pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 02/01/2017
Date of Incident: 10/03/2017
Date of Report to ChildLine: 10/03/2017
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:
Completed by State Reviewer

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 11/01/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	02/01/2017
[redacted]	Mother	[redacted]1994
[redacted]	Father	[redacted]1993
[redacted]	Sibling	[redacted]2017
[redacted]	Sibling	[redacted]2013
[redacted]	Sibling	[redacted]2015

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed information from the Pennsylvania Child Welfare Information System (CWIS) and the Philadelphia Family and Children Tracking System (FACTs 2) for case documentation related to past and present case-management of the child, siblings and the Child Protective Services (CPS) investigation outcome. The Program Representative also reviewed case documentation from [redacted] that provided services to the family as the case was opened to them at the time of the incident. The Program Representative also reviewed medical records from the [redacted] as well as reports from subsequent follow up outpatient medical appointments. The Program Representative will obtain information related to any criminal investigations related to the Alleged Perpetrators should charges be filed and an arrest is made.

Children and Youth Involvement prior to Incident:

Philadelphia Department of Human Services (DHS) involvement with the family dates back to December of 2013 when a report was accepted for evaluation by the Philadelphia DHS regarding an older sibling ([redacted]) who was born with [redacted] in her system. As a result the mother was referred to community services to address any drug and alcohol issues and the case was closed with the completion of a safety assessment which determined the child to be safe in the home. Since that time, there have been a number of valid General Protective Services (GPS) reports which include concerns related to the inability of both parents to find and maintain appropriate housing and issues related to continued parental drug abuse. At present, there are 4 children in the home, including the victim child. The family received in-home services through [redacted] from 12/2015 to 12/2016 and again from 02/2017 to 07/2017 when the family unexpectedly moved without leaving a forwarding address. The family was located again on 09/14/2017 when a GPS referral was made to the Philadelphia DHS stating that the family was living in "deplorable conditions." An assessment related to those issues was pending at the time of the incident.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 10/03/2017, the victim child (9 months old) was brought to the Emergency Room at the [redacted] by her parents after having what appeared to be a seizure. The physicians were concerned as the child's sodium levels were at a low range. The child was also extremely underweight which appeared to indicate that the parents, who were later named as alleged perpetrators (APs), were not adequately feeding the child. On 10/03/2017, the physician at [redacted] determined the child to be in serious condition and as a result certified the report as a near-fatality due to suspected child abuse or neglect. The child was hospitalized because of her condition. The child also has a twin sibling. The hospital staff requested that the parents bring that child in as well to be examined. The parents would not cooperate with [redacted] efforts to gain identifying information about the family and refused to answer pertinent health related question concerning the victim child and siblings including the whereabouts and location of the 3 other siblings. The mother admitted to current Philadelphia Department of Human Services (DHS) involvement and revealed a substantial drug and alcohol history which also required DHS intervention. On 10/03/2017, the report was called to Childline and forwarded to the Philadelphia DHS to begin a Child Protective Services (CPS) Investigation. On 10/03/2017, an [redacted] was obtained and all of the siblings [redacted]. The victim child remained in the hospital for several more days and then was released [redacted] through [redacted] On 10/31/2017, the Philadelphia DHS determined the report to be "indicated" on both parents. It should be noted that the child's failure to thrive condition was as a result of the parent's failure to adequately feed and care for the child as well as other underlying medical issues. The child was diagnosed with [redacted] which was effecting the child's growth as well. Initiation

of the necessary medical treatment to address the issues have taken place, and the child will continue to be followed on an out-patient basis. Since that time, [redacted] and receive in-home services by [redacted]. The children are up-to-date on their medical appointments and received developmental assessments to address any delays. [redacted] continues monitoring the victim child [redacted]. The parents visit the child on a regular basis and are complying with case management services. [redacted] will occur once the parents have met their Family Service Plan goals, maintained stability and can properly care for the special medical needs of the child. A police investigation is pending however charges are not expected.

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 Act 33 team felt that the Philadelphia DHS worker completed an appropriate CPS investigation which was determined to be "indicated" on 10/31/2017.

  The team felt that two (2) recent GPS investigations (2/2/2017 and 9/14/2017) were determined to be "valid" with recommendations for the family to receive services. The family was receiving services from a contract provider agency ([redacted]), at the time of the near-fatality/CPS investigation (initiated on 10/3/2017). During the course of the last GPS investigation, the worker assessed allegations pertaining to inappropriate safety conditions in the home and addressed safe sleeping practices. Medical records were obtained by the social worker and follow up recommendations were made to the family to schedule an appointment for the twins with the pediatrician.

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

  The following deficiencies were noted:

  The team felt that even with regular visitation to the family, the [redacted] did not appear to recognize or comprehend the significance of weight loss regarding the infant or address the situation by scheduling an immediate medical appointment.

