pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON NEAR FATALITY OF:

[redacted]

Date of Birth: 09/21/2005
Date of Incident: 08/25/2017
Date of Report to ChildLine: 08/25/2017
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:
2/28/2018

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 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 09/17/17.

Family Constellation:

First and Last Name	Relationship	Date of Birth
[redacted]	Biological Mother	11/10/1984
	Biological Father	[redacted]1982
	Full Sibling	[redacted]2010
	Full Sibling	[redacted]2013
	Full Sibling	[redacted]2014
	Paternal Half Sibling	[redacted]2004
	Victim Child	[redacted]2005
	Maternal Grand Father	[redacted]1934

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documentation, and documents pertaining to the Family. Contact was made with the county case worker to obtain the documents listed; Structured Case Notes, Safety Assessment, Risk Assessment, Medical Records, County Report, CY47, and CY48.

Summary of Circumstances prior to Incident:

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

On September 23, 2011, DHS received a [redacted] report stating that a 2 weeks old infant was pronounced dead at CHOP. The reporter stated that [redacted] fell asleep on the floor with the infant while [redacted] was asleep on couch. [redacted] woke up at an unknown time because one of the other children was upstairs screaming. When they came back downstairs, they found the infant unresponsive. The maternal grandmother called 911, none of the other siblings

were harmed. The family received support services for 4 months between 11/2011-02/2012.

On February 21, 2014, DHS received a GPS report alleging that one of the sibling tested positive for marijuana and [redacted] at birth. [redacted] It was noted that the mother received prenatal care, however she was not tested for drugs during her pregnancy. The mother admitted to taking [redacted] she also reported that the father smoked marijuana, and denied having any issues of mental health. The family received in home services through [redacted] for 4 months between 04/2014-07/2014.

Circumstances of Child Fatality and Related Case Activity:

On 8/25/17 Philadelphia County received a CPS of near fatality that a 11-year-old male had shot himself in the face with a firearm that was inside of the home along with 4-5 bullets that were not locked in a secure place. The victim child sustained [redacted], the report indicates that the child was left home alone for approximately one hour when the incident occurred. The child was able to get the firearm from the grandfather's bedroom, who also resides in the home. The grandfather and the biological father were aware that the firearm was located in the upstairs bedroom, they were also aware that the firearm was not locked in a secure place. The biological parents left the home to go to the store around 12:00 midnight. While they were out, they received a call from their 13yr old daughter, who informed them that the victim child had been shot. All the other siblings were in the home at the time of the incident, none of them were injured. The biological parents returned home to find the victim child wandering the streets, and immediately transported him to Jefferson Hospital in Philadelphia.

The Multi-Disciplinary Team Social Work Services Manager (MDT SWSM) interviewed the biological parents; The biological father stated that he was aware that the maternal grandfather (MGF) had a firearm (454 Taurus Raging Bull Casull Revolver) in the bedroom of the home, there was ammunition with the firearm, and the firearm was not locked or secured away. The incident occurred on the second-floor bedroom of the home. The biological father also stated that he previously asked the MGF if the firearm was locked away. Neither of the two followed up with making sure that the firearm was locked and secured away. The biological father stated that the MGF was planning to sell the firearm, but that did not happen. The biological father admitted to having other firearms in the home, and that they are stored in a safe box. The biological father shared an Instagram video that the police obtained from the victim child's cell phone. The video was texted to the biological father, who forwarded via email to the (MDT SWSM). The video showed the victim child loading a handgun, spinning the chamber, and pulling the trigger with the gun under his chin. The video named "Russian Roulette" at the end of the video the words "so bored" were written diagonally across the screen.

The biological mother stated that she was not aware that the MGF had a firearm in the home; however, she was aware that the biological father had firearms. She also

stated that she does not like the idea of the firearms being in the home, but as long as the biological father is responsible and is on top of keeping the firearms safe and properly secured she would be ok with the guns in the home.

Both parents stated that they left the home to go to the store, all the children were at home, the victim child was watching movies in his bedroom, and the MGF was not at home. Soon after leaving the home, they received a call from the daughter letting them know that the victim child shot himself. The biological mother stated that she could hear the victim child yelling in the background that it was an accident. The parents were not able to say if the victim child was attempting suicide or reacting to peer pressure. The victim child is described as "empathetic" and is concerned about what others think about him. The victim child recently began to hang out with new friends and that they appeared to be rough, according to the biological father, the victim child started asking to go to the gun range one week prior to the incident, and that he had never expressed interest in going to the gun range in the past. The victim child was interviewed at the Philadelphia Children's Alliance, (PCA). During the interview, the victim child said that he knew for about one year that the firearm was in the MGF bedroom. He admitted to playing "Russian Roulette" and he thought that he could beat the game. The victim child denied that he had been suicidal or that he intended to harm himself. He also stated that he thought that he had removed the bullet prior to shooting himself.

On August 31, 2017, a safety assessment was completed, contact was made with all of the siblings, and safety threats were identified; caregivers in the home were not performing duties and responsibilities to the safety of the children, the caregivers cognitive, emotional, and behavioral protective capacities were diminished. There were concerns for gun safety and storage in the home and supervision of the children. A safety plan was developed by the (MDT SWSM), the plan stated that the children should not be returned home, pending the outcome of the investigation. The children will live with the maternal aunt and uncle until the investigation is completed.

[redacted] The family is currently receiving case management services, "in home safety" from Bethanna, a Community Umbrella Agency. [redacted]

On 10/16/2017 the CPS report was determined to be indicated, the APs are the MGF as a perpetrator by commission, and the father will be indicated as perpetrator by omission.

The criminal investigation was conducted by the [redacted] Police Department, charges were not filed.

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

- The Act 33 Team discussed the numerous reclassifications of the reports during the course of the investigation. Initially, on August 25, 2017, DHS received a GPS report regarding the incident. Although a physician had certified that the child's condition met the definition of a near fatality at the time, the report was not registered as a near fatality with the PA DHS/ChildLine. On August 30, 2017, ChildLine received new information and the GPS report was upgraded to a CPS. The child's condition was also registered as a near fatality and additional CPS reports were filed for each child who was in the home at the time of the incident. On September 11, 2017, ChildLine conducted an internal review of the case which resulted in the downgrade of the CPS to GPS. As a result, the near fatality certification was also removed from the case. The CPS reports for the other children were also reclassified as supplemental reports. On September 13, 2017 representatives from Philadelphia DHS spoke with representatives from ChildLine and disputed the downgrading of the child's report. Following the discussion, the report was reclassified as a CPS and reregistered as near fatality.

  At the time of the Act 33 review, a representative from ChildLine was not available to discuss the issues related to the classification of the reports and the near fatality certification process. Representatives from PA-DHS Office of Children, Youth and Families, Southeast Regional Office, offered to assist with facilitating a conversation between Philadelphia DHS and ChildLine so that the identified issues would be discussed.

- Strengths in compliance with statutes, regulations and services to children and families: None identified

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

  None identified

  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: None identified

Department Review of County Internal Report:

The Southeast Region concurs with the County's Report.

Department of Human Services Findings:

County Strengths:

None identified

County Weaknesses:

None identified

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

None identified

Department of Human Services Recommendations:

None identified