pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/09/2014
Date of Report to ChildLine: 10/05/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

The Philadelphia Department of Human Services

REPORT FINALIZED ON:
09/06/2018

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 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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/03/2017.

Family Constellation:

[redacted]	Victim Child	10/09/2014
	Mother	[redacted]1987
	Father	[redacted]1971
	Sibling	[redacted]2007
	MGGM	[redacted]

*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

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 staff. The Southeast Regional Office of Children, Youth and Families participated on the county review team convened on 11/03/2017.

Children and Youth Involvement prior to Incident:

The family was known to the Philadelphia Department of Human Services. On 02/07/07 the mother gave birth to a child who tested positive for [redacted] and [redacted]. The report was valid, and Services to Children In their Own Home (SCOH) and [redacted] were provided to the family.

The mother/AP was asleep in a car with the VC and when the police approached the car, the mother/AP woke up, ran, leaving the VC in the car. It was reported that the mother/AP gave the impression to be high off of [redacted] and the police took the AP to [redacted]. It was reported that the VC appears to have normal functioning. It was reported that the AP gave the MGF's name, as a person who can care for the VC; however, when the police visited the MGP's, according to the police both of the MGP's were too intoxicated to care for the VC. The MGP identified the

MGGM as a possible person to care for the VC. It was reported that the home was appropriate, the MGGM was appropriate, the VC was happy to see the MGGM, and vice-versa. At the time the father was incarcerated. The victim child [redacted]. The court stated that the mother was not to have unsupervised visits with the victim child.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child resides with his father in Delaware County but was with the mother in Philadelphia at the time of the incident. The mother stated that she went to her [redacted] program in Philadelphia with the victim child. She stated that the process is that you go into a booth and is monitored by the nurse. The nurse allowed the victim child in the booth with his mother because the victim child was having a temper tantrum. The mother stated that she asked for a cup of juice for the victim child. The nurse handed the mother a cup and she gave it to her child. Then the nurse handed her the mother a second cup as the mother takes [redacted] with water or juice. When the mother turned back to get her cup the nurse informed her that the first cup (the one that was handed to the child) was the cup for the mother.

The mother asked the nurse if she thought the child ingested her [redacted]. The nurse responded no. The mother was upset that she was identified as the perpetrator when it was the nurse that made the mistake. The mother was told that if she suspected that the victim child ingested [redacted] that she should have taken the child to the hospital immediately. The mother took the child to his father. The father noticed that the child was sleeping off and on and not breathing well. The father asked if the child was sick. The mother disclosed what occurred. The father transported the victim child to [redacted] and later transferred to [redacted]. It was stated that when the father arrived to the house the child was sleeping; but, according to the father the child did not seem to be normal to him, the father noticed that the child was "breathing funny." It was stated that the father brought the child to Emergency Department and the child was unresponsive and barely breathing when the child arrived to ED. It was stated that the ED suspected Serious Physical Neglect since the child seemed to be overdosed on [redacted]. It was stated, by the certifying physician, that the child was in critical condition, the child was "very sedated and not breathing properly for unknown period of time" also, was necessary to administrate several doses of [redacted] and the child's mental status was "waxing and waning multiple times". The effects on the child's brain and internal organs and the child's prognosis were unknown at the time of the incident.

The CPS was made to Delaware County Children and Youth but later called into the Philadelphia Department of Human Services.

It was unclear where the mother resided. The mother gave an address in Philadelphia. However later both mother and father confirmed that mother stays there sometimes and they do have a relationship. The mother [redacted] at the time of the incident. That child was born on 12/18/2017. Both parents were [redacted]. Mother admitted using [redacted] and [redacted]. The father appeared shocked that she was using drugs. The father thought the mother was

drug free and would be a responsible person for the care of the child. A safety plan was completed, and father was identified as the caregiver. The mother was not to have contact with the child except during supervised visits. The MGGM was also identified as a caregiver for the child when the father is at work. The Department closed the case and transferred it to Delaware County Children and Youth on 11/09/2017, as the parents are now residing in Delaware County.

It could not be determined if the victim got the [redacted] from the program or ingested it elsewhere. The county attempted to interview the nurse but was referred to their attorneys. There is no other documentation if their attorneys were contacted. The county received a report from [redacted] that the mother was present on that date however the victim child was not mentioned. The [redacted] reported that the mother did bring the child with her at times but the child stays in the waiting area.

Delaware County Children and Youth staff are providing in-home services to both parents. The mother is receiving [redacted], and the plan is for the mother to access [redacted] to address any underlying issues relating to her addiction. The mother is supervised with both children. The worker makes unannounced visits to the home and has confirmed that the children are being taken to the MGGM while the father is at work.

The father was confronted about not following the court order and allowing mother to have unsupervised visits with the victim child. He stated that he had planned on going to court to get the order amended but realizes now that the mother should be supervised.

The older sibling according to mother is residing with his father but their whereabouts are unknown. Mother does not have any contact with her oldest child.

There is police involvement but no charges have been filed.

The victim child is doing well, with no medical concerns.

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; Early in the investigation DHS, MDT, SWSM, and CYS did a great job in gathering information detailed information on the family and extended family. They identified strengths that the father is an appropriate caregiver with protective capacities to care for the child. The father is free of drugs and thought the mother was drug free and able to care for the child. The father violated the court order but was going to get it amended as he thought the mother was appropriate. The social worker team did a good job investigating the allegations. They secured a safety plan that involved the parents and extended family.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  There were none identified.

- 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 county recommended that a letter be sent informing the Pennsylvania Department of Human Services and [redacted] of the alleged incident at [redacted]. There should be clear regulations regarding the presence of children at [redacted] clinics.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  There were none identified.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  No recommendations reported

Department Review of County Internal Report:

The Act 33 report was timely and the investigation was thorough. The Act 33 meeting occurred on 09/15/2017. The investigation was consistent with all interview statements. The interviews content and findings are representative of what was discussed during the interviews. The Department received the County's report dated 12/14/2017 and is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
  Philadelphia County conducted a thorough investigation with the family, extended family, police and medical staff and [redacted] clinic. OCYF finds the county report accurate with its findings.

- County Weaknesses:
  There were no weaknesses identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
  No areas of non-compliance identified.

Department of Human Services Recommendations:

OCYF concurs with the recommendations of Philadelphia County. All [redacted] programs should have clear guidelines as to who is in the booth when medication is given. Child care should be provided for parents who bring their children into the clinic while they get treatment. [redacted] programs should report any incidents where a child ingests medications.