pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/02/2005
Date of Incident: 08/29/2017
Date of Report to ChildLine: 08/31/2017
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
06/06/2018

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 Department of Human Services (Philadelphia DHS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 07/11/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	01/02/2005
[redacted]	Mother	[redacted]1981
[redacted]	Father	[redacted]1969
[redacted]	Sibling	[redacted]2006
[redacted]	Mother's Paramour	[redacted]1988

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) attended the county review team meeting on 09/29/2017 where the investigation of the report and analysis of the family's past and current status was discussed. SERO reviewed the documentation related to the investigation and provision of services to the family in the County's Electronic Case Management System. Documentation included structured progress notes, safety assessment, safety plan and supervisory conference logs.

Summary of circumstances prior to Incident:

The family had no prior involvement with any Children and Youth agency.

Circumstances of Child Fatality and Related Case Activity:

On 08/31/2017, the Philadelphia DHS received a Child Protective Services report that stated the 12-year-old female child arrived at the hospital emergency department on 08/29/2017 after suffering two seizures at home. The child had another seizure episode at the hospital. The child required intubation and mechanical ventilator support and was subsequently transferred to the pediatric intensive care unit of another hospital for further care.

The report of suspected child abuse alleged that the child's seizures and her need for emergency medical intervention were due to inadequate caloric intake and water overload. The child weighed 56 pounds and had only gained nine pounds in two years.

The report was assigned to a DHS Multi-Disciplinary Team Social Work Services Manager for investigation. The mother and the mother's paramour reported that on the day of the incident, the child had a seizure at 3:00 PM that lasted approximately four minutes. The mother reported that she heard a loud noise while the child was in the bathroom. The mother stated she saw the child lying on the floor and shaking. The mother and the paramour held the child's head to prevent injury. The mother stated she tapped the child to see if she was okay. According to the mother, the child vomited but the child then said that she was okay. The mother and the paramour moved the child to the mother's bed and the child vomited again. The two moved the child to the floor where she had another seizure at approximately 4:30 PM. The mother and the paramour then used a ride-sharing service to take the child to the hospital instead of calling an ambulance. The child's 10-year-old brother, who also lives in the home, was left at the home to watch his 5-year-old cousin who was visiting.

The mother and the paramour reported that for the past two years the child consumed significant amounts of water at home each day including up to four 44-ounce servings. The mother reported she only cooks when she has the day off, generally one day per week. The mother reported she makes a large container of food for the children to heat up each day. She stated both children eat the same meals, such as oatmeal, bread, and noodles, every day. The mother and the paramour denied eating the same meals as the children and indicated that they cooked meals for themselves. Both have admitted to supplementing the children's meals with water**.** The paramour stated the children have cried for food and she has told them to drink water because she doesn't know what else to do.

During the investigation a home assessment was completed. It was reported there was an ample amount of food in the home along with gallons of water in the kitchen closet. A padlock was observed on the kitchen cabinet where snacks had been stored. The padlock was used after the children reportedly had stolen snacks.

The mother consented to allowing the Multi-Disciplinary Team Social Work Services Manager to take the brother to the [redacted] on 08/31/2017. The brother received a medical evaluation and was admitted to the hospital immediately for concerns of severe malnutrition. He had gained only 11 pounds in three years.

The Multi-Disciplinary Team Social Work Services Manager, in consultation with the Philadelphia DHS nurse, learned the child was seen by an endocrinologist in January 2015. The mother was advised to return with the child for a follow up appointment one year later however she did not. At the time of the child's hospitalization, the child's body mass index was reportedly significantly lower than at her primary care physician appointment in December 2016. The hospital was completing testing to

identify factors that could have caused the child's seizures and lack of physical growth, however the cause was likely water intoxication and malnutrition.

Case management services for the family were initiated on 09/06/2017 by a Community Umbrella Agency. On 09/08/2017, the children were [redacted] from [redacted]. DHS obtained [redacted] for the children and they were [redacted]. On 09/12/2017, the child [redacted]. A Special Needs social worker was assigned by the children's medical insurance provider to coordinate the children's follow-up medical care. On 09/15/2017, the children received forensic interviews at the children's advocacy center, and as a result, were referred for [redacted]. It was determined the children did not need in-home therapeutic services. They were transferred to a [redacted] provider closer to [redacted] home.

