pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/17/2013
Date of Incident: 05/29/2017
Date of Report to ChildLine: 05/29/2017
CWIS Referral ID: [redacted]

FAMILY WAS 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:
01/12/2018

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. 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 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 06/23/2017.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/17/2013
[redacted]*	Half sibling	[redacted]2008
[redacted]	Full sibling	[redacted]2015
[redacted]	Full sibling	[redacted]2016
[redacted]	Biological mother	[redacted]1988
[redacted]	Biological father	[redacted]1987

* 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 obtained and reviewed all current and past case records pertaining to the [redacted] family. A follow-up interview was conducted with the Community Umbrella Agency (CUA) worker on 10/03/2017. The regional office also participated in the County Act 33 Review on 06/23/2017.

Children and Youth Involvement prior to Incident:

On 05/22/2015, the Philadelphia Department of Human Services (DHS) received a General Protective Services (GPS) report stating that the victim child's sibling and mother tested positive for [redacted] when the sibling was born on 05/21/2017. The mother explained that she had [redacted] The report stated that the mother admitted to testing positive for drugs when she was arrested in April 2015. The mother stated that she did not know that she was pregnant until she was five months pregnant. She did not inform her doctor of her pregnancy. The reporting source stated that the

mother would continue [redacted]
The report was determined to be valid. On 06/28/2015, Turning Points for Children, CUA, began providing in-home services to the family and on 09/28/2016, those services were terminated.

On 11/11/2016, the Philadelphia DHS received a GPS report stating that the victim child's other sibling tested positive for [redacted] at birth. It was stated that the mother tested positive for [redacted] at the child's birth. The mother reported [redacted] The mother also reported that she did not know that she was pregnant until 6 months into her pregnancy and admitted that she had not informed her physician of her pregnancy. The mother did not receive any prenatal care. This report was determined to be valid. On 11/22/2016, the Philadelphia DHS accepted the family for services, and the case was referred to Turning Points for Children.

There is no record of either parent receiving child welfare services as children.

Circumstances of Child Near Fatality and Related Case Activity:

On 05/29/2017, the Philadelphia DHS received a report stating that the victim child presented at a local hospital lethargic, and had not been urinating or eating. It was reported that the victim child was [redacted] and that she needed daily medication. It was alleged that the victim child had not received her medication for the past four days. The victim child was transferred to Children's Hospital of Philadelphia. The report was noted to be a near fatality.

On 05/29/2017, a Philadelphia DHS investigator met with the biological parents. It was noted that both parents presented as being under the influence of a substance, due to fast and slow speech and erratic behavior. The mother confirmed that she was aware that the child had needed her medication four days prior. The mother described efforts to obtain the medication on an emergency basis [redacted], having done that several times in the past year. The victim child was scheduled for a medical appointment on 05/30/2017. The mother also reported that she is [redacted] The father stated that he was last in the home on 05/25/2017, due to his work schedule. He was not aware that the victim child had not had access to her medication.

The children were placed in the care of the maternal aunt on 05/29/2017. A home assessment was completed on the maternal aunt's home, and the home was deemed appropriate.

On 05/30/2017, when the Philadelphia DHS investigator met with the Philadelphia DHS nurse for a consult about the case, [redacted] On 05/31/2017, the Philadelphia DHS investigator met the victim child at the hospital. [redacted] The investigator

also met with another maternal aunt of the child, who stated that the mother has been on drugs since high school.

On 05/31/2017, the Philadelphia DHS investigator contacted the maternal aunt who had been caring for the victim child at the time of the incident. The maternal aunt stated that when she picked up the victim child, the child was lethargic and would not eat. The maternal aunt stated that, since none of the children eat or sleep on a schedule, she thought the child was sleepy. She began to worry when she noticed that the victim child was not urinating. When the victim child did not urinate from 2pm on Sunday through Monday afternoon, the maternal aunt took the victim child to the hospital. The maternal aunt contacted the mother about the medication, and mother reported that [redacted] would no longer provide emergency medication as they had in the past. The maternal aunt stated that she was not able to get in touch with the doctor's office, though it was unclear why. At the Children's Hospital of Philadelphia (CHOP) [redacted] the maternal aunt was told that the victim child had missed appointments with [redacted] The maternal aunt was also told that the victim child had not been given her medication for up to four months. The maternal aunt stated that she would ask the mother about the victim child's medication, and the mother would respond that she had given the child the medication, or she would do it when the child returned home. The victim child appeared healthy, so the maternal aunt believed the mother.

[redacted]

The victim child was ready [redacted] on 06/02/2017. The Philadelphia DHS visited the maternal aunt's home to evaluate the home for the maternal aunt's readiness to care for the victim child. The maternal aunt agreed to complete training necessary for the child's [redacted]

[redacted]

On 06/07/2017, a GPS report was received, stating that the victim child's 2-year-old sibling had not had a well visit since he was four months old, and the victim child's 7-month-old sibling had missed his four month and six month well visits. The 2-month-old child was also reportedly born testing positive for [redacted] The reporting source expressed concerns that the mother was [redacted] It was also reported that the mother was [redacted]

On 06/11/2017, it was reported that the 7-month-old child was hospitalized with a [redacted] from 06/05/2017 to 06/06/2017. Both the 7-month-old and the 2-year-old children had appointments to receive immunizations on 06/16/2017. The victim child had an [redacted] appointment [redacted] on 06/13/2017.

