DEPARTMENT OF HUMAN SERVICES ACT 33 TEAM FATALITY REVIEW REPORT DAVID HESS

Date of review meeting: 11/04/2016

Date of report: 10/14/2016

Child's names: David Hess

Mother's name:
Address:

Father's name:
Address

Siblings:

Alleged perpetrators:

Relationship to child: Wordsworth Residential Treatment Facility Staff

CASE SUMMARY

On October 14, 2016, the Pennsylvania Department of Human Services (PA-DHS) received a Child Protective Services (CPS) report alleging that David, a resident of Wordsworth Academy's residential treatment program, had died the day prior. It was reported that David was restrained by staff after acting aggressively and destroying property. Per the reporter, David hit his head during the restraint. David was a resident of Lebanon County at the time of his death.

A residential treatment facility is defined as a 24-hour living setting in which care is provided for one or more children. Residential facilities in Pennsylvania are licensed and regulated by PA-DHS. The PA-DHS Bureau of Human Services Licensing is responsible for the oversight of regulations related to the facilities and their programs. Wordsworth's license was most recently renewed in August 2016. Following David's death, PA-DHS revoked Wordsworth's license and issued an order for an emergency closure. PA-DHS officials remained on site at Wordsworth until all residents were relocated.

The CPS report was assigned to a PA-DHS program representative for investigation. The assigned PA-DHS investigator, another PA-DHS investigator, and the PA-DHS Office of Children, Youth, and Families-Southeast Regional Office (OCYF-SERO) Director traveled to Wordsworth Academy to begin the investigation. They were provided with a safety plan for the other residents in the program. Three of the alleged perpetrators had been placed on administrative leave pending the outcome of the investigation. The PA-DHS staff observed David's room. The light fixture was broken and there were shards of glass on the floor. David's clothing had been placed in trash

bags. Wordsworth staff reported that police had informed them that the room did not need to be kept secure. PA-DHS staff reviewed video footage of the night David died. The door to David's room was visible in the footage. The PA-DHS staff noted which Wordsworth staff persons and residents went into David's room and when they left.

The PA-DHS staff interviewed nine youths who lived on the same floor as David. The youths provided various accounts of their observations. One youth reported that he heard screaming and talking but that he could not define what he heard. He noted that did not like David and alleged that, during a restraint two weeks prior, took advantage of the situation and punched David in the chest. Another youth reported that had been upset with David since the start of the shift and that Wordsworth staff were beating on David prior to taking David into his room. A third youth reported that David had stolen his iPod and that staff had gone into the room to retrieve the iPod. Two other youths noted that David had been put into restraints on two occasions that evening, the first of which occurred when staff went into David's room to get the iPod. After staff left David's room, there was a bang and the sound of glass breaking. Afterwards David was restrained a second time during which he could be heard taunting staff and then later telling staff to get off of him because he could not breathe. Another youth reported that, one month prior, had hit David in the face during a restraint. The remaining youths reported hearing banging and the sound of glass breaking coming from David's room. They stated that they saw a number of staff entering and exiting David's room during the incident.

The PA-DHS investigators interviewed three Wordsworth staff who had been involved in the incident. the floor supervisor, stated that, sometime before 8:00 PM on the night of the incident, David stole an iPod from another resