigated and the determination was [redacted]

On 11/06/2016, Philadelphia-DHS received a [redacted] report alleging that the VC was transported to hospital after an incident where she was assaulted by five male peers for refusing to perform oral sex on them. The reporter indicated that the VC's mother did not appear concerned for the child or that she had been talking about performing sexual favors. The VC denied any physical or sexual abuse at home and reported being safe in her mother's care. However, the VC and her sibling (SC) presented as dirty with matted hair. It was reported that the VC tested positive for [redacted] The reporter questioned if the VC was possibly using drugs. The reporter noted that the VC [redacted] and she was still complaining of pain. [redacted] This report was investigated and determined [redacted]

On 12/21/2016, Philadelphia-DHS received a [redacted] report affirming that the VC was pronounced dead by EMS. The child was found unresponsive on her living room floor. Around 7:15am, mom stepped over the VC when she opened the door for [redacted] to come inside. Mom then turned and she saw blood coming out of the VC's mouth. [redacted] performed (CPR) cardiopulmonary resuscitation until the EMS arrived. It was also reported that there was no superficial signs of trauma or neglect on the VC. Moreover, three weeks earlier, the VC had suffered a broken arm and the cast was taken off on 12/20/2016. It was reported that the mom came to the door stating she had overslept and the home was in disorder with clothes on the floor, dressers pulled out and beds without sheets. The report also mentioned that the home had minimal amount of food. However, the special needs child [redacted] was cleaned and dressed appropriately. The mom reported that she had a relative living in her home; but, she had put him out once she learned of his heroin and [redacted] usage. The mother reported talking to the VC about drug usage and the child denied using drugs. The mom reported that she suspected the child's death was drug-related. This report was investigated and determined [redacted]

On 01/23/2017, Philadelphia-DHS received supplemental information that the VC's two female siblings had missed an excessive amount of school days. It was

reported that there was a meeting with the parents on 01/19/2017 to develop a plan for the children to return to school on 01/20/2017, but as of 01/23/2017 the children had not returned to school. The father claimed that the children were still grieving the death of their sister; the report suggested that they were truant before the sister's death.

On 04/19/2017, Philadelphia-DHS received a report [redacted] had disclosed that the VC's stepfather had beaten the VC and was mean to her. No injuries were noted as well any other description of abuse. However, [redacted] reported that [redacted] was not telling the truth for she never saw any abuse [redacted] The reporter noted that the parents appeared to be close to their children and caring about their needs especially with dealing with the loss of the VC. This report was [redacted] but, the information sent to Philadelphia-DHS MDT (Multidisciplinary Team).

Circumstances of Child Fatality and Related Case Activity:

The VC was born on 05/08/2002 and her Date of Death was 12/21/2016.

The Southeast Regional Office received the [redacted] referral investigation [redacted] on 05/16/2017 (conflict of interest investigation as the family received [redacted] from the Philadelphia DHS). It was reported that the VC based on the medical examiner's report had [redacted] found in the VC's femoral blood sample. The report stated that the child's mother [redacted] and she had a known heroin addict residing in her home. Also alleging that mother was associating with drug addicts and there is a possibility, that [redacted] gave the child the [redacted] Regional Office requesting from Philadelphia DHS a Safety Assessment and Plan for the remaining children in the home. The Safety Plan documentation was received from Philadelphia-DHS dated 05/16/2017, which ensured that the children's safety within 24 hours of the [redacted] report. Report to Law Enforcement was hand delivered to the Philadelphia Special Victims Unit immediately to begin the collaboration with the Police on the investigation.

The investigation revealed [redacted] Nor was the mother's home ever identified by police as a drug home or associated as a known house where drugs addicts frequent. Additionally, there was no evidence to support that the mother was associated with drugs as she had been saying all along. On 11/06/2016 the VC was transported to [redacted] hospital after alleging that five boys had assaulted her because she would not give them oral sex. [redacted] the child was given a drug test where it was discovered that the VC tested positive for [redacted] The mother denied that she was ever told of this information by the [redacted] investigator. At that time, the mother was a licensed foster care resource parent and she had adopted a special needs child.

The mother stated on 12/21/2016 (the day her daughter died) she and all her children were in the living room area watching television. Mother stated she slept on the couch next to her special needs child while her three daughters laid under

blankets where they all fell asleep in front of the tv. The mother reported that she woke up when she heard knocking on the door. Mother added it was [redacted] Mother stated that she looked at the VC still lying partially under the blanket and saw blood coming from her mouth. Mother stated [redacted] began CPR until the EMS arrived. Mother stated she had talks with her child about drugs but the child denied its usages. Mother added that the child's attendance in school was a problem because the child would have issues with her peers and that information was confirmed [redacted] Mother appeared visibly shaken as she was interviewed about her child's death. The [redacted] investigation was rendered [redacted] as it related to the VC's mother providing the child drugs. The [redacted] was completed on 07/15/2017. The Philadelphia-DHS [redacted] report was rendered [redacted] The family was not accepted for services but they were referred to DHS's education support unit for additional voluntary services. The case was closed on 07/05/2017. The police completed their investigation and no report of any charges being rendered.

