



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 3/13/14
Date of Incident: 4/22/14
Date of Oral Report: 4/22/14
Date of Near Death Report (supplemental) 5/19/14

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

March 12, 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.)

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, DPW 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 has convened a review team on June 6, 2014 at 9 am 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	3/13/14
[REDACTED]	Mother	[REDACTED]/85
[REDACTED]	Father	[REDACTED]/71
[REDACTED]	Sister	[REDACTED]08
[REDACTED]	Brother	[REDACTED]/04

Notification of Child Fatality:

The victim child was born on 3/3/14 and was considered to be a healthy full term baby. On 4/22/14 the parents brought the child to [REDACTED] at Children's Hospital of Philadelphia (CHOP) due to the child having a watery stool, vomiting and a weight loss of 2 pounds which was 25% of the child's weight. The child had not had any primary health appointments since birth. The child's condition was determined [REDACTED] to be as a result of malnutrition which in part led to dehydration and an electrolyte abnormalities. Organic reasons for the child's condition were ruled out. As a result a [REDACTED] report was called to ChildLine on 4/22/14 [REDACTED]. There was a [REDACTED] team meeting on 4/24/14 (that included the DHS worker) at which time the child's medical condition was certified (by the physician) to be a Near-fatality. Although DHS involvement continued with the family, a Near Fatality report (CY -47 supplemental) was not called into ChildLine [REDACTED] until 5/19/14. The reason for the delay was due to confusion that the report had been made when in fact it had not.

Summary of DPW Child 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. Included in the packet were also medical records from the Children's Hospital of Philadelphia (CHOP) detailing the child's medical diagnosis and treatment. The Southeast Regional Office Program Representative also obtained information from the Act 33 meeting which was held on June 6, 2014 where a thorough case presentation was given.

Summary of Services to the Family:

Children and Youth Involvement prior to the Incident:

The family was not known to the Philadelphia DHS in the last 16 months but did have a history with the Agency. A referral was made to DHS in October of 2007 for GPS concerns related to neglect and supervision of [REDACTED] oldest son, [REDACTED]. The family received [REDACTED] services through [REDACTED] from 11/9/07 to 9/5/08. The services were discharged because the family stabilized. In July of 2009, a GPS report was substantiated (child ran away from the home of a relative who was babysitting) however a service need was not established and the case was closed with no services being implemented after it was determined that there were no concerns for the supervision and care that the child was receiving at the [REDACTED] home.

Circumstances of the Fatality and Related Case Activity:

Information learned about the mother prior to the child's [REDACTED] and referral to DHS (4/22/14) was that the baby was being breast fed however due to poor latch and poor intake, the mother supplemented [REDACTED] Soy instead of a cow's milk based formula. The child did not appear to be able to handle this formula and so mother, a vegetarian chose to transition the child to a rice formula after discontinuing the [REDACTED]. The mother did not follow up with [REDACTED] to determine what alternatives would be best for the child. The child continued to lose weight which eventually led to the child's visit to the [REDACTED] CHOP. Even though the family had 2 visits from [REDACTED], the child still had not yet been seen by a pediatrician. The mother states that this was due to her lack of a car seat and carrier to transport the child in.

A visit was made to the home on 4/23/14 by the Philadelphia DHS worker to assess the safety of the home and to interview the other children in the home. The DHS worker interviewed [REDACTED], age 9 and [REDACTED], age 6. Both children appeared to be developmentally on target, comfortable in the home and well groomed. [REDACTED] does have [REDACTED] but has not had to use a [REDACTED] for a long time. The home was safe and appropriate for children and there were no obvious safety threats. There were no concerns about school attendance or performance. A safety assessment conducted on 4/23/14 found [REDACTED] the subject of the CPS investigation to be safe with a plan and [REDACTED] and [REDACTED] to be safe in the home, with no issues regarding their safety however physical examinations for each of the children was deemed a priority.

The child was [REDACTED] at CHOP from 4/22/14 to 4/24/14. The child underwent [REDACTED] which triggered changes and upgrades to the child's nutritional and hydration regimen. The child received a physical examination [REDACTED] on 5/2/14 which indicated that the CHOP medical team had addressed most of the issues related to the child's condition at admission. Recommendations [REDACTED] were to increase the child's feeding with an enhanced Similac formula provided to give the child adequate nutrition to foster weight gain.

Concrete diet and feeding instructions were also included. The child was also recommended to see the pediatrician in 2-3 days upon discharge. It was also advised that the Philadelphia Department of Human Services continue to follow up on the baby's progress.