  There was no evidence that an Ages and Stages developmental tool required for infants and toddlers who are at risk of child abuse/neglect (CAN) was used to assess the victim child and a twin sibling.

It was learned that the family was using [redacted] for the children's primary health care.

It was learned that the child had missed several medical appointments and Philadelphia DHS was not notified by the medical provider.

Medical records were not loaded into the Electronic Case Management System (Philadelphia DHS/FACTS 2) on a timely basis so that comprehensive, periodic medical care as recommended by to the American Academy of Pediatrics could be tracked.

It was noted that there were barriers to obtaining medical records and information from provider, as the CUA worker is not a county staff with legal authority to gain access to this information.

It was noted in a previous GPS investigation, that the family was not cooperative and moved without notifying the Agency of the new location. After the family disappeared, relatives did not cooperate by providing information which they may have had to locate the family.

It was noted that the parents were not complying with obtaining a Drug & Alcohol assessment and a higher level of services may not have been recommended.

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse</u>;

  Recommendations were made that Philadelphia DHS draft a letter to medical providers, including local hospitals to inform physicians of Pennsylvania laws which mandate their cooperation with child welfare investigations, and the provision of ongoing services. The letter will include the applicable statues that mandate physicians' compliance. A fee for activities related to the release of records is recommended and should be explored to compensate medical providers for their time and efforts.

  Philadelphia DHS University, in conjunction with the DHS nurses should develop ongoing educational opportunities for DHS and CUA staff regarding child medical care which could include a number of topics such as child development, common child health concerns and training to identify issues related to failure to thrive which need to be brought to the immediate attention of medical authorities. The follow-up development of a check list to assess the health and well-being of children which can accompany the caseworker in the field was also recommended.

  Philadelphia DHS should amend its mandatory Nurse Consultation policy to require case consultations whenever a child's medical care is significantly out of compliance with the recommended schedule of well-child visits.

Philadelphia DHS will reiterate to DHS and CUA staff policies and procedures for requesting a private investigator search to locate a missing family.

The team recommended that a medical assessment be given to all of the siblings in the home as well as the victim child.

It was recommended that the Philadelphia DHS develop policies to require mandatory nurse consultation on cases where children have scarce or undocumented medical care. The nurse will participate in a home visit to provide on-site consultation to the case manager to address the lack of health care and specific ways that the problem can be addressed with medical providers.

The team recommended that a mechanism needs to be developed so that an immediate medical appraisal can occur when serious medical concerns are identified.

It was recommended that the Philadelphia DHS recommends policy to specify situations in which a mandatory telephone call to the DHS nurse should occur.

It was recommended that additional staff positions be created and included in the CUA case management system to support case managers in obtaining and uploading medical records into the FACTs system so that timely information is not delayed.

It was recommended that medical professionals report missed appointments (no shows) for children.

It was recommended that additional education is provided so that all staff working with families are aware of the American Academy of Pediatrics (AAP) recommended schedule of well-child care medical visits.

- 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.

  The team recommended that there be exemptions to Health Insurance Portability and Accountability Act (HIPPA) laws relating to privacy rules for child welfare cases.

Department Review of County Internal Report:

The Act 33 meeting occurred on 11/01/2017. The County's Review Team Report was received on February 1, 2018 and a response from the Department was sent on 2/05/2018.

Department of Human Services Findings:

The Department has reviewed case records from the Philadelphia Department of Human Services and is in agreement with the Child Protective Service (CPS) investigative findings of "Indicated." CPS as well as medical authorities found the child's condition to be in part, as a result of a failure by the parents to adequately feed the child which led to the child suffering substantial medical issues as a result and led to a near-fatality condition. The findings of the CPS investigation supported that view.

- County Strengths:

  Philadelphia DHS conducted and completed an appropriate CPS investigation within 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

- County Weaknesses:

  Are contained in the report.

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

  There Department is researching if the County as required completed Ages and Stages Assessment. A citation on Bulletin 3490-10-01 will be issued, if needed.

Department of Human Services Recommendations:

The PA Department of Human Services is in agreement with the Philadelphia DHS to support federal and state legislative action to change existing laws which promote confidentiality barriers to the sharing of information related to drug & alcohol and mental health histories and treatment regarding the parents which could cause a safety risk to the children. This action should be extended statewide.

The PA Department of Human Services is in agreement with the Philadelphia DHS to develop and provide additional technical support and training to the medical community to understand the CPSL as it relates to the release of medical information concerning children who are victims of a CPS/GPS investigation. This may be done by way of an informational mailing to medical practitioners which includes CPSL information which is easily

interpreted and understandable even to the educated recipient. Additional focus in this areas should be developed statewide.

The PA Department should also (as per Philadelphia DHS) consider establishing reimbursement or a fee to medical providers for time and efforts that have been undertaken to provide a copy of the child's medical records, due to the increased demand as a result of the CPSL to provide such information. A fee scale should be established and distributed statewide.