pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/04/2003
Date of Incident: 11/27/2017
Date of Report to ChildLine: 11/28/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Department of Human Services

REPORT FINALIZED ON:

09/06/2018

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.

Montgomery County has convened a joint review team meeting with Philadelphia Department of Human Services (DHS) in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Biological Mother	[redacted]1983
	Biological Father (deceased)	1979
	Father of Half Sibling	1973
	Biological Half Sibling	2005
	Victim Child	06/04/2003

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families attended the Act 33 meeting, reviewed all documentation relevant to the case, and spoke with case managers Montgomery County Office of Children and Youth and Philadelphia Department of Human Service administrators.

Children and Youth Involvement prior to Incident:

This family first became known to the Philadelphia Department of Human Services (DHS) on 05/28/2008, as a result of a Child Protective Services (CPS) report. The CPS report was unfounded and expunged.

On 06/12/2008, DHS received a General Protective Services (GPS) report alleging that the mother used inappropriate discipline with the children and also failed to seek appropriate medical care for the children. The report was determined to be invalid. A service need was not established.

On 12/10/2013, DHS received a GPS report alleging that the mother and her sons were living in poor housing conditions. The report was determined as invalid. The

family was not accepted for services but was referred to [redacted] voluntarily for their [redacted] to receive financial support regarding repairs to the family home. There were no safety threats identified. There were no concerns with the medical care or the boys' education.

On 09/01/2014, DHS received a GPS report alleging that the mother used illegal substances and failed to meet the needs of the children. The report was determined to be invalid. The family was not accepted for services but was referred to [redacted] voluntary [redacted] program for assistance obtaining medical insurance for herself and for her son. There were no safety threats identified.

On 01/11/2017, DHS received a CPS report alleging that the mother allowed a family friend to reside in the home and the friend had an inappropriate sexual relationship with the victim child. The report was unfounded. The child denied the allegations and the mother removed the friend from the home. No safety threats were identified. No dependent service need was established. The child at the time was [redacted] due to his [redacted]

On 05/25/2017, DHS received a GPS report alleging that a [redacted] concerning the child was held on this date. DHS was ordered to investigate the family. The mother was consistently [redacted] while having the children in her care. The report was validated. The case was accepted for services on 06/28/2017. The child was [redacted] in the [redacted] on 06/29/2017.

[redacted] assumed case management services for the family on 07/27/2017. [redacted] began providing in-home non-safety services to the victim child's brother [redacted]. [redacted] were being implemented.

It is noted that the victim child's father had a history of dependent services (both in-home and placement) and a history of delinquent services (both in-home and placement).

<u>Circumstances of Child Near Fatality and Related Case Activity:</u>

On 11/28/2017, a report was received from ChildLine stating that the victim child arrived at [redacted] and was transferred from [redacted] The child was originally brought to [redacted] by ambulance from [redacted].

The victim child was found by a peer hanging from a shelf above the washer and dryer in the laundry with a belt tied around his neck. The victim child was unconscious. At approximately 8:30 PM. students were engaged in evening activities such as watching television, playing games, listening to music, etc. A staff was responsible for monitoring the cube that the victim child was in however he

was able to leave the cube and go into the laundry room where he hung himself with a belt from a shelf. When the staff noticed that the victim child was not present in the cube, another student was already waving for the staff to come to the laundry room. The nurse checked victim child's vital signs and assessed for injury while other staff secured the area and called 911. Police and paramedics arrived. The victim child was then taken by ambulance to [redacted] and after being stabilized was transferred to [redacted].

The victim child had [redacted] from 10/06/2017 through 10/18/2017, for [redacted] and was required to have a one-to-one staff with him at school. Significant diagnoses of the victim child include [redacted].

Montgomery County Office of Children and Youth scheduled a forensic interview for the victim child with [redacted]. A detective from [redacted] and an Assistant District Attorney from Montgomery County were present for the forensic interview.

The victim child was [redacted] with Philadelphia County at the time of the incident. The victim child [redacted] after conducting a home invasion with his mother's previous boyfriend. Victim child also had a history of [redacted] while [redacted] for probation.

At the time of this report the police investigation has been completed and no criminal charges have been pursued at this time. The staff person present and responsible for the victim child's supervision was initially suspended with pay but has since been re-instated. The Montgomery County Children and Youth investigation was unfounded.

[redacted] was [redacted] from [redacted] on 11/28/2017 to [redacted] and transferred to the [redacted] after being stabilized. He was then sent to [redacted] and was there until 01/05/2018.

[redacted] was sent to [redacted] from 01/05/2018 until 03/12/2018. On 03/13/2018 [redacted] was [redacted] in Philadelphia and was there until 04/03/2018. [redacted] was [redacted] in Philadelphia from 04/03/2018 until 04/09/2018. While [redacted] left without [redacted] knowing his whereabouts. He invited friends and his girlfriend to [redacted] without [redacted] permission. He was reported to have mixed drugs [redacted] with the intent of distributing them at school. He was also reported to have stolen from and fought with household members [redacted].

[redacted] was again sent to the [redacted] on 04/10/2018 and was there until 05/03/2018. On 05/03/2018 he [redacted]. He was also placed on GPS monitoring with a 45 day trial period for his behaviors to be

monitored. While [redacted] he stayed out past curfew, was non-compliant with house rules, [redacted], was verbally disrespectful towards his mother, and was non-compliant with treatment services.

On 08/21/2018, he attended a court date and the recommendation from juvenile probation was for he be [redacted] for his non-compliance and increase in negative behaviors. The youth went AWOL from the courthouse. His whereabouts are unknown at the time of this report. A missing person's report has been filed and a private detective will be utilized to assist in locating the youth. The family claims they do not know his whereabouts.

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;

  Montgomery County Office of Children and Youth and Philadelphia Department of Human Services jointly conducted the Near Fatality review.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  No deficiencies were noted in statutes or regulations. It was noted, however that several mandated reporters were aware of near-fatality incident but had not reported it to ChildLine. Training for staff at Residential Treatment Facilities regarding reporting requirements, particularly when it pertains to attempted suicide is recommended.

- 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 requested that the Pennsylvania Department of Human Services, Office of Children, Youth and Families (PA-DHS OCYF) consider completing all investigations of licensed facilities, regardless of county contracts with the facility. This practice would allow for consistency and ensure that the facility is concurrently assessed for any licensing issues.

- 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.

  It is recommended that boundaries for children placed in RTF facilities be reviewed when children require a higher level of care. The system is not as

responsive as it should be for children in need of a higher level of behavioral health treatment.

RTF facilities should be encouraged not to accept youth that do not fit their programs.

RTF referrals should include behavioral health evaluations.

Department Review of County Internal Report:

The Department concurs with the County Internal Report. However with regards to the recommendation that PA-DHS OCYF complete investigations of licensed facilities regardless of county contracts with the facility, the Department does not concur. This procedure will remain compliant with regulatory standards and all parties will conduct investigations as prescribed by regulations.

Department of Human Services Findings:

- County Strengths:

  Montgomery County conducted a thorough investigation and was able to coordinate a joint review team meeting. There was contact with multiple agencies throughout this investigation.

- County Weaknesses:

  None identified.

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

  None identified.

Department of Human Services Recommendations:

A review of the regulations and program guidelines specific to residential facilities should occur specifically in the areas of staff training, ratios and therapeutic skill levels.