A CPS investigation was completed by the Philadelphia Department of Human Services on 5/21/14 with [REDACTED] resulting in a physical condition on both parents. Ultimately the result was based on the parent's failure to provide adequate nutrition and medical care which caused the child's weight loss and near-fatality condition. Although the report was [REDACTED] there were questions from the MDT members as to whether this was the right outcome, given that the parents may have gotten poor advice from [REDACTED] who they felt should have directed the family to be more proactive towards meeting the child's medical and nutritional needs.

Current Case Status:

[REDACTED], the child was recommended to return home with a compliment of services to be instituted by the Philadelphia DHS. A safety plan was implemented by DHS which included [REDACTED] to be delivered through provider agency [REDACTED]. A family service plan (FSP) was implemented on 5/19/14. Among important objectives in the plan were for the parents (1) to participate in [REDACTED], particularly to understand why the child was neglected, (2) to participate in parenting skills education (3) to make and keep medical appointments for all the children and (4) to provide regular nutritious meals.

All medical appointments were kept for the victim child [REDACTED] who did well and continues to gained weight on a consistent basis.

[REDACTED] is 9 years old and appears to be age appropriate with no reported delays. The child looks bigger than his stated age [REDACTED] has [REDACTED] and is [REDACTED]. A well visit was scheduled for June 2nd, 2014 which did occur. The child's last physical exam was on 9/24/09. The child had a sick visit on 4/27/11. The child does have some unexplained absences from school which are being addressed and monitored through the provider agency.

[REDACTED] is a 5 year old female child who appears to be her stated age physically and is developmentally on target. [REDACTED] was last seen for a physical examination on 12/2/13 and is not expected to return for a follow-up until December of 2014.

Both children presented as clean, neat and well groomed and had no unmanageable behavioral issues or significant children care or supervision concerns.

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

Strengths:

The Philadelphia DHS conducted their investigation and assured the safety and well-being of the victim child and siblings during the course of the CPS investigation.

The Team felt that case documentation was thorough and that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

Deficiencies:

The following concerns were identified by the MDT members at the June 6, 2014 Act 33 meeting.

There were concerns about the [REDACTED] provider's failure to act, even with information during the visits that the infant child was losing weight. Based on the information in the report, [REDACTED] may not have "addressed the critical needs of the child" and did not seem to follow its own protocols. The practitioner determined the child to be losing weight and did not appear to recognize the "medical emergency" which should have precipitated necessary follow up. A letter to [REDACTED] and [REDACTED] describing the problem was recommended.

The Team had concerns that the near fatality report (supplemental) was not called into ChildLine until 5/19/14, almost a month after the initial report was made. The report initially came in as a GPS report however DHS received a supplemental from ChildLine on 4/23/14 that upgraded the report to a CPS. There was no mention in the supplemental that this was a near fatality case. On 4/24/14, the assigned intake worker met with the [REDACTED] and asked [REDACTED] if this was a near fatality case which he responded yes to the worker but had not at that point submitted the case to the Hotline. The worker continued her investigation and waited for [REDACTED] to submit the information to the Hotline. [REDACTED] was contacted by Philadelphia DHS on 5/16/15. Apparently there was some confusion and [REDACTED] didn't realize that the Hotline had not been contacted re: the near fatality certification. [REDACTED] called in the certification that following Monday 5/19/14 and ChildLine was notified the same day by the Philadelphia DHS.

There were concerns that the results of the CPS investigation was determined to be "indicated" as some of the team members felt the child's condition may not have been brought about by an intentional attempt to harm the child by her parents, but by other factors which may have been out of the control of the parents.

Recommendations for Change at the Local Level: It should be noted that the family was not opened to the Philadelphia Department of Human Services at the time of the incident and as a result there were no recommendations for change at the local level.

Recommendations for Change at the State Level: There were no recommendations for change at the State Level.

Department Review of County Internal Report: The Department has received the County's report dated September 2, 2014 and is in agreement with their findings. A letter

stating that the Department was in agreement with the findings was mailed to the Philadelphia DHS on February 24, 2015.

Department of Public Welfare Findings:

County Strengths: The CPS investigation was completed in 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

County Weaknesses:

The Department identified no further deficiencies other than those already contained in the report.

Statutory and Regulatory Areas of Non-Compliance: A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Public Welfare Recommendations:

The Department has no further observations or recommendations.