On 07/27/2017, the Child Protective Services report regarding the victim child was determined to be indicated on both parents for Causing Serious Physical Neglect of a Child, Failure to Provide Medical Treatment to a Child.

On 08/09/2017, the GPS report regarding the victim child's siblings was determined to be valid on both parents for the provision of Inadequate Healthcare.

The victim child's oldest sibling has lived with the maternal grandmother for the past two years. The other three children, including the victim child, her 2-year-old brother, and her 11-month-old brother, have lived with their maternal aunt since June 2017. The maternal aunt was recently certified as a kinship foster parent. The maternal aunt is receiving in-home case management services, through the Turning Points CUA. The goal for this family is reunification.

The parents have not participated in visits with the children since they were removed. [redacted] The parents' visits were suspended until they make themselves available for drug screens.

The victim child's medical status is stable, and she takes her medication daily. The victim child is receiving [redacted] services through [redacted] The victim child's 2-year-old sibling is also receiving [redacted] services [redacted]

Criminal charges have not been filed against either parent regarding the incident.

Summary of 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 Team felt that the MDT SWSM did a good job with the investigation.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  - The Team felt that TPFC had failed to appropriately address the medical needs of the children during both periods that TPFC provided in-home safety services. The Team did not understand how it could be that TPFC was not aware that the children were not receiving appropriate medical care.
  - When the case was initially closed in September 2016, complete medical records had not been obtained. TPFC leadership agreed that medical documentation is necessary for case closure and noted that the case should not have closed given the lack of medical care for all of the children.

- TPFC was aware of [redacted] and need for ongoing medical care. TPFC closed the case without documentation confirming that [redacted] was receiving necessary medical care.
- During the first round of in-home services, a DHS nurse completed 7 to 8 home visits with the family and provided education about [redacted] condition. The last home visit occurred in March 2016. [redacted] It appears that [redacted] appointment occurred in August 2015. [redacted] TPFC was under the impression that the July 2016 visit was an appointment with [redacted]
- The Team felt that additional training was necessary so that CUAs are clear as to what constitutes a visit with a doctor, as having blood drawn without seeing the doctor should not be mistaken for a doctor visit.
- The Team requested information regarding TPFC's standard practice for obtaining medical records. TPFC noted that there is a protocol but there are sometimes challenges in obtaining the records in a timely manner. The standard practice is for case managers to keep requesting records until they are obtained.
- The Team stressed the need for case managers to be persistent when trying to obtain medical records but also emphasized the need to consult with a DHS nurse if medical providers do not comply with multiple requests for records.
- DHS leadership noted that TPFC should have completed consultations with the DHS nurses throughout the life of the case.
- TPFC failed to follow protocol mandating consultation with DHS nurses regarding children with chronic medical conditions. In addition, TPFC should have consulted with a DHS nurse when the mother gave birth to a substance-exposed child and prior to closing the case. The Team discussed the missed [redacted] appointments and questioned if there was a mechanism in place for [redacted] to notify DHS. The Team felt that a report should have been made to DHS prior to [redacted] recent medical crisis and subsequent hospitalization.
- Following the meeting, [redacted] to discuss prevention strategies or alerts to identify patients who do not show for appointments and might not be receiving the necessary treatment. There appears to be variability in how and which patients receive greater surveillance. [redacted] case has prompted further discussion [redacted] on how to more systematically address this issue, including the development of strategies to improve medical follow up, consideration of earlier reporting for medical neglect, and how to identify risks when children are likely not receiving their medications.
- The Team reviewed the investigation and service history for the family. The family's case was closed before TPFC received any confirmation that the identified safety issues had been resolved.

- The mother seemed to be clearly struggling [redacted] The Team requested a status [redacted]
  - TPFC reported that the mother [redacted]
  - The Team noted that the mother neglected [redacted] but did not seem to have any issues [redacted]
  - The Team also questioned if the mother was failing to inform her doctor of her pregnancies because she wanted to continue [redacted]
- The Team discussed the Family Team Conference which occurred when the family's case was first closed. The mother attended the meeting via telephone. At the closing conference, TPFC did not identify any continuing safety issues and noted that the children's medical care was up to date.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - DHS should explore mandating that a DHS nurse participate in Family Team Conferences for which there are identified medical issues in the family.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

Department Review of County Internal Report:

The county report was received by the Southeast Regional Office of Children, Youth and Families on 09/20/2017. The Department reviewed the report and concurs with the findings.

Department of Human Services Findings:

- County Strengths: The investigator completed a thorough investigation.

- County Weaknesses: As noted in the Act 33 report, there were a number of issues relating to case management around medical issues, including obtaining medical records, following up on medical appointments, and ensuring that the Philadelphia DHS nurse is involved in teaming meetings.

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

  3490.55(a): The victim child was not seen by county staff within 24 hours of the receipt of the report.

Department of Human Services Recommendations:

Case managers should obtain medical documentation to confirm that children have attended all relevant medical appointments, and that children are receiving appropriate medication treatment for medical concerns prior to case closing. Case manager supervisors should review cases prior to authorizing case closure to assure that all relevant case factors have been assessed.