pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/10/99
Date of Incident: 11/9/15
Date of Report to ChildLine: 11/11/15
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:
May 6, 2016

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))

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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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/4/15.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	11/10/99
[redacted]	Mother	[redacted]/74
[redacted]	Stepfather	Unknown
*[redacted]	Father	Unknown
[redacted]	Half Sibling	[redacted]/10
*[redacted]	Full Sibling	[redacted]/94
*[redacted]	Half Sibling	Unknown

* None are household members.

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current CPS investigative information including the CY-48 as well as written case documentation from the Philadelphia Department of Human Services (DHS). The Program Representative also reviewed updated case information in the Philadelphia Department of Human Services - Facts system- and the PA Department's Child Welfare Information Solution (CWIS). The Program Representative also obtained periodic case updates from the Philadelphia DHS Social worker and the [redacted] service worker.

Children and Youth Involvement prior to Incident:

It should be noted that the victim child did not reside with the family until 2015 and is presumed to have been living with his father in Florida.

A history of Agency involvement is as follow:

On 12/27/05, a General Protective Services (GPS) referral was made with concerns for the care and supervision of an older sibling who is now an adult. Information in the Philadelphia DHS record reveals that this child was also an [redacted] and there were concerns which centered on the parent's ability to facilitate regular and ongoing medical care for the child and to adequately manage the child's [redacted] regimen. An assessment could not be fully completed on the family as they could not be located despite numerous efforts to do so by the Philadelphia DHS worker. On February 3, 2006, the report was determined to be "invalid" and the case was closed.

On 8/30/10, another GPS referral was made with additional allegations. This report was made on the youngest child after a bystander observed the child playing in a window which was thought to be dangerous. There were also concerns about the use and selling of drugs by the parents. Philadelphia DHS records revealed that the report was determined to be "invalid, as a service need was not established." On 10/1/10, the case was closed. It should be noted that written case documentation could not be found in the Philadelphia DHS record to describe the interventions utilized or information that supported the decision to close the case at the conclusion of the investigation.

On 3/11/11, there was a third GPS report made to the Agency again with concerns related to the care of the sibling with [redacted] There were also truancy concerns and a host of other issues related to the parental care and supervision of the children. The allegations were not assessed as the family could not be located despite numerous efforts by the Philadelphia DHS including the use of a private investigator. The case was closed on 5/15/11 without locating the family.

On 11/19/14, a 6 month old female sibling died as a result of Sudden Infant Death Syndrome (SIDS) while the family was vacationing in [redacted], Nevada. Philadelphia DHS obtained information from the Medical Examiner's Office in Clark County, Nevada. The cause of death is listed as "undetermined," however "there were no signs of neglect or abuse." A police investigation in [redacted] did not occur.

A 9 year old male sibling reportedly lives with his father and his location is not presently known, therefore a present safety assessment of the child's living arrangement did not occur.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/9/15, the victim child was seen in the Emergency room at Methodist Hospital and was determined to be in [redacted] which is a serious complication that can be life threatening. The child was admitted to Methodist Hospital and [redacted] Later that night, the child was signed out against medical advice (AMA) by his mother who believed that the child was well enough to be discharged with a follow-up doctor's appointment (next day) at Children's Hospital of Philadelphia (CHOP). Part of the motivation for removing the child was that his birthday was the next day and the child did not want to remain in the hospital.

The following morning, 11/10/15, the child was found at home by his mother and stepfather in an unresponsive state and could not be aroused. As a result, the child was brought to CHOP Emergency Room and was placed in [redacted] with concerns for possible [redacted] and other complications due to the child's [redacted] condition.

On 11/11/15, a report was called into Childline [redacted] and was registered for "serious physical neglect for egregious failure to provide medical treatment, resulting in a near fatality." The child's medical condition was certified by [redacted] a physician at CHOP. It was felt by the medical team at CHOP and the Philadelphia DHS that the mother demonstrated poor judgement by assisting with the child's removal from the hospital against medical advice, which was felt directly aided in the deterioration of the child's medical condition.

On 11/13/15, a meeting was held at CHOP [redacted] but concerns persisted around the family's understanding and ability to manage the victim child at home with regards to maintaining the child's follow-up medical care and home regimen. As a result, [redacted] based on the severity of the child's medical condition and the near-fatality status of the CPS report. [redacted] The Philadelphia DHS also made a home visit and conducted a preliminary safety assessment on 5-year-old [redacted] a sibling living in the home. This child was allowed to remain in the home as he does not have [redacted] and the mother did follow through with a recommended doctor's appointment.

[redacted]

[redacted] Liberal visitation was granted to the mother. A review hearing was scheduled for 1/14/16.

On 12/10/15, the Philadelphia DHS determined the CPS investigation to be "indicated" on the mother for "an egregious failure to supervise and a failure to provide medical care resulting in serious physical neglect and inadequate medical care."

[redacted]

Both the mother and the child have received education to enhance their knowledge and skills concerning and its management. It was noted that the child had difficulty managing his diet

In-home services through a Community Umbrella Agency (CUA) are currently being provided to the family. Visits have been made by the Philadelphia DHS worker and the worker. Much emphasis is being made to monitor the child's medical condition and to provide education and support. The child is expected to be followed by This is currently being set up by the mother and being monitored for compliance by The child is now enrolled in school and is adjusting with few absences This has not occurred as of yet; however, the mother is being encouraged to complete this The sibling is doing very well and assessed to be safe. The mother is in compliance with following through with both the child's medical and dental care.

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

The Act 33 meeting occurred on 12/4/15. The following information was obtained from the County Review Team Report submitted on 2/29/16.

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

  The Act 33 team felt that the Philadelphia DHS Multidisciplinary Social worker did a "very good job with the investigation, particularly with sorting out the inconsistencies in the information provided by the family and with obtaining collateral information from other jurisdictions." It was also noted that the social worker did a good job in conferencing with her chain of command regarding case decisions at every level of the investigation.

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

  None 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 send letters to the emergency room chairs at Methodist Hospital and Children's Hospital of Philadelphia. In

light of their roles as mandated reporters, the letter should explain why the situation should have been reported to the Philadelphia DHS due to the child's non-compliance with medical treatment.

- 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.

Department Review of County Internal Report:

The Department received the County's report dated 2/29/16 and is in agreement with their findings. A written response from the Pennsylvania Department of Human Services was submitted on 3/10/16.

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) investigation findings which determined the investigation to be "indicated." The Philadelphia District Attorney's Office declined to pursue charges against the mother.

- County Strengths:

  Philadelphia Department of Human Services conducted and completed an appropriate CPS investigation within 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490. It was also noted that the DHS worker did a competent job in sifting through and interpreting an enormous amount of information related to the child's medical condition, treatment and parental concerns related to the child's safety and well-being. The DHS worker also interacted with a myriad of medical providers on a regular basis. Much time and effort was made to facilitate stabilization of the child's medical treatment in placement, and subsequently back in the home upon the child's discharge.

- County Weaknesses:

  Due to the child's medical needs [redacted] and the scarcity of beds available, the Philadelphia Department of Human Services did not secure a placement resource for the child within close proximity to the child's home.

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

  None were noted.

Department of Human Services Recommendations:

The Department recommends that more resources be allocated to developing placement resources for children with [redacted] serious medical issues.