pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ethan Okula

Date of Birth: 12/27/2005
Date of Incident: 02/10/2016
Date of Report to Child Line: 02/11/2016
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:
10/25/2016

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))

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 03/04/2016, and then 05/06/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Ethan Okula	Victim Child	12/27/2005
[redacted]	Foster Mother	[redacted]1957
	Foster Brother	[redacted]2004
* [redacted]	Foster Mother's Friend	[redacted]1962
* [redacted]	Biological Mother	[redacted]1990
* [redacted]	Biological Father	[redacted]1987
* [redacted]	Biological Brother	[redacted]2007

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [redacted] family. Follow up interviews were conducted with the Referral Source, DHS Fatality Coordinator, Foster Mother, and the Foster Mother's Friend on 02/11/2016. Interviews were conducted with the child's teacher, teaching assistant, school principal, school police officer, and county Children and Youth worker on 02/12/2016. A visit was made to the other foster child who lived in the foster home on 02/14/2016. The primary care social worker was interviewed on 02/18/2016. Follow-up interviews were conducted at the school with the victim child's teacher, the teaching assistant, school police officer, and the school principal on 02/18/2016. The Southeast Regional Office of Children, Youth and Families attended a forensic interview for the other foster child who was in the home on 02/25/2016. The regional office also participated in the County Internal Fatality Review Team meetings on 03/04/2016, and 05/06/2016.

Children and Youth Involvement prior to Incident:

12/27/2005 – The victim child was born at 25 weeks gestation [redacted]

Philadelphia DHS services from 2007 – 2009

Philadelphia DHS conducted an investigation into injuries that had been sustained by Ethan and his biological brother on 12/30/2007. The agency investigation found that [redacted] was responsible for the injuries to the children. Medical evidence was present to support the finding. The children were placed in foster care on 01/28/2008 through 05/17/2009. The children were returned to their parents, and the family received In-Home Protective Services through 11/25/2009.

Philadelphia DHS services from 2011 – 2016

On, 07/07/2011, a [redacted] report received for concerns that father was not giving Ethan [redacted] that he was supposed to be using daily. The children were living with maternal grandmother, and father refused to give [redacted] to maternal grandmother. The agency did find validity in the allegation. Then on 08/23/2011 it was reported that Ethan appeared to have a bruise that was turning yellow. Reporting Source also said that the father left the child home alone. At that time, the father had full custody of both children, and mother was attempting to gain custody. The agency did not find any evidence of maltreatment however based on the case history and recent referral; In-Home Protective Services were implemented beginning on 10/25/2011.

A report was filed on 01/18/2012 alleging that Ethan came to school with bruising on the bridge of his nose and under his left eye. Child had reportedly run into the street and said "Daddy got mean." The investigation did not reveal any evidence of maltreatment. The family remained open for services.

One month later on 02/20/2012, the agency received a report on Ethan's younger brother. The child was brought to CHOP, and father stated that the child had fallen off of his bike, and that father was outside with the child. The father then changed his story and stated that he was inside when the child was riding his bike. [redacted] Throughout 2012 and 2013 the children remained in their foster care placement setting.

On 11/26/2013, the agency received a call from [redacted] that the foster parent was leaving Ethan and his brother home alone with her 12-year-old son, and that she and her son were hitting the children. The children were removed and placed in another foster home. The investigation did not find evidence of the allegations however the children remained in their new placement setting. [redacted]

Shortly thereafter on 12/03/2013 a report was received alleging sexual assault of the younger brother in that the father had put his private part in the child's butt. This report was [redacted] The children remained in care.

On 02/06/2014, Ethan and his brother were moved to [redacted] foster home from [redacted] foster home. [redacted] They remained there until September. On 09/18/2014, both children were moved to a pre-adoptive home. [redacted]

Turning Points Community Umbrella Agency #3 assumed case management responsibilities from the Philadelphia Department of Human Services on 01/28/2015. The boys remained in their foster/adoptive home with supervision from Turning Points until a report was received in July expressing concerns over the care they received. [redacted] The children were removed from their foster/adoptive home as there were concerns expressed [redacted] over the care being provided to the children in this home. It is noted that at a later date after the children's relocation, the agency received a formal referral that found that Ethan had been left alone outside by the previous foster parents and forced to wait outside for his social worker, without his cell phone, eyeglasses, [redacted] On 07/22/2015, Ethan was placed in the Alleged Perpetrator's home, and his brother was placed in another foster home with a different agency. It is unclear as to the basis for the separation of the boys.

