pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/24/2015
Date of Incident: 09/01/2017
Date of Report to ChildLine: 09/01/2017
CWIS Referral ID: [redacted]

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

Philadelphia Department of Human Services

REPORT FINALIZED ON:
09/02/2018

Office of Children, Youth, and Families, Southeast Regional Office
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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 09/29/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	10/24/2015
	Mother	[redacted]1984
	Father	[redacted]1981
	Sibling-Full	[redacted]2009
	Sibling-Maternal Half	[redacted]2005

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. There was an Act 33 Review on 09/29/2017. The case was determined to be indicated on 10/20/2017. The police investigation is ongoing.

Children and Youth Involvement prior to Incident:

The Philadelphia Department of Human Services (DHS) had no prior agency involvement with either the family or the alleged perpetrator.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/01/2017, a Child Protective Services (CPS) referral was made regarding the child; reporting that the child had failure to thrive, developmental delays, and Osteopenia (meaning her bones had no or low mineral density; soft or weak bones). X-rays revealed multiple fractures with multiple stages of healing. Fractures included the child's ribs, right fibula, right and left alma, left humerous, and fingers on both hands - specifically the middle finger. It was unknown if the fractures were a result of abuse or neglect, the result of the child's condition, or a combination of both. The child was seen by her Primary Care Physician (PCP) who completed an

examination on 08/31/2017. The child was sent immediately to the Emergency Room for failure to thrive. The child was in the zero percentile of height and weight. The child did not attend day care and was watched during the day by her father - the alleged perpetrator. The child had been attending doctor's appointments regularly up to one year of age. It was reported that the child missed her 15-month checkup, but was seen at 19 months on 06/02/2017, at which time it was noted the child had severe failure to thrive and developmental delays.

It is reported that the child had been referred to [redacted] but the child was not taken to or evaluated by [redacted]. The mother stated she was not given sufficient information to have the child evaluated for services. The child was scheduled to return to her PCP in a month, but the child did not return to be seen until three months later.

The [redacted] was notified on 09/01/2017.

On 09/02/2017, the DHS Social Work Services Manager (SWSM) visited the child at the hospital and found the mother present. The hospital social worker reported the child was to remain in the hospital because she was not eating or drinking. The SWSM presented the mother with CPS allegations, and the mother stated she was open to accepting services in the home. At that time, the mother stated the child had missed multiple medical appointments because of the father cancelling. The mother further stated the father had health issues, as being [redacted] and [redacted]. The mother stated the father was not an appropriate caregiver for the child; however, due to limited supports she had no other means of childcare.

On 09/05/2017, the case was assigned to the Intake SWSM. The SWSM contacted the reporting source for additional information. The SWSM was told the child had rickets (softening and weakening of bones – Vitamin D deficiency) and her fractures were consistent with rickets. The child was receiving a Vitamin D supplement and regular feedings. The child was to remain hospitalized. The reporting source was concerned that the child had not received medical care and the child had pain because of the fractures. The reporting source did not think the child was up-to-date on her immunizations. The SWSM consulted with a DHS nurse, and the hospital social worker. It was reported the child had been breast-fed but she stopped feeding and would not take formula. On 06/02/2017 the mother took the child to the pediatrician because the child was losing weight. The mother stated she was feeding the child pizza, chicken nuggets and cheese. The mother reported she fed her children when they were hungry. The mother further stated the doctor told her to give the child what she liked. The mother indicated that the child was seen by another doctor because the child's PCP was not present, and the doctor who saw the child on 06/02/2017 did not think anything was wrong with the child. At that time, the mother was referred to [redacted]. The mother stated she did not follow up with the appointment scheduled in a month because she had to work. The child was not seen until 09/01/2017. The child was taken the pediatrician and sent to [redacted]

After the hospital visit, the SWSM went to the home and provided the father with the CPS allegations. The SWSM observed the father's [redacted] and [redacted].

The SWSM questioned the child's half sibling and he appeared comfortable in his environment. The half sibling stated he can eat whenever he wants to and denied that he and the other children were being physically disciplined. The half sibling also denied being left alone to care for the other children.

On 09/06/2017, the DHS hotline received a phone call from [redacted] at [redacted] stating the condition of the child was being considered as serious and was certified as a near fatality. The child had severe malnutrition and her bones had not formed properly. The child's limbs were visibly deformed and she was non-weight bearing. The child had a pic line inserted for nutrition and the doctor was looking into a referral to the [redacted]

There were two other children residing in the home. The children appeared to be of appropriate weight and did not appear to be malnourished or dehydrated. The full sibling was [redacted] as a part of a Safety Plan. The half sibling was to stay with his biological father during the investigation. The victim child remained hospitalized [redacted].

