pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/23/2015
Date of Incident: 04/24/2017
Date of Report to ChildLine: 08/24/2017
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:
05/10/20178

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 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 09/15/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	05/23/2015
[redacted]	[redacted]	[redacted]1991
[redacted]	[redacted]	[redacted]2012

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families reviewed the case file, including medical records, case notes, and other documentation, and maintained ongoing communication with the Philadelphia Department of Human Services intake staff.

Summary of circumstances prior to Incident:

A general protective services (GPS) report was received by Philadelphia Department of Human Services (DHS) on 05/23/2015, alleging that the mother tested positive for [redacted] when the victim child was born. The victim child was healthy but his drug screen was pending at the time of the report. The mother admitted that she took [redacted] 1 to 2 days prior to her delivery for pain in her back and feet. Throughout the mother's pre-natal care, there were no reports of her testing positive for any substances for the duration of her pregnancy. It was also reported mother cannot care for the victim child because of housing issues. The mother stated that she was planning to move from the victim child's father home and relocate to her godparent's home. However, the mother did not provide an address to the godparent's home and refused to discuss any further housing concerns with the Intake investigator. The report was investigated by the Philadelphia Department of Human Services (DHS), and was determined to be "valid." The family received voluntary prevention services through the [redacted] from 06/08/2015 through 09/04/2015.

A GPS report was received by Philadelphia DHS on 04/24/2014, stating that the victim child was transported to [redacted] with an altered mental status. The mother stated that the victim child was in his usual state of health prior to being put to sleep for a nap at 11:40 AM. When he woke up from his nap, the mother noticed the child seemed drowsy, unresponsive and "out of it." The victim child was transferred to the [redacted] and admitted to [redacted] for critical care management. The medical team suspected his condition was as a result of ingesting an unidentified substance. Further testing needed to be completed at the time of the report to conclusively validate these claims. It was reported that the father was previously encouraged to file for custody of the victim child due to the mother's alleged substance abuse history. The report was investigated and determined to be valid. In August, information was received that this report met the criteria to be registered as a near fatality report and it was registered as this current near fatality report.

A new report was generated on 07/07/2017, to open the case for services. On 08/08/2017, [redacted] began in-home safety services to the victim child's sibling. The victim child is still in the care of his father.

Circumstances of Child Near Fatality and Related Case Activity:

The report was assigned to a Multi-Disciplinary Team Social Work Services Manager (MDT SWSM) for investigation. The father was interviewed regarding the 04/24/2017 incident. It was reported by the father that he started to care for the victim child on 04/24/2017 in the afternoon and that the victim child was given [redacted] to treat his cold two times a day. The father reported that the victim child was his usual self by the next morning. The father took the victim child to the mother since the father had to work that day. It was the father's understanding that the victim child would stay at the home with the mother and his maternal grandmother.

The father stated that on 04/24/2017, the next day at 11:00 am, he received a telephone call from the mother telling him that the victim child was unresponsive and was taken to the hospital. It was reported by the father that the mother told him that she and the child had spent the previous night at the mother's paramour's house. The father denied having any information regarding the mother's paramour. He was also unable to provide any additional information about how the victim child may have ingested any substances. He stated that he did not think the mother intentionally tried to harm the victim child; however, he no longer trusted the mother with his son. The father reported that he gets upset when he hears neighbors talk about how the mother would leave the VC in neighbors' care for short periods of time.

The MDT SWSM also met with the victim child who had been in his father's care since he had been [redacted] from [redacted] on 04/25/2017. The child appeared be

clean and happy. The MDT SWSM completed a safety assessment of the father's home and found it to be appropriate for the victim child.

The MDT SWSM also met with the maternal aunt (MAU), the maternal grandmother (MGM) and the VC's five-year-old sibling. [redacted] had been providing in-home safety services to the victim child's sibling since 08/08/2017. The MAU reported that the mother contacted her in late April or early May and said that she needed help. [redacted] had been in the MAU's care since that time. The MAU reported that she had met with numerous people, including [redacted] but she was still confused about what was going on with the family's case. Both the MAU and MGM reported that they did not know where the mother was living.

The MDT SWSM privately met with the victim child's sibling and it was informed that he has been living with the MAU for a while and he did not have any concerns about staying with the MAU. The MDT SWSM noted that the sibling appeared to be physically healthy and did not have any bruises or marks to his body. The MDT SWSM attempted to interview the sibling about the victim child incident but due to his age, the sibling was unable to answer questions about the victim child. He was also unable to remember being in his mother's care.

A safety assessment was completed for the sibling and safety threat was identified as the mother's whereabouts were unknown and the circumstances surrounding the victim child's ingestion on 04/24/2017, remained unexplained. A new safety plan was completed with the MAU and the MGM. The mother was not to have any contact with the sibling until further notice from Philadelphia DHS.

The MDT SWSM made attempts to meet with the mother during the course of the investigation however her whereabouts were unknown. The MAU and the MGM also both denied having any information on the mother's whereabouts.

