pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/14/2016
Date of Incident: 10/13/2017
Date of Report to ChildLine: 10/23/2017
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Department of Human Services

REPORT FINALIZED ON:

05/14/2018

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 Service 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 DHS has convened a review team in accordance with Child Protective Services Law related to this report. The county review team was convened on 11/17/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/14/2016
	Biological Mother	[redacted]1995
	Biological Father	1974
	Sibling-full	2016
	Maternal Grandmother	1976
	Maternal Aunt	1998
	Maternal Aunt	2000
	Maternal Aunt	2005

* 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 (SERO) obtained and reviewed all current case record pertaining to the [redacted] family. SERO staff interviewed the Detective, Community Umbrella Agency (CUA) Case Manager, Supervisor and [redacted], and the Philadelphia DHS; reviewed the Data Collection Tool, CY48 reports, Safety and Risk assessments, medical progress notes, nursing notes, and case documentation provided by Philadelphia Department of Human Services (PDHS).

Children and Youth Involvement prior to Incident:

PDHS did not have prior involvement with this family. The father was known to DHS as a father and currently not involved with the family. The mother was not known

to DHS, is unemployed, denies any substance abuse or [redacted] issues. She's the caregiver for the child.

Circumstances of Child Near Fatality and Related Case Activity:

On 10/13/2017, a 16th month-old female child was transported to [redacted] after she was found unconscious and not breathing in her home. At [redacted], she was treated for a possible seizure and then transported to [redacted] for continued care. The victim child was discharged on 10/22/2017 to the care of her mother.

During the hospitalization, the victim child received a [redacted]; which [redacted]. The second [redacted] had not been available until 10/23/2017, which [redacted] The victim child was not given [redacted] while she was hospitalized, and the reporter was concerned that the child may have ingested [redacted] in the home. The victim child lives with her mother, maternal grandmother (MGM), three maternal aunts (MAU) and a twin sister.

On 10/23/2017, PDHS received a Child Protective Services (CPS) report to investigate the allegations of causing serious physical neglect of a child. The report was assigned to Multi-Disciplinary Team (MDT) Social Worker Services Manager (SWSM) discussed the case with her supervisor and received a consult from the [redacted] about the [redacted]. It was noted by the nurse that [redacted] are easily obtained through illegal channels; however, [redacted] is not commonly prescribed outside of a hospital setting. The [redacted] further noted that [redacted] is often used to treat pain associated with cancer. The [redacted] received a recommendation from the nurse to have the MDT SWSM observe and take any photographs of all the prescription bottles in the home. The family had no prior involvement with PDHS.

On 10/23/2017, the PDHS MDT SWSM met with the victim child, mother, maternal grandmother, 12 year old maternal aunt, and a twin sibling. The mother reported on the day of the incident, 10/13/2017, the victim child and the twin sibling were in the bedroom as they were playing on the floor. Mother stated that she was getting prepared to feed them, when the food was ready mother went down stairs and when she returned she noticed victim child was laying on the floor. Mother thought that child's twin had pushed her down on the floor because sometimes they would fight. However, when she got closer, she noticed victim child was foaming at the mouth and mother picked her up. Mother thought that the child was having a seizure. MGM's friend rushed the child to the [redacted] in the private vehicle. The victim child was intubated and given medication. Mother reported that [redacted] was unable to tell her what was going on and they transported the child to [redacted]. When they arrived to [redacted], the child was given more medication and [redacted] was unsure of child's diagnosis. Child remained at [redacted] for further observations. On

10/23/2017, the child was discharged with only one recommendation to follow up with primary pediatrician. Mother denied being in possession of [redacted] and stated that she does not hang around anyone that abuses prescription drugs.

MGM reported that she was [redacted] and [redacted] on 09/20/2017 and takes prescription [redacted] for her [redacted]. MGM keeps her medication secured and children have no access. During her interview, MGM denied abusing any types of prescription pills and denied having company that deals with [redacted]. MGM allowed the PDHS SWSM to take photographs of her prescription medication.

PDHS SWSM interviewed a 19-year-old-MAU who lives in the home. MAU reported that she was not aware of the incident until later that day as [redacted]. The MAU denied having any access to [redacted] and reported that she was only prescribed [redacted] and [redacted] after [redacted].

The MDT SWSM interviewed the 12 year-old-MAU. The MAU reported that she never observed the mother nor any of the household member acting strange. She felt safe in the home and she was not aware of what type of drugs the MDT SWSM was asking her about. The 17-year-old-MAU was not at home to be interviewed due to being at work.

On 10/23/2017, the MDT SWSM completed a Safety Assessment and a threat was identified for the victim child and her twin sibling. The safety plan was put in place to protect the vulnerability of the child. Mother suggested that the father of the child did express interest in caring for the twins; however, when the MDT SWSM reached out to him, he did not respond. The mother identified a friend resource who was cleared by PDHS and the child with twin sibling [redacted]

On 10/30/2017, MDT SWSM met with the 17-year-old-MAU who also resided in the home. The MAU was in the home when child became unresponsive and remembers the mother of the child screaming and MAU ran upstairs. When MAU ran into the room, she observed the child's face and lips were blue. MAU thought that the child was having a seizure and started administering CPR, the child started crying again and her face and lips became pink again. While MAU was administering CPR the mother ran outside to get the MGM's friend who then transported the child to the hospital. MAU denies having a history of substance abuse or associating with anyone who uses drugs.

On 11/07/2017, the MDT SWSM completed [redacted]. There were no [redacted] histories for the mother, MGM or MAUs.

On 11/17/2017, an Act 33 meeting was held and discussed the child's medical record. There was no record that the child was given [redacted] at either [redacted] or [redacted]. [redacted] representative would review the [redacted] to determine if the screens discerned between [redacted] and [redacted] ingestion. It was further noted a

root-cause analysis would be completed to determine why there was a delay in receiving the [redacted] and use the analysis to improve their internal processes. The source of the [redacted] remains unknown. The alleged perpetrator was also unknown.

On 11/30/2017, Community Umbrella Agency assumed case management service for the family. They provided in home safety services.

The MDT SWSM reached out to [redacted] and the child was last seen at the office on 09/14/2017.

On 12/4/2017, PHDS determined the CPS report to be unfounded. The unfounded allegation was “Repeated, Prolonged, or Egregious Failure to Supervise”. The unfounded outcome reason is “incident was not caused intentionally, knowingly, or recklessly”. The investigation did not establish that a prolonged, egregious, or repeated lack of supervision resulted in the child ingesting [redacted]. Possession of [redacted] could not be connected to any caretaker or household members. The possibility remains that a visitor to the home may have inadvertently dropped [redacted]; which the child subsequently ingested. No criminal charges have been filed.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County’s Child Near Fatality Report:

The team felt that the MDT SWSM did a good job investigation the repot

- Strengths in compliance with statutes, regulations and services to children and families;
    - The team noted that the MDT SWSM effectively conducted the investigation. The Team cited the MDT supervisor’s consultation with [redacted].
    - The Team discussed that other Pennsylvania county child welfare agencies are able to complete drug screens in the field during the course of an investigation. It is unclear upon what authority these other Pennsylvania child welfare agencies perform drug tests.
- Deficiencies in compliance with statutes, regulations and services to children and families;
    - None
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

    - None

- 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 Act 33 meeting occurred on 11/17/2017. The Department received the County's report dated 02/15/2018 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

- Philadelphia DHS responded to the referral received in a timely manner and conducted thorough assessments.

County Weaknesses:

- None

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

- None

Department of Human Services Recommendations:

There are no recommendations as a result of this review.