While in his new home, Ethan was the subject of two reports alleging maltreatment by the current foster mom and her friend as well as an older cousin. There was no evidence found in support of these allegations. [redacted]

On 11/30/2015, the agency received a report stating that another foster child in the home, age 11, was inappropriately touching the victim child. On 12/23/2015, a Philadelphia Department of Human Services social worker visited the foster home to investigate the [redacted] reports from November. The investigator spoke with each child alone, and no concerns were noted. The foster parent appeared to be concerned for the children's welfare and involved in their care.

There were no other reported concerns about the child's care or the foster home until the child's death.

Circumstances of Child Fatality and Related Case Activity:

On 02/10/2016, the Philadelphia Department of Human Services received a report stating that the victim child had arrived unresponsive at Hahnemann University Hospital via ambulance. He was revived briefly at the hospital, but was later pronounced dead. Staff from the DHS hotline visited the home to ensure the safety of the other foster child in the home. The other foster child was moved out of the home. It was discovered that the victim child complained of chronic stomach and abdominal pain while in school.

On 2/11/16, a [redacted] report was received by the Southeast Regional Office of Children, Youth and Families, alleging that the child had been reporting stomach pain early in the morning, and that the named perpetrator picked the child up from school around 12:00pm after the school contacted the foster mother surrounding the child's illness. The child's chief complaint was stomach and abdominal pain. The alleged perpetrator verbally acknowledged her intent to not take the child to a medical provider as recommended by school personnel given the magnitude of the child's condition. The perpetrator asserted that the child's current behavior and claim of stomach and abdominal pain was an habitual occurrence which did not warrant medical attention and that the child would be taken home and sent to his room. The alleged perpetrator used profanity when stating that she did not want the child, who had reportedly had a bowel accident, to be in her car. School personnel provided her with a trash bag to put on the seat of her car. The alleged perpetrator was verbally and physically inappropriate with the child while placing him in the vehicle to transport him home.

On 2/11/16, staff from the Southeast Regional Office of Children, Youth and Families visited the foster home and spoke with the foster parent and [redacted]. It was stated that the foster mother received a call from the school nurse at 9:38 in the morning, saying that the child was sick and needed to be picked up. The foster mother stated that she worked in West Philadelphia, and that she would not be able to get to the school for some time. She called [redacted] who agreed to pick up the child from school. [redacted] arrived at the school around 12 or 1, and then brought him home. He was given some water and he lay on the couch. The foster parent checked on him periodically, and gave him some water to drink at 6:00 in the evening. She found him unresponsive and called 911. The police arrived at the house, took the child to the hospital, and told her that she would not be able to accompany the child to the hospital because her house was a crime scene.

On 2/12/16, staff from the Southeast Regional Office of Children, Youth and Families visited the school and met with [redacted] It was stated that school staff were not aware of the child's death until the school bus driver said that she had gone to the house and been told that the child had passed away. School staff were concerned that the child's death had been related to a denial of medical care, as the [redacted] stated that she was not going to take the child to obtain

medical care. [redacted] stated that the [redacted] stated that the child had eaten too much the previous day, and that he had a stomachache from that. She told school staff that he often eats too much, and that he needs to face the consequences for eating so much.

On 2/12/16, the Philadelphia Department of Human Services worker stated that the foster parent called her at 7pm or so, stating that the school contacted the foster parent around noon, and that he was picked up within an hour.

On 2/25/16, a forensic interview was held at the Philadelphia Children's Alliance with the other foster child in the home. The child said he returned to the foster home from a visit with his mother. There was a lot of commotion in the home, and the foster mother was shaking and crying. The foster mother told him to go upstairs and watch TV. He heard her telling someone on the phone that the victim child had gone to work with her the previous day. He did not see the victim child downstairs, so he thought the victim child went upstairs. He stated that the foster mother's nephew was in the home, trying to calm her down. The child stated that [redacted] was not in the home at the time.