On 09/12/2017, the Intake SWSM contacted the hospital social worker and was told the child was eating soft foods and was taking Pediasure, calcium, Vitamin D, and sodium phosphate. The child was slowly gaining weight.

On 09/15/2017, it was discovered that the child's insurance provider rejected the rehab program, and the child's date of discharge was anticipated to be 09/18/2017, with a recommendation for [redacted]. The Intake SWSM also spoke to the nurse who was providing care for the child at [redacted]. There were concerns that the mother may have been handling the child inappropriately, because as the child's bones were mineralizing, new fractures were appearing. The child was in need of surgery for some of her fractures. A skeletal survey revealed all of the child's ribs were fractured. The child was to have an magnetic resonance imaging/computerized axial tomography (MRI/CT) scan of her head, and an eye exam. The hospital social worker reported that the mother was a distraction while the child was in therapy, further stating the child did well when the mother was not present.

On 09/18/2017, the SWSM contacted the hospital social worker and was told the child was not ready for discharge because several tests needed to be run.

On 09/21/2017, a petition was filed on behalf of the child's siblings. The Intake SWSM would consult with the law department regarding the father's custody of the half sibling. The victim child remained in the hospital with no anticipated date of discharge.

On 10/20/2017 the CPS report was indicated. Both the mother and father were indicated for serious physical neglect of the victim child for failure to provide child with nutrition/hydration. The neglect resulted in the child's failure to thrive. The police investigation is ongoing.

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 discussed DHS and [redacted] protocols restricting visits with victim children. [redacted] wanted to stop mother's visits due to concerns regarding how the mother handled the child. It was noted that DHS was unable to restrict the mother's visits without a court order.

The Act 33 Team also discussed the child's history of inconsistent medical care. The child's medical issues were not addressed by her PCPs. The Team questioned if because of the child's history of failure to thrive and the significant risk to her health and development, the PCP should have called in a report of neglect when the mother missed the follow up visit.

Medical providers on the Team noted that missed medical appointments are an ongoing systemic issue. The medical providers often do not have sufficient staff to track families to determine if caregivers have sought medical care with other providers, or if they are failing to meet the medical needs of their children.

The Team also stated that medical providers, school, and other agencies employing mandated reporters should be better educated regarding malnutrition in children.

Since the twelve year old half sibling was enrolled in [redacted] and the eight year old full sibling had never been enrolled in any school, it was not clear if the [redacted] or [redacted] was aware of the full sibling's existence and the fact that she was school aged. It was also noted that the [redacted] is responsible for ensuring that all children residing in the city receive an education; however, [redacted] does not receive any official records regarding children who are born in or living in the city. There were additional concerns that the half sibling had truancy issues. It was reported that [redacted] and [redacted] are working together to ensure that all children are enrolled in kindergarten, through a review of immunization and health records.

A representative from [redacted] agreed to explore what information was known about the full sibling and provide a report of what actions should have occurred to ensure that she was enrolled in school.

Regarding the half sibling's possible truancy issues, the representative from [redacted] stated that [redacted] can address truancy issues in their own way, or they can address truancy issues via the [redacted] procedures. The representative noted that new legislation requires all schools to send truancy information to the Department of Education.

The Team also discussed the full sibling's service history with [redacted]. The mother reported that [redacted] diagnosed the full sibling with [redacted]. It was not clear if any follow up occurred when the full sibling stopped receiving services. The Team questioned if early intervention providers have a system in place to identify when children stop attending recommended services.

It was reported that parents do not have any legal obligation to continue early intervention as they are voluntary services.

At the time of the report, the family did not have an open case with DHS and was not receiving any services.

On 09/27/2017, [redacted] a community Umbrella Agency (CUA), assumed case management services for the family.

On 10/02/2017, the victim child was [redacted] from [redacted]. An [redacted] was obtained and the child was [redacted]. The [redacted] process was initiated. The cousin ensures that the child receives all necessary medical care, proper nutrition and early intervention services.

On 10/18/2017, an [redacted] was obtained for the full sibling. She remains in the care of her step grandmother. She has been enrolled in school and receives regular medical care. She was referred for supportive services.

On 10/20/2017, an [redacted] was obtained for the half sibling. He was [redacted] as the victim child. The half sibling's father was not providing for him and had left him in the care of the paternal grandmother. She was unable to continue providing care to the half sibling.

The parents' visitation with the children is supervised.

As per Family Court Order, the parents will be referred for parenting capacity evaluations, dual diagnosis assessments and random drug screen.

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

There were none noted.

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 of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. The regional office attended the Act 33 on 09/29/2017.

Department of Human Services Findings:

County Strengths:

Philadelphia County did a great job of conducting and completing this investigation in a timely manner and coordinating efforts with the hospital staff and the extended family members.

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:

The Department concurs with the findings in the County's report. There were no additional recommendations made.