The report was indicated on 10/18/2017 naming the mother and the mother's paramour as the alleged perpetrators. On 09/13/2017, DHS received a Child Protective Services report regarding allegations that the brother had been [redacted] on 08/31/2017 due to [redacted].

On 09/18/2017, DHS received a Law Enforcement Only report alleging the child was touched inappropriately by an 11-year-old during an incident that had occurred sometime in the past year. The report was assigned to Law Enforcement because the 11-year-old did not meet the definition of perpetrator in the Child Protective Services Law.

On 10/27/2017, DHS received Child Protective Services reports regarding the child and her brother alleging physical abuse of the children by the mother and the paramour. The reports were unfounded on 12/28/2017 and 12/21/2017 respectively.

The mother and her paramour were arrested on 10/19/2017 and charged with aggravated assault, conspiracy, two counts of endangering the welfare of a child, simple assault, and recklessly endangering another person. They were both incarcerated until 12/04/2017 when the judge dismissed the criminal charges at the preliminary hearing due to a lack of evidence.

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 stated that the Multi-Disciplinary Social Work Services Manager effectively conducted the investigation. The Act 33 Team also commended the Multi-Disciplinary Social Work Services Manager for ensuring that the child's sibling was medically evaluated. When the sibling was brought [redacted] by the Multi-Disciplinary

Social Work Services Manager, medical staff initially stated that he did not need to be examined. The Multi-Disciplinary Social Work Services Manager was concerned with the sibling's appearance, however, and insisted that he be formally evaluated.

- Deficiencies in compliance with statutes, regulations and services to children and families; The Act 33 Team discussed the failure to have the sibling immediately evaluated following the child's [redacted].
    - [redacted] representatives acknowledged that the child's sibling should have been evaluated when the child was admitted given the severity of the child's condition and the concerns for abuse. [redacted] representatives agreed to review the situation with staff and reiterate the importance of having all household children immediately evaluated when there are concerns for abuse.

- The Act 33 Team also discussed the initial Family Court hearings for the children. The Court allowed the mother and her paramour to have line-of-sight and line-of-hearing supervised visits with the children. The team questioned why visits were not suspended and expressed concerns that that the visits would cause further [redacted] to the children.
    - Representatives from the Law Department reported that, at the time of the initial court hearing, there was not enough evidence to support a request to have the visits suspended. In light of new evidence that had been collected following the hearing, however, a request to have the visits suspended was being drafted.

- The Team also did not understand why the mother's paramour was appointed an attorney since he was not a biological parent. It was noted that the Family Court judge acknowledged that the paramour was standing in loco parentis and was therefore given standing in Court. In addition, the paramour was permitted to have line-of-sight and line-of-hearing visits.

- The Act 33 Team reviewed the concerns expressed by the children's school counselor. As a mandated reporter, the counselor should have called ChildLine to make a report if she had any suspicions of abuse or neglect. Although malnutrition could be attributed to poverty, it could be a form of abuse.
    - The [redacted] staff need to be aware that the DHS can refer families for prevention services to address poverty issues. Staff should also be aware of food banks in the neighborhoods.

- The [redacted] representative provided information about the trainings for mandated reporters that are provided to staff. The representative stated that they would emphasize the penalties for failure to report suspected abuse and neglect. If the children were exhibiting warning signs for neglect, someone should have called in a report. The representative

stated that she would explore whether or not staff had taken appropriate action in this case and, if not, disciplinary action would be initiated against staff.

- The Act 33 Team also discussed the children's prior medical care. The mother did not ensure that the children had regular medical care. She had also changed medical providers for unknown reasons in December 2016. It was noted that the new medical provider had an obligation to review old medical records and track the children's growth, particularly since the nurse practitioner documented that the child was of short stature and underweight. The children, however, were noted to be healthy. Proper nutrition was discussed at the visit.
    - The Team noted the child's condition progressed over a period of time. Her body adapted to the [redacted]. If her [redacted] had dropped quickly, she would not have survived.

- 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; 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 Southeast Regional Office received the Philadelphia Department of Human Services Fatality Team Report on 12/28/2017 and is in agreement with the report.

Department of Human Services Findings:

- County Strengths: The County conducted a thorough investigation. The County advocated for the brother to have a medical evaluation when it was initially determined by medical staff that there was no need for an exam.

- County Weaknesses: and
  None noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  None noted

Department of Human Services Recommendations:

The Department recommends training for [redacted] staff on recognizing abuse and neglect, including malnutrition, and the requirements for reporting suspected abuse.