pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Avery Howze

Date of Birth: 12/13/2016
Date of Death: 09/23/2017
Date of Report to ChildLine: 12/11/2017
CWIS Referral ID: [redacted]

FAMILY 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:

08/30/2018

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 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 01/19/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Avery Howze	Victim Child	12/13/2016
[redacted]	[redacted]	1983
[redacted]	[redacted]	1977
[redacted]	[redacted]	2001
[redacted]	[redacted]	2003
[redacted]	[redacted]	2005
[redacted]	[redacted]	2007
[redacted]	[redacted]	2013
[redacted]	[redacted]	2014
[redacted]	[redacted]	2015

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth, and Families (SERO) attended the county review team meeting on 01/19/2018 where the investigation of the report and analysis of the family's past and current status was discussed. SERO reviewed the documentation related to the investigation and provision of services to the family in the county's Electronic Case Management System. Documentation included structured progress notes, safety assessment, safety plan and supervisory conference logs in addition to the Medical Examiner's report.

Children and Youth Involvement prior to Incident:

On 09/07/2001, Philadelphia Department of Human Services (DHS) received a [redacted] report regarding [redacted], who was born on 08/03/2001. [redacted] received care in the [redacted] until [redacted] on 08/11/2001. [redacted] was to have follow up [redacted] however [redacted]

[redacted] did not show up for any of the appointments. The report was investigated and [redacted].

On 11/26/2014, DHS received a [redacted] report alleging that [redacted] had [redacted] and was being physically abused by [redacted]. The report was investigated and [redacted]

[redacted] provided [redacted] services to the family from 12/12/2014 to 11/13/2015.

On 02/12/2016, DHS received a [redacted] report alleging [redacted] crushed a piece of candy like it was lines of cocaine. [redacted] said [redacted] knows what [redacted] is doing because [redacted] sees it every day. [redacted] had violent tendencies and was disruptive in school. The report was [redacted] as there were no allegations of abuse or neglect.

On 07/03/2017, DHS received a report alleging [redacted] had a behavioral problem. It was reported [redacted] arrived home to find damaged possessions. [redacted] reportedly had been angry with [redacted] because [redacted] would not give [redacted] money. The police were called and [redacted] refused to let [redacted] back in the home. It was alleged that [redacted] stayed out all night and did not follow rules. [redacted] was employed and meeting [redacted] [redacted] needs. There were no concerns for [redacted], domestic violence or [redacted] in the home. The report was [redacted] when the fatality report was received. The [redacted] report was later [redacted].

<u>Circumstances of Child Fatality and Related Case Activity:</u>
On 12/11/2017, Philadelphia DHS received a [redacted] report and a [redacted] report when the [redacted] were reported as [redacted]. A [redacted] report was made when [redacted] died on 09/23/2017 however there were no suspicions at that time that [redacted] death had been the result of abuse or neglect. The report alleged [redacted] had fallen asleep the previous night while feeding [redacted]. When [redacted] awoke the next morning, [redacted] was unresponsive. [redacted] administered cardiopulmonary resuscitation. [redacted] called emergency medical services. Emergency medical services found the child unresponsive upon arrival, however, there were no signs of trauma. [redacted] admitted to co-sleeping with [redacted] every night and it was suspected that [redacted] rolled over on the child.

The [redacted] report from 09/23/2017 was [redacted] on 11/12/2017 however [redacted] when [redacted] in December. [redacted] was informed of [redacted] reports. At that time [redacted] reported [redacted] was [redacted] following automobile accidents in 2016 and 2017. [redacted] stated [redacted] stored the medicine in the medicine cabinet in the bathroom and took the medication as needed. [redacted] further stated that [redacted] sometimes took the medication to get high therefore it could be possible that [redacted] could have dropped some pills on the floor. [redacted] believed when [redacted] was crawling she

may have found the pills and put them in her mouth. [redacted] provided no other explanation for the ingestion.

On 09/24/2017 Philadelphia DHS completed [redacted] of the home and determined [redacted] were safe. The family's case was [redacted] on 09/25/2017. [redacted] began case management services on 10/24/2017. At the time of the reports in December, [redacted] were [redacted] to address truancy and behavioral issues.

Information provided by the [redacted] Detective confirmed that [redacted] had a [redacted] for [redacted] that was written by her family physician. The [redacted] Detective reported that [redacted] was initially prescribed 120 pills per month however in January 2018 the prescription dropped to 45 pills per month. The police investigation could not rule out that the drug was administered intentionally, nor could it rule out that [redacted] found a pill on the floor and ingested it. The final autopsy report revealed the cause of [redacted] death was [redacted]. The manner of death was undetermined. The [redacted] report was [redacted] on 02/02/2018. The [redacted] report was [redacted] on 02/14/2018. No criminal charges have been filed.

<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>;

- The Team discussed the initial classification of [redacted] death as possibly the result of co-sleeping and not necessarily suspicious for abuse or neglect. The medical providers on the team noted that it was unlikely that a 9-month old child would die due to co-sleeping. They believed that [redacted] sudden, unexpected death should have raised suspicions at the hospital. It was noted that hospitals are able to complete [redacted] to the Medical Examiner's Office.
    - It was reported that [redacted] noted no signs of physical trauma to Avery and there were no suspicions that [redacted] was intoxicated. [redacted] did complete a skeletal survey. Additionally, [redacted] responded to the home following [redacted] death. The Team questioned if the Medical Examiner's Office should have expedited [redacted] given the unexplained nature of [redacted] death.

[redacted]DHS had not received a [redacted] report when [redacted] was born so it was unknown if had [redacted] at birth. The Intake Social Work Services

Manager would attempt to secure [redacted] birth records from [redacted]

  - [redacted] had the prescription for [redacted] when [redacted] was born. If [redacted] for [redacted], it would indicate that [redacted] was not taking [redacted] medications. If [redacted] was not taking [redacted] medications, the Team questioned why [redacted] would continue to fill [redacted] prescriptions.
  - If [redacted], the hospital may not have made a report since [redacted] legally obtained the medications through her physician. A report, however, would have provided an opportunity to assess the family for a service need. Additionally, the hospital should have developed a plan of safe care for [redacted] if she [redacted] at birth.
  - The Team also discussed the critical timeframe between discharge from the hospital and the first well-baby visit. The transfer of care between physicians provides an opportunity for continuity of care. The Intake SWSM would follow up with [redacted] regarding [redacted] history of well-child care.

- The Team reviewed [redacted] for [redacted]. [redacted] previously received a large number of pills per month but the physician more recently reduced [redacted] prescription. It was unknown why and it was not clear if the physician was made aware of [redacted] cause of death. The Team questioned if the physician was being monitored as part of the registry that tracks physicians who prescribe opiates.

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

- No deficiencies were noted.

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 Team recommended that Philadelphia DHS provide routine training and have discussions with DHS and CUA staff regarding safe sleeping practices and the dangers of co-sleeping so that staff can provide adequate education to families with infants.

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

- The County had no recommendations.

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

- The County had no recommendations.

Department Review of County Internal Report:

The Southeast Regional Office received the Philadelphia County Fatality Team Report on 04/23/2018 and is in agreement with the report.

Department of Human Services Findings:

- County Strengths:
  The County completed an extensive investigation.

- County Weaknesses:
  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:

Education should be provided to [redacted] to address the potential consequences of co-sleeping. In addition to education being provided by medical and child welfare agencies, a publicity campaign geared toward educating the public should be created by utilizing social media platforms.

A campaign utilizing similar avenues should be created to educate the public about safe storage practices in the home for all prescription medication.