



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 05/24/2011
Date of Incident: 02/18/2014
Date of Oral Report: 02/18/2014

FAMILY KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON:
06/22/2015

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	05/24/2011
[REDACTED]	Mother	[REDACTED]/1988
[REDACTED]	Maternal Grandmother	Adult
[REDACTED]	Father	[REDACTED]/1988
[REDACTED]	Paternal Grandmother	[REDACTED]/1962
[REDACTED]	Maternal Cousin	[REDACTED]/1991

*At the time of the incident, the child was living with her mother and maternal grandmother. The father and paternal grandmother also had joint shared physical custody of the child. Each lived in separate households. Since then the father has been awarded sole physical custody of the child through the courts. The maternal cousin was the caretaker for the child on the date of incident.

Notification of Child Near Fatality:

On 02/18/2014, the Philadelphia Department of Human Services received a report alleging the child ingested [REDACTED] which caused the child to be unresponsive and lethargic. The child was given [REDACTED] at the hospital and had a positive response. She was in the care of her maternal cousin that day. It is unknown where or when the child ingested the [REDACTED].

Summary of DHS Child Near Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the investigation. SERO reviewed the county's investigation/assessment, structured case notes, safety assessments, safety plans, and risk assessments. Interviews were completed with the investigative social worker as well as the case manager from the Community Umbrella Agency (CUA). SERO attended the Act 33 Review Team meeting held on 03/07/2014.

Children and Youth Involvement prior to Incident:

The family became known to Philadelphia DHS on 12/19/2013 as a result of a report alleging the paternal grandmother found drug paraphernalia in the child's diaper bag when the mother dropped her off for her visit. The child was not harmed and a finding for the report was still not made at the time of this most recent incident. It has since been determined not to be substantiated.

Also noteworthy is the fact that the mother has a history as a minor with [REDACTED]. She was the victim of both physical and sexual abuse. The father has no history as a minor.

Circumstances of Child Near Fatality and Related Case Activity:

DHS received the referral regarding the child on 02/18/2014 and immediately assigned the case to assess for the child's safety. The caseworker subsequently saw the child in the hospital and obtained her medical status.

A safety plan was developed by the county with the family to ensure the safety of the child. The mother would have no unsupervised contact with the child. An Order of Protective Custody was filed the following day placing the child with the paternal grandmother.

The caseworker interviewed all family members for each household, medical staff, and law enforcement. Information obtained revealed that the child was being cared for earlier in the day by a maternal cousin. The mother returned and noticed the child was lethargic and unresponsive. She was taken to Einstein Hospital and then transferred to St. Christopher's Hospital. Testing revealed that she had cocaine in her system. No one could provide an explanation for her condition.

A similar incident occurred in January 2014. A maternal aunt was caring for the child at that time. The mother returned and noticed the child was lethargic. The child was taken to Einstein Hospital and transferred to St. Christopher's that time as well. The doctors were unable to determine what caused her condition. Neither Philadelphia DHS nor the police were notified of the incident.

On 03/31/2014, the report was substantiated as the agency determined the mother, as the responsible caregiver, was unable to ensure appropriate supervision for the child. The child ingested [REDACTED] which caused a negative physical reaction requiring immediate medical attention.

Current Case Status:

The child currently resides with her father. There are no safety concerns while in his care as the incident did not happen while under his supervision. There are no other children residing in the mother's home. There are no ongoing medical concerns. The criminal investigation continues.

The child and father are receiving [REDACTED] through [REDACTED]. The father is taking anger management classes. Both parents were referred for [REDACTED]. No issues were identified for either parent. [REDACTED]. Mother maintains regular bi-weekly supervised visits at the agency.

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

- Strengths: The county noted the social worker did a thorough investigation and conferencing with her chain of command.
- Deficiencies: The county noted concerns regarding timeliness of the prior investigation and documentation. The report had not yet been determined when this incident happened, which was beyond the agency's 60 day policy. The report was determined on day 63. Also, the case documentation was not entered into the electronic case management system in a timely manner. Furthermore, it was concerning that the agency was not aware of the January 2014 incident despite the fact that there was an active agency investigation for the December 2013 report.
- Recommendations for Change at the Local Level: Philadelphia DHS has developed a plan to increase the use of electronic case management system and improve timeliness of documentation into the system. The executive leadership will monitor regularly to ensure improvements are made.
- Recommendations for Change at the State Level: None identified.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county dated June 2, 2014. We are in agreement with the county's findings as per letter dated July 22, 2014.

Department of Public Welfare Findings:

- County Strengths: The county provided clear documentation in the case notes and investigation report. All relevant parties were interviewed. Children were seen in a timely manner. The county collaborated with the hospital and law enforcement throughout the investigation.
- County Weaknesses: Timeliness of GPS investigation findings and case documentation into the electronic case management system.
- Statutory and Regulatory Areas of Non-Compliance: The agency did not make a finding regarding the December 2013 report within 60 days. Therefore, a Licensing Inspection Summary will be issued for non-compliance with PA Code Title 55 Chapter 3490.232(e) which states the county shall complete an assessment within 60 calendar days to

determine whether or not the child and family should be accepted for general protective services, or close the case.

Department of Human Services Recommendations:

Hospitals need to be educated regarding situations that ought to be brought to the attention of the county agency or police department. Had the January 2014 emergency room visit and medical treatment of this child been reported, intervention could have occurred which may have impacted future incidents occurring. If a family is already being assessed by the county agency, this information could be crucial in the county's findings and level of services provided.