pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/12/2016
Date of Incident: 09/22/2017
Date of Report to ChildLine: 09/22/2017
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:
09/06/2018

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (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 10/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	victim child	03/12/2016
	mother	[redacted]2000
	father	[redacted]1996
	maternal grandfather	[redacted]1967
	maternal aunt	[redacted]1995
	maternal cousin	[redacted]2012
	maternal aunt's paramour	[redacted]1993

Summary of OCYF Child Near Fatality Review Activities:

For this review, the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation, including the investigation/assessment, safety assessments, and safety plan. SERO spoke with the county caseworkers, medical staff and law enforcement. SERO attended the Act 33 team meeting on 10/20/2017.

Summary of Circumstances prior to Incident:

On 03/15/2016, it was reported the current victim child's mother was truant and recently gave birth to the child. In-home safety services were provided through [redacted] beginning on 04/18/2016. On 09/23/2016, while the case was still open, it was reported the mother had continued truancy issues and she and the child were [redacted] through [redacted]

[redacted] The mother [redacted]. On 12/29/2016, they [redacted] to the maternal grandfather's home with in-home non-safety services being provided by [redacted]. The county closed the case on 03/24/2017.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/22/2017, Philadelphia Department of Human Services (DHS) received a Child Protective Services (CPS) referral that an 18-month-old male child was unresponsive when he arrived at the hospital via ambulance. His breathing was irregular and pupils were dilated. The child was administered [redacted], used to treat a drug overdose. Although [redacted], his response to the [redacted], along with [redacted] that showed abnormal liver function, suggested the child ingested an opioid. The father reported he was prescribed [redacted] and it was possible the medication was within the child's reach in the home.

The child's safety was immediately assessed. He was admitted to the pediatric intensive care unit (PICU) for observation. It was noted his breathing had improved. The Social Worker interviewed both parents. The father was responsible for the child around the time it is believed the child ingested the drug. The mother was working at the time and was not home. The father reported that he gave the child a drink in a sippy cup and went to use the bathroom. Upon his return he placed the child on his chest and the child stopped breathing. While a family member called 911, the father reported that he began CPR. The child vomited and started to breathe again. The parents stated that the child had difficulty breathing for several days prior, however, he was not taken for medical intervention as the symptoms were not persistent. The father confirmed that he had been prescribed [redacted] several months ago for surgery to his hand, although he could not recall the name of the physician. He did offer that the physician's office had been raided and the physician was arrested. The father described storing the medication in its proper container in a nightstand but claims the pills were disposed of following the incident. He stated there were only 2 pills remaining and that they were broken into several pieces. The mother reported the child attempted to open the drawer on multiple occasions, but she was always able to stop him. She also reported the maternal grandfather was also prescribed [redacted] but he kept his pills in a safe in his bedroom. The father stated the child was not left unsupervised for an extended period of time on the day of the incident. The father denies [redacted] but did admit he had been arrested a few months prior on drug-related charges.

The multi-disciplinary social worker (MDT SW) conducted a home assessment on 09/25/2017. The maternal grandfather was interviewed and stated he was not home at the time of the incident. The home was infested with cockroaches and appeared in disarray. There was trash strewn about both inside and outside the home. Cat feces was observed on the kitchen floor. Cabinets and counter tops were broken. The MDT SW did not observe any loose pills or prescription bottles in the child's or parents' rooms. The maternal grandfather had his [redacted] and the father's [redacted] and [redacted] medications in a locked safe in his bedroom.

A 5-year-old maternal cousin who at times will reside in this home with his mother, the maternal aunt, have been staying with another relative since the incident. A safety assessment determined this child to be safe with a plan as long as he remained in the home with this other relative. This child was unable to provide much information about the incident due to his age when he was interviewed by the MDT SW.

The MDT SW then interviewed the maternal aunt's paramour who was present in the home on the day of the incident. He reports the father told him the child was choking and observed the child slumped in the father's arms. He called 911 while the father performed CPR. Later that evening he and the maternal aunt disposed of any drugs from the home. He reports he found 5 [redacted] pills in a plastic bag in the nightstand and an unidentified pill on top of the nightstand. He reports he has been residing in the home for 15 months and he has observed loose pills throughout the home, including the bathroom floor, the steps, and throughout the first floor of the home. He observed the father to be under the influence on many occasions.

On 09/26/2017, DHS obtained an [redacted] as the family was unable to identify a suitable family member to care for the child. The family was accepted for services on this date.

On 10/19/2017 DHS received a referral for General Protective Services concerning the child's minor (16-years-old) biological mother. The maternal grandfather was not meeting her daily basic needs or educational needs. He was permitting the 21-year-old father of the child to reside in the home and maintain a sexual relationship with the mother. This was also referred to law enforcement and there is an ongoing investigation regarding the statutory relationship of the parents as the age difference and ages of the parents at the time of the child's conception could be a criminal matter. The father of the child has since moved out of the home.

On 11/09/2017, DHS indicated the report naming the child's father as the perpetrator for causing serious physical neglect of the child. His egregious failure to supervise his son resulted in the near fatality condition of the child. The criminal investigation is ongoing. However, the father was arrested on 12/10/2017 for a non-related offense and is currently incarcerated.

The child [redacted] through [redacted] and is receiving [redacted] and speech therapy at the daycare. The child's family is receiving case management services, [redacted], parenting education and parenting for young parents. The mother is compliant with all services and has weekly supervised visits with the child. The father was minimally compliant with services prior to his incarceration. There are no visits occurring with the child while he is incarcerated. There are no medical concerns for the child at this time.

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 noted that the MDT team effectively conducted the investigation. The MDT SWSM consulted multiple times with a DHS nurse and also with a representative from the [redacted]. The MDT SWSM proactively sought out education regarding different opioids, their effects and the uses of [redacted].

  There was misinformation during the course of the investigation. Specifically, the assigned detective informed that [redacted] was also used to alleviate respiratory conditions such as asthma. Fortunately this misinformation did not derail the investigation.

  In addition to the CPS report, a GPS report was generated for the minor mother as a case child. The safety plans for both investigations dictated that the child's father would leave the home while the investigations were ongoing.

- 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;

  The Act 33 team recommended a brief memo regarding [redacted] uses and effects be circulated to staff at the Philadelphia police department, district attorney's office and DHS. A representative from [redacted] offered to write the memo.

  The team discussed providing additional [redacted] training to all police personnel, not just those officers who are carrying [redacted] during their shifts.

  The team recommended the Act 33 Chairperson reach out to the Philadelphia Fire Department's Director of Emergency Medical Services to request that this case be reviewed to determine if administering [redacted] to the child would have been an appropriate medical response during the child's transport to the hospital.

- 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 additional recommendations.

Department Review of County Internal Report:

The Department has received and reviewed the county report dated 01/18/2018. The Department is in agreement with the county's findings.

Department of Human Services Findings:

- County Strengths:

  There was clear documentation in the case notes. All relevant parties were interviewed. There was good collaboration and safety was ensured for not only the victim but the maternal cousin as well. Appropriate services are being offered and appropriate referrals for investigation concerning the minor mother were made.

- County Weaknesses: and

  None noted.

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

  None noted.

Department of Human Services Recommendations:

Continued outreach to families with children, especially young children, concerning the importance of securing all medications out of reach of the child. This outreach could be done at all pediatric appointments, upon discharge from the hospital after birth, and through public service announcements. Community outreach should also focus on empowering family members to intervene when observing medication left accessible to children.