On 2/29/16, [redacted] reported that a call was made from the home at 6:59pm, saying that the child was unresponsive. At 7:10 pm, emergency medical services arrived on the scene. The child was found on the floor next to the couch not breathing and unresponsive. The foster mother allegedly reported to emergency medical services that the child had been throwing up in school. She also stated that the child had been unresponsive for 30-60 minutes

On 3/2/16, a [redacted] report was generated, alleging a Delay or Denial in Healthcare. The other foster child in the home, age 11, reported that he had not been given [redacted] That report was found to be [redacted]

On 4/7/16, a [redacted] report was made for Failure to Provide Medical Treatment/Care by [redacted]. The Philadelphia Department of Human Services determined that the case was [redacted] based on supporting evidence in the investigation that the nurse did not call 911 when the child was in medical distress. This investigation was [redacted] on May 10, 2016. [redacted]

On 04/08/2016, [redacted] contacted the Southeast Regional Office of Children and Youth. She stated that she was agreeable to being interviewed, but that she had to rearrange her schedule, and that she would contact the Regional Office to arrange an interview. It was explained that a decision needed to be made, and that an interview would need to be arranged for the next two days.

The Pennsylvania Department of Human Services [redacted] the case on 04/11/2016, naming [redacted] as perpetrators. [redacted] for causing serious physical neglect of a child and [redacted] for causing the death of a

child through any act/failure to act. Law enforcement has declined to file criminal charges or further investigate the matter. The Philadelphia Department of Human [redacted] the report regarding [redacted] on 5/10/16 that was generated alleging Failure to Provide Medical Treatment/Care. The Philadelphia Department of Human Services investigator found this report to be [redacted] due to supporting evidence of the investigation that the perpetrator did not call 911 when the child was in medical distress.

The case remains open with the Agency as the victim child's sibling is currently in the custody of the Agency.

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

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

- The Team noted that the other foster child's case management team, from NET CUA #7, was doing a solid job.

Deficiencies in compliance with statutes, regulations and services to children and families, according to the county Act 33 report from 5/31/16:

- The Team noted a significant number of concerns related to the case management practice, supervision, and administrative handling of the child's case.

- The Act 33 Team will convene a second meeting related to this case. An addendum to this report will be issued following the meeting.

- The Team had a number of serious concerns related to the actions of the Philadelphia School District staff that had contact with the victim child on the day that he died.
    - The Team felt that [redacted] did not meet her responsibilities as a medical care provider.
    - The Team questioned why no one at the school contacted 911 given that their policy allows anyone to call 911 in the event of an emergency and given that at least two staff members stated that they felt he needed immediate medical attention.
    - The Team agreed that school staff did not fulfill their responsibilities as mandated reporters. The school staff should have made a report to DHS when [redacted] was observed verbally and physically mistreating the child. Although Philadelphia DHS would not have responded as quickly as 911, a two-hour response time could have been assigned to a DHS report if one had been made immediately following the incident.
        - The Deputy Chief of the Office of Student Rights and Responsibilities of the Philadelphia School District noted that most school district staff had the Act 126 mandated reporter

training but that the paraprofessionals needed to be trained as well.

- The Team questioned how the [redacted] behavior would be addressed since she had clearly missed noting how sick the child was. It is not clear if she adequately triaged the child's symptoms as her notes and verbal statements to the PA-DHS Investigator were inconsistent. [redacted] reported that she did not keep a copy of the M-34 form; however, there were copies of previous M-34's in her files. It was also not clear what instructions were given to the teaching assistant.
    - The Deputy Chief of the Office of Student Rights and Responsibilities of the Philadelphia School District stated that District administrative staff would meet with the team and review what happened. The M-34 policy will be made clear and the quality of [redacted] documentation will be addressed. If there is evidence of misconduct, then the District would begin the discipline process. It was not clear if [redacted] would be removed from service during the District's investigation. An official complaint against [redacted] license could be made.

- The Team suggested that all schools acquire temporal thermometers to assist in taking temperatures of children that are unable or unwilling to use oral thermometers.

