pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

David Hess

Date of Birth: 09/22/1999
Date of Death: 10/13/2016
Date of Report to ChildLine: 10/14/2016
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:
July 17, 2017

REPORT UPDATED ON:
December 21, 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 of Human Services, through the Office of Children, Youth and Families, 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 related to this report in accordance with the Child Protective Services Law. The county review team was convened on 11/04/2016. [redacted] was present at the review meeting. David's death was determined to be a homicide from asphyxia based on medical reports.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
David Hess	Victim Child	09/22/1999
[redacted]	Mother	[redacted]/1957
	Father	[redacted]/1948
	Brother	[redacted]/1997
	Brother	[redacted]/1996

*Residential Facility Staff:

First and Last Name:	Title:	Date of Birth
[redacted]	Residential Supervisor	[redacted]/1985
	Residential Counselor #4	[redacted]/1989
	Residential Counselor #5	[redacted]/1989
	Residential Counselor #2	[redacted]/1990
	Staff Nurse #2	[redacted]/1983
	Residential Counselor #1	[redacted]/1981
	Residential Counselor #3	[redacted]/1980

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) conducted 25 interviews with Wordsworth Academy staff, medical staff contracted with Wordsworth, and residents on the floor where David resided. SERO examined Wordsworth staff training records, David's [redacted] history, and video footage of the 4th floor rotunda where David's room was located on the day of his death. SERO obtained and reviewed the First Responder's Report completed by the City of

Philadelphia Fire Department. SERO examined Wordsworth's Emergency Medical Plan and Search and Seizure policy, and participated in the ACT 33 review on 11/04/2016.

Children and Youth Involvement prior to Incident:

On 03/08/2016, Philadelphia Department of Human Services (DHS) received a [redacted] report [redacted] Additionally, it was reported that David was [redacted] to the age of five. The report was investigated and determined to be [redacted]; the DHS case was closed.

David was [redacted] through the Philadelphia Department of Human Services (DHS) in 2004. David's [redacted] family resides in Lebanon County and the family had no prior child welfare history. David was placed at Wordsworth Academy on 9/22/2015 through the Lebanon County [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 10/14/2016, SERO received a [redacted] report alleging that David, who was a resident of Wordsworth Academy's residential [redacted] program, had died the previous day. The report alleged that David was restrained due to aggression and destruction of property, and that during the intervention, David hit his head and subsequently passed away. Wordsworth provided a safety plan for the other residents in the facility, placing the three staff members [redacted] on administrative leave pending the outcome of the investigation.

Sometime before 8:00 PM on the night of 10/13/2016, David had stolen an iPod from another resident. The resident had gone into David's room in an attempt to retrieve the iPod and an argument ensued. Residential Counselor #1 entered David's room and escorted the other resident back to his own room, while Residential Counselor #5 assisted, who was stationed in the hallway between the children's rooms, assisted Residential Counselor #1 with diffusing the tension between David and the other resident. Residential Counselor #1 reentered David's room with Residential Counselor #2 and confronted David about the iPod, which David denied having in his possession. Residential Counselors #1 and #2 searched David's room, and found the iPod in an empty soap box by Residential Counselor #1. Residential Counselor #1 returned the iPod to the other resident. Shortly thereafter, Residential Counselor #2 attempted to enter David's room after hearing loud noises in the room, however David had barricaded the door with furniture. The Residential Supervisor was able to enter David's room and he attempted to deescalate David as David was pacing back and forth. The Residential Supervisor left David's room a short time later when he felt David was fine. Residential Counselors #1, #2, and #3 reentered the room due to David acting aggressively and breaking the ceiling lights. The three counselors subsequently placed David into a restraint.

The Residential Supervisor reported that he came back to David's room and observed staff trying to get David off of his bed, however, he claimed to not have seen the restraint. The Residential Supervisor reported that he left the room and made a call to the nurse; the nurse did not answer, and he did not make a second attempt to reach the nurse.

Residential Counselor #5 reported he looked in David's room after Residential Counselors #1, #2 and #3 had entered and observed the Residential Supervisor and Residential Counselor #2 using verbal prompts to deescalate David. Residential Counselor #5 reported it seemed that everything in David's room was calm. Residential Counselor #5 then left the floor for another assignment.

Residential Counselor #4 was standing in the hallway outside of David's room when he heard the glass break in the room. Residential Counselor #4 reported he entered David's room to see what happened but left quickly because he decided he was not needed. A minute later Residential Counselor #4 went back into the room and saw Residential Counselors #1, #2, and #3 restraining David. Residential Counselor #4 moved furniture out of the way to give staff more space for the restraint and then he left the room because he thought the situation was under control. He then left the building for his dinner break.