A new GPS report was received on 09/01/2017, by Philadelphia DHS alleging that the MAU had found the sibling and his 6 year-old cousin together in the cousin's room with the door closed. The children were in bed under the covers and they both had their clothes on. When questioned, the cousin stated that the sibling had touched her private parts. It was unknown if the touching had occurred on top of or underneath the clothing. In addition, the sibling stated that he got a beating from the MAU for doing something that he was not supposed to be doing. It was reported also that the sibling and another cousin had also been touching each other. It was reported that the sibling's mother had substance abuse issues. The mother was currently homeless and her whereabouts were unknown. The reporter stated that all of the sibling's basic needs were being provided for by the MAU. The MAU was in the process of becoming [redacted] for the victim child's sibling.

At the Act 33 Review, the team discussed the type of substance that [redacted] may have ingested. Although [redacted] tested positive for [redacted], this was not consistent with [redacted] condition but all other tests for drugs were negative. The medical professionals on the team felt that a pesticide or a synthetic opioid, both which

would not have shown up on the tests that had been completed, would have explained [redacted] condition. The precise substance that [redacted] ingested remains unknown.

On 10/11/2017, the child protective services report was determined to be indicated, naming the mother as the perpetrator. On 10/24/2017, the GPS report was determined to be invalid. There is no criminal investigation regarding this matter.

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;

  - Compliance with statutes and regulations.

    - The Act 33 Team stated that the MDT SWSM did a good job investigating the case.

    - The Act 33 Team questioned why PA-DHS Childline did not agree to certify the April 2017 GPS report as a near fatality. The report specifically noted that a physician had certified [redacted] condition to be near fatality due to suspected abuse or neglect. In addition, although Childline did not agree to update the GPS report to a CPS report at the time, the law (Act 33 of 2008) does not require there to be a CPS report in order for a case to be certified as a near fatality.

      - Representatives from the PA-DHS Office of Children, Youth and Families, Southeast Regional Office (OCYF-SERO) reported that an oversight had been made at Childline and that the report should have been formally certified in April. OCYF-SERO Representatives also reported that Childline had instituted a new process whereby GPS reports in which a physician has certified the child's condition as a near fatality will receive a secondary review if the report is not upgraded to a CPS report. This process was not in place at the time of the April 2017 report.
      - Representatives from OCYF-SERO also noted that, if Childline does not agree to upgrade a report, the county can contact Childline to request an upgrade after additional information is obtained.
      - CHOP representatives noted that, subsequent to the April 2017 report, the toxicology report revealed that [redacted] had high levels of [redacted] in [redacted] system. In addition, during the course of the April investigation, the mother admitted to giving [redacted] to [redacted]. It was unknown why DHS did not contact Childline at the time to discuss having the report upgraded.

- The Act 33 Team discussed Childline staff being permitted to overrule physician's decisions regarding the seriousness of a child's condition and their suspicion that said condition was non-accidental. Representatives from [redacted] and [redacted] reported concerns that their physicians have certified cases as near fatalities, but the cases have never come to the attention of the Act 33 Team.

    - The Act 33 team noted when PA-DHS receives notice that a case has been certified as a near fatality through its on-line Child Welfare Information Solution portal, there is no follow-up with the reporter to assess whether the certification is consistent with the Act 33 law. In addition, if a report is erroneously certified as a near fatality, the county agency must initiate a detailed decertification process. Childline does not have any similar internal formal process for decertifying a case.
    - The Act 33 Team also noted that since Childline must acknowledge the near fatality certification before a case can be identified for an Act 33 review, then the statewide statistics on near fatality cases are likely to be inaccurate.

- The Act 33 Team noted that since the April 2017 report was a GPS, a police report was not generated until the CPS report was generated in August. Had the police been contacted in April, a scene investigation could have occurred and additional evidence may have been collected that would help to identify the substance that [redacted] had ingested.

- The Act 33 Team also discussed the services that had been provided to the family following the May 2015 report. A review of the record revealed that the family had not been compliant with the voluntary prevention services. The DHS Hotline had been contacted at the time; however, the reporter's attempt to file a new report was rejected. It was unclear why a new report was not generated. Representatives from DHS announced that they would look into the matter.

- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>;
    - None

- <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>;
    - The Act 33 Team recommended that [redacted] and [redacted] compile lists of children whose conditions and had been certified as near fatalities and forward the lists to DHS. DHS should review the cases to verify if they were formally certified by Childline and follow up with any children who were not certified to determine if reviews are necessary.

- <u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies.</u>

- The Act 33 Team recommended for DHS to hold a meeting with Childline to discuss the issues surrounding the near fatality certification process.
- The Act 33 Team recommended for DHS to hold an internal review of its process for certifying near fatality cases and ensure that all forms and procedures are clear and current.

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

Department Review of County Internal Report:

The Department received the County's report dated 12/13/2017, and is in agreement with their reporting of the meeting.

Department of Human Services Findings:

- County Strengths:
  - The Team felt that a competent investigation was completed by Philadelphia Department of Human Services. The Team felt that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the investigation.

- County Weaknesses:
  - None

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:

Additional education and clarification regarding the statutory definition of Near Fatality and guidance to medical providers when making reports of suspected child abuse should be developed through collaborative efforts with DHS and the American Academy of Pediatrics.