- The DHS Acting Commissioner acknowledged that there were significant issues with Turning Points for Children's management of the child's case.
    - After the September 2015 medical appointment had been missed, the child's primary care physician had multiple contacts with the case manager and her supervisor. In spite of these outreach efforts, however, the appointment was never rescheduled. [redacted]
    - The DHS Acting Commissioner stated that ensuring that the child made all of his medical appointments is a basic case management responsibility that should not have been neglected regardless of the Court's focus. In addition, the case remained assigned to TURNING POINTS FOR CHILDREN CUA #3 until November 2015. As such, it was not acceptable that the child missed his September medical appointment and that he was not up-to-date on his specialty medical care.
    - The DHS Acting Commissioner reiterated the expectation that, while a case is active with CUA, the case management team is ultimately responsible for ensuring that all of the child's needs are met, even if that child is in foster care.

- The DHS Acting Commissioner also acknowledged the Team's concerns related to the transition from Turning Points for Children CUA to DHS. The communication was not clear and it had a negative impact on the case.

- NET foster care was not clear on when they officially transitioned from a CUA subcontractor to a direct DHS provider. NET's foster care responsibilities differ based upon whether a case is being managed by DHS or a CUA. Under CUA management, the CUA worker assumes case management responsibilities while NET foster care is only responsible for licensing the foster home. Under DHS management, NET foster care assumes both the licensing and case management responsibilities.
- Turning Points for Children CUA #3 reported that they had given the foster parent all of the information regarding the child's medical care when he was placed in her home, however it was not clear if this information was ever conveyed to the NET foster care team.
- The DHS Acting Commissioner stressed that the medical information and other case documentation should have been uploaded into the electronic case management system (ECMS) so that they are easily accessible to all staff.
- Acknowledging the fact that some CUA cases have been court ordered back to DHS, the DHS Acting Commissioner pledged that her leadership staff would examine this transition process. This may include the development of an official transition meeting between all parties.

- NET foster care's administrative oversight of the foster home was severely lacking.
  - Representatives from NET's foster care program reported that the foster mother's training was not up-to-date and, as a result, the certificate licensing her home as a foster home had lapsed. She had only two hours of training and should have been on a provisional license. As a [redacted] foster parent, she was required to have 30 hours of training.
  - The foster parent also had a criminal history from 1979 and 1982 that was not documented in her file. Though the offenses would not have precluded the foster parent from being a foster parent, this information is routinely used during the foster parent certification process to assess the foster parent's suitability as a caregiver.
  - NET foster care had no child abuse or criminal clearances on file for [redacted] Though school records listed [redacted] as an emergency contact for the child, it did not appear that NET was aware that the foster parent was allowing [redacted] to provide care for the children.
  - The NET Vice President agreed that the oversight was very problematic and noted that NET will be taking corrective actions. They have hired an independent consultant who will be reviewing the files on all NET foster parents.

- There were a number of concerns related to the [redacted] ongoing care of the child. Despite being a [redacted] foster care parent, she was not well educated on the child's needs and his routine medical care needs were not

being met. In addition, the NET foster care worker should have ensured that the child had a physical examination within 60 days of NET foster case assuming the case management services.

- NET has initiated the process to have [redacted] decertified as a foster parent and DHS has flagged her home so that no other DHS children will be placed in her care. PA-DHS has notified the National Registry of Investigation so that other foster care agencies are aware of the foster parent's history as a foster parent.

- Allegations were made that NET had falsified some records but a comprehensive investigation was needed to determine the extent. It was clear that some documentation was not entered into the ECMS until after the child's death.
  - Both the DHS Acting Commissioner and the foster care agency Vice President stated that the allegations would be taken very seriously.
  - PA-DHS planned to complete an independent review of the NET foster care case records.

- The Team also noted systemic issues between the Philadelphia Police Department and the District Attorney's Office (DAO). The SVU Detective assigned to the case did not notify the DAO of the investigation and thus the DAO was unable to provide assistance and guidance in the early stages of the investigation. There were several issued noted with the police investigation. At the time of the Act 33 meeting, it was unclear if the SVU Detective had interviewed [redacted]. The Detective also did not attend the other foster child's PCA interview. Additionally, the communication between PA-DHS and SVU was inadequate.