Summary of 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 Act 33 Team questioned why the [redacted] report had not been generated until almost six months after the VC's death. Although the autopsy report was completed on 02/17/2017, no report was made to DHS because the VC was fourteen-years-old and her death was determined to be an accidental drug overdose. The Chief Medical Examiner for the City of Philadelphia and Chair of the Act 33 Team, reported that he had reminded his employees that they need to call Philadelphia-DHS regarding any child death that is not due to natural causes.

  The Act 33 Team felt it was unacceptable that the PA-DHS Investigator did not make his first attempt to contact the family until thirteen days after the [redacted] report was received. The PA-DHS Investigator explained that since the VC had died several months prior, his first step in the investigation was to gather information so that he could be prepared to confront any false statements that might be made by the family. The Act 33 Team noted that, irrespective of the reasoning behind said delays, the failure to respond within 24 hours of the receipt of a [redacted] report constituted non-compliance with the standards set forth in the Pennsylvania Child Protective Services Law.

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

  The Act 33 Team was concerned with the quality of the November 2016 [redacted] investigation. DHS Leadership agreed that the Intake team had several missteps which limited their understanding of the family's strengths and service needs. As a result, the comprehensive safety assessment that was

done at the conclusion of the investigation lacked several vital pieces of information.

The Intake SWSM violated DHS policy by failing to consult with a DHS nurse. In this case, the DHS nurses could have assisted [redacted] and her positive drug test results.

During the course, of the May 2017 [redacted] investigation, the VC [redacted] records were obtained and reviewed by a DHS nurse. The records confirmed that the VC tested positive for [redacted] however, she was complaining of stomach pain while at the hospital. This raised a concern that the VC was exhibiting drug-seeking behaviors.

The Act 33 Team was concerned that the Intake Team's assessment of the family may have been biased. The apparent preponderance of strengths within the family, including the mother's status as a licensed care provider and her previous adoption of a child with special needs, may have led the Intake team to discount evidence that there were safety and risk issues affecting the family.

The Act 33 Team was very concerned that the clearest and most significant piece of evidence (i.e. The VC's positive drug test result) was not obtained during the investigation.

Although the report narrative to DHS stated that the VC had tested positive for [redacted] the mother seemed to be in denial about the drug test results. The Intake SWSM failed to confront and address the mother's denial [redacted]

There was no coordination between the Philadelphia Police Department and the DHS Intake Team regarding the VC's assault in November 2016. The police were unable to interview the VC as the family did not respond to outreach efforts. The Act 33 Team noted that the police and the Intake SWSM may have been able to secure the family's cooperation by working together. Information obtained during a police interview may have also provided the Intake SWSM with further insight into the family's general functioning.

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

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:</u>
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 reviewed the County's internal report and concurs with its Team assessment of the way the [redacted] referrals were managed during this family involvement with Philadelphia-DHS. The Department will now respond to the concern of the Act 33 Team with not seeing the family in 24 hours. The Department as well as Philadelphia-DHS workers are both equally proficient in assessing safety of the families that we come into contact with. With that being said, in collaborative investigations either worker can and does ensure that the remaining children in the home are safe. There is a Present Danger Assessment form associated with this report in which Philadelphia-DHS completed on 05/16/2017 which was the same day that the report was issued [redacted] Moreover, the CPS Laws reads that the VC is to be seen within 24 hours and there is no mention of seeing the family in that same time table. The VC was deceased and the County assessed the safety of the remaining children in the home on the same day that the [redacted] referral was made. (3490.55. Investigation of reports of suspected child abuse states that the agency shall begin its investigation within 24 hours of receiving the report. That was done in this report as written. However, the other 24 hours requirement was related to seeing the child.) (3490.55 (d) states when conducting its investigation, the agency shall, if possible, conduct an interview with those persons who are known to have or may have reasonably expected to have, information relating to the incident of suspected child abuse and there are 1-7 people listed but there is not a 24-hour time limit attached to this requirement.

Department of Human Services Findings:

- County Strengths: The County moved quickly when asked if they were going out to assure the safety of the remaining children in the home since the VC has been deceased for several months now. The County completed the In-Home Safety Assessment and Plan as required within 24 hours and provided documentation to PA-DHS of its completion. Kudos to the County for its appropriate collaboration in the [redacted] investigation.

- County Weaknesses: Within the previous 16 months of Philadelphia-DHS being involved with this family, DHS acknowledged that its Intake Department failed to act on significant red flags as it relates to their assessment of the family's needs. The failure to utilize their nurses to ensure that the VC medical needs were address as well as [redacted] is unacceptable. Moreover, failure to obtain and act upon the VC's best interest when a positive drug test was rendered is mystifying. The latter should have been a very instrumental tool in the child's life in terms of shedding light on a very serious problem the child had that evidently led to her death.

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

  3130.31 (B) (iii): Responsibilities of the County Agency:

  The county failed to utilize its resources (DHS Nurses) to assist the family [redacted] even after learning of the positive drug test result for the child.

Department of Human Services Recommendations:

Coroners and Medical Examiners should be held to the same standards as the rest of the medical community as it relates to mandatory reporting requirements. In this case, there was a 3 month delay between the identification of [redacted] in the child's system to the report to ChildLine. The presence of [redacted] found in the victim child's body was identified in February 2017 was the report to ChildLine was filed on 05/16/ 2017.

County agencies must fully utilize its own resources available to assist staff in assessing families through staff adherence to internal policies and procedures. A mechanism for monitoring the use of these resources, such as staff nurses, should occur on a routine basis.