Residential Counselor #1 reported that during the restraint, Residential Counselor #2 punched David in the ribs. Residential Counselor #2 reported that Residential Counselor #3 put David in a headlock and placed his forearm on David's neck. Residential Counselor #2 stated that it seemed that David was not breathing so Residential Counselor #3 moved his arm. Residential Counselor #2 stated David was gasping for air so he started chest compressions. Residential Counselors #1 and #3 called the staff nurse from their personal cell phones. By the time a second call was made to the nurse, approximately two to three minutes after the restraint ended, David reportedly lost consciousness. Residential Counselor #2 reported he was trained in CPR, however, he only did chest compressions. Residential Counselor #1 was also doing chest compressions, however, grew tired and began to use his foot to do the compressions. When the nurse entered the room, Residential Counselor #2 reported that Residential Counselor #3 had stated that David had hit his head. Residential Counselor #2 stated that he felt pressured to agree at that time, but Residential Counselor #2 later told police that David had not hit his head.

Two nurses were present on the night of the incident. Nurse #1 stated she received the call from staff on David's floor that David was involved in an Emergency Safety Intervention. Nurse #1 was [redacted] on another floor at the time and had instructed Nurse #2 to go to David's room. Nurse #2 arrived at David's room at 8:35pm and a few minutes later contacted Nurse #1 for a blood pressure cuff. Nurse #1 ran to the room and when she arrived, Nurse #2 was performing CPR on David using chest compressions. Nurse #2 then asked someone to get an oxygen tank. Nurse #1 and a staff supervisor ran to the nurse's station on a floor below to get the tank. When they returned, they put the oxygen mask on David and staff continued CPR. It was reported that Nurse #2 made the 911 call.

A report from the Philadelphia Fire Department stated that the call was received at 8:52pm. When in route to Wordsworth, the dispatcher informed emergency medical services that it was a “code blue” call. When emergency medical services arrived at Wordsworth at 8:55pm, the responders were delayed in getting to David’s room because Wordsworth security did not know the floor where the emergency was occurring. Police were also dispatched to the scene. David was transported to the hospital where he was pronounced dead.

At the time of the initial investigation in October 2016, Residential Counselor #2, Residential Counselor #1 and Residential Counselor #3 were [redacted] Residential Counselor #2 and Residential Counselor #1 [redacted] however, Residential Counselor #3 [redacted] Throughout the course of the investigation, the Residential Supervisor, Residential Counselor #5 and Staff Nurse #2 were [redacted]

Following David’s death, the Pennsylvania Department of Human Services (PA-DHS) [redacted] to Wordsworth every day during every shift to monitor resident safety and [redacted]

SERO received the autopsy results for David on 12/19/2018. The autopsy determined the cause of death to be asphyxiation and the manner of death to be homicide. The [redacted] report was [redacted] on 12/20/2018 on [redacted] The Department also [redacted] the Residential Supervisor and the Staff Nurse #2 for [redacted] The [redacted] that Residential Counselor #5 was not [redacted] There had been no criminal charges filed related to David’s death as of the last report update.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County’s Child Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

  None

- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>;

  The ACT 33 team noted that Wordsworth needed to better develop its staff through coaching and a comprehensive staff development program. The

team questioned if the training that staff received, such as crisis intervention and the use of physical restraints, was sufficient. The ACT 33 Team felt that trainings needed to occur more frequently than on an annual basis and include sessions where staff could practice responding to emergency situations.

The ACT 33 Team questioned if the alleged use of a headlock during the child's restraint was an anomaly or if the practice was a common occurrence during other restraints. The Team asked what policies and procedures could be put into place to ensure no other staff members would engage in improper restraint procedures. It was reported that the restraint training includes the directive that nothing should be put on a child's neck during a restraint. The ACT 33 Team stressed that training should also clearly prohibit punching a resident while employing a restraint. The ACT 33 Team stressed that the use of restraints needs to be practiced regularly and must be supervised by high level staff who can provide redirection as necessary. The ACT 33 Team also noted that, when an employee is disciplined for violating a procedure or protocol, they must receive further training in that area before they are returned to their position.

The ACT 33 Team noted that, while staff was attempting to deescalate the situation, someone should have concurrently called the nurse.

The ACT 33 team recognized that CPR was not done correctly by any of the Wordsworth staff. Although several staff members reported giving CPR, through interviews, it was learned that staff had performed only chest compressions and that no one gave the child rescue breaths. The ACT 33 team noted that there is a "mental barrier" that needs to be overcome in order to provide mouth-to-mouth rescue breaths. Though Wordsworth was not required to have breathing masks, the team noted that this relatively inexpensive piece of equipment may have helped to overcome compunctions that the staff may have had.

The ACT 33 Team did not understand why Wordsworth does not require that nurses keep shift logs to document their activities. This information could have been important in understanding why staff had difficulty contacting the nurses when the child became unresponsive.

The ACT 33 Team felt it was unacceptable that emergency medical responders were delayed in reaching the child. In addition to Wordsworth staff's failure to call 911 in a timely manner, when the first responders arrived at Wordsworth, security personnel did not know on which floor the emergency was occurring. This further delayed medical care for the child.