<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>:

- The Team made a recommendation for all schools to acquire temporal thermometers to assist in taking temperatures of children that are unable or unwilling to use oral thermometers

<u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:</u>

- None

<u>Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:</u>

- None

<u>Department Review of County Internal Report:</u>

- The Pennsylvania Department of Human Services concurs with the county's report, with additional recommendations

Department of Human Services Findings:

County Strengths:

- The County Children, Youth and Family Services conducted timely investigations in conjunction with law enforcement officials and the Pennsylvania Department of Human Services.
- The County agency afforded the foster family and biological family an opportunity to grieve the loss appropriately by conducting separate funeral services.
- [redacted] services were provided to the sibling of Ethan.
- The Philadelphia Department of Human Services conducted a timely investigation into the other foster child's allegations [redacted]

County Weaknesses:

- Ineffective communication within the county regarding its practices on moving children from one agency to another and ensuring that all of the child's records are provided to ensure that the child's needs can be met
- The county failed to ensure that Ethan was placed in an appropriate foster home. The Philadelphia Department of Human Services failed to ensure that the foster parent had the extensive 24 hours of training as required for [redacted] Foster Homes in the agency contract with the Philadelphia Department of Human Services and the Community Umbrella Agencies.
- County failed to ensure that the foster parent was aware of and trained to address the victim child's medical needs, [redacted] and need for a follow-up appointment with the pediatrician.
- County failed to ensure that Ethan attended all necessary medical appointments to ensure that his medical needs were being appropriately addressed

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

- 3700.62(c): [redacted] serving in a capacity as substitute caregiver, and listed as an emergency contact on school documents, did not have clearances, evaluation, or training

- 3700.65: The foster parent did not have the 6 hours of training as required by the 3700 regulations; documentation was found for only 2 hours of training.

- 3700.51(d): The county failed to ensure that the private foster care agency brought the child to an initial dental exam within 60 days of admission to the agency.

- 3680.32(10): The county failed to ensure that educational reports were maintained in the foster care agency record.

- 3680.42(a): The county failed to ensure that the child's Individual Service Plan was completed in a timely manner by the foster care agency, as it was not completed in maintained in the foster care record.

- 3680.32(15): The county failed to sign a consent for medical treatment for the new foster care agency to obtain routine and emergency medical, dental, and behavioral health treatment for the child.

- 3130.43(b)(7): The county agency failed to ensure that the child was provided recommended medical treatment, a follow-up appointment with his pediatrician to monitor the child's weight, due in September 2015.

- 3130.61(d): The county agency failed to invite the child advocate attorney to the service planning meeting

- 3490.232(c): The county failed to visit the foster home in the 3-day timeframe designated for 2 different [redacted] reports. The worker first attempted to visit the child 08/03/2015 for the 07/28/2015 General Protective Services Report; the worker's first attempt to visit the children was 11/30/2015 for the 11/06/2015 General Protective Service Report.

Department of Human Services Recommendations:

The Community Umbrella Agency (CUA) staff should be supported and guided in understanding all tasks that need to be completed regularly for children in placement.

County staff should be trained to discuss medical and psychiatric diagnoses, equipment, and treatment with new foster parents and other caregivers immediately upon placing a child in a new foster home.

County staff should be trained to obtain current training records for foster parents caring for children in county custody.

County staff should receive guidance in signing consents for medical treatment in cases where the child's rights have been terminated, to facilitate the timely provision of medical services.

It is recommended that the county streamline communication procedures when children are moved from one agency to another.

County staff should develop a procedure to ensure that child advocate attorneys are invited to service planning meetings in a timely manner, and that invitation should be maintained in the record.

County staff should evaluate the assignment of reports to allow investigation staff adequate time to respond in the timeframes specified in each report.

The School District of Philadelphia should create and implement a procedure for maintaining documentation of any medical guidance given to parents in the event that medical treatment is provided at school.

The School District of Philadelphia should ensure that all staff, including paraprofessionals, nurses, and school police officers, receive training about the new Child Protective Services Law, and guidance regarding the changes to Mandatory Reporting of child abuse allegations.