The ACT 33 Team felt that it was not clear if Wordsworth was able to meet the child's [redacted] health needs. Wordsworth leadership noted that they had agreed to accept the child into their program in spite of the fact that he had been denied by other programs. Wordsworth leadership noted that, in

the past, youths with a need for a [redacted] of care were often sent to facilities in other states. Other states are permitted to use different types of [redacted] and different restraint methods. When this practice stopped, many of these children ended up being placed at Wordsworth. If Wordsworth could not meet the child's needs, he should not have been admitted into the program. Children must be admitted to the [redacted] environment that will best meet their individual needs. The ACT 33 Team stressed that keeping children closer to their homes can be counterproductive and should not outweigh the need for appropriate [redacted]. Wordsworth leadership noted their Residential [redacted] Program accepts children with [redacted] health issues some of whom also have delinquent issues. Since children in these two very different groups often need different types of [redacted], additional services are necessary. Wordsworth leadership reported that they had preliminary conversations with PA-DHS to discuss creating two programs to separate the populations.

The ACT 33 Team felt it was inappropriate that the decisions to confront and then restrain the child were made by an employee who had little training and experience. Proper protocols were clearly not followed. The decisions should have been made by supervisory staff that had additional experience and training. Wordsworth leadership reported that the funding for the children that they service needs to be increased in order to attract more experienced applicants who are better able to meet the needs of the children. Philadelphian DHS Commissioner [redacted] noted that line staff spend the most time with the children and they often have the highest turnover rates in Residential [redacted] Facilities.

- 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 Pennsylvania Department of Human Services should consider amending its regulations regarding first aid supplies for residential [redacted] programs and other congregate care facilities. Current regulations do not require facilities to have access to life-saving equipment such as CPR barrier masks and automated external defibrillators (AEDs). Staff should also receive regular training on how to properly use the equipment.

  The Philadelphia Department of Human Services should consider amending its contractual requirements for congregate care providers to mandate that facilities have access to life-saving equipment such as CPR barrier masks and automated external defibrillators (AEDs). Staff should also receive regular training on how to properly use the equipment.

- 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 recommendations.

PA Department of Human Services' Review of County Internal Report: The Department received the County's report on 02/01/2017 and agreed with its findings.

PA Department of Human Services' Findings:

- County Strengths: Not applicable
- County Weaknesses: Not applicable
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  Not applicable

PA Department of Human Services' Recommendations:

The Pennsylvania Department of Human Services should conduct a review of and update the Chapter 3800 Child Residential and Day [redacted] Regulations to reflect enhancements and stronger controls in the following areas:

STAFFING:

- Staffing requirements such as minimum education, orientation and ongoing trainings to reflect the needs of the population being served need to be enhanced along with defined screenings of applicants;
- Annual and ongoing staff training should include emergency medical responses and enhanced clinical trainings to support trauma-informed practices; and
- The number of hours a staff person may work in a 24-hour period should be limited to reduce staffing fatigue which impacts the effectiveness of staff.

TREATMENT AND PROGRAMMING:

- Programming in facilities, from day-to-day supervision to [redacted] interventions, should be detailed in a facility's program description and must be updated annually to ensure services are meeting the needs of the specific population served; and
- Facilities should have a process in place for staff to be educated at the start of each shift as to the current status of each ongoing resident. There should also be a process by which staff are formally debriefed on each new resident to a facility and/or to a specific unit in a facility so that staff have the required background information and training on the children they are

responsible for to ensure they can be aware of the child's diagnosis, triggers and can properly respond in times of crisis; and

- Facilities' safe crisis management processes should have a primary focus on early identification and de-escalation. The process must specify that utilizing hands-on restrictive procedure practices should be employed as a last resort for protecting a child or other resident from harm. Facilities should be required to maintain restraint data and submit the data to the Department on a routine basis. There should be identified thresholds which would require agencies to develop Restraint Reduction Plans that would be assessed and monitored by the Department.

MEDICAL CARE:

- First aid supplies for residential [redacted] programs and other congregate care facilities should be expanded to include immediate access to life-saving equipment such as automated external defibrillators (AEDs) or any other recommended equipment. Staff should also have orientation and annual training on how to properly use the equipment; and
- While current regulations require emergency medical plans for residents, the facility itself should have a standard medical emergency response plan customized to that facility's needs. The emergency response plan should detail communication protocols; resource needs, such as handheld radio transceivers; the location of life saving equipment within the facility; and designated staff per shift who would be responsible to greet emergency responders and take them directly to the person in crisis.

PHYSICAL SITE STRUCTURE:

- Cameras in all common areas in residential facilities are a necessary tool for oversight of interaction between staff and residents. Cameras provide a mechanism for monitoring programming and the immediacy of crisis interventions. They are also a management tool that assists in measuring staff performance and informing training needs.

The Pennsylvania Department of Human Services should continue its ongoing improvement efforts related to licensing of programs serving the most vulnerable Commonwealth citizens. This work includes the process and timing of licensing, verification and monitoring of corrective action plans, and the provision of technical assistance to providers. A review of staffing levels, qualifications, orientation and ongoing training of licensing staff is critical so that the highest standards are met, and the safety of children and youth is ensured. Training for staff should not only include applicable chapter regulations and how to apply them, but also trauma and secondary trauma, triggers, and special needs and diagnoses of the children that are placed in these facilities. This training will enable staff to assist providers in the provision of quality treatment to residents and further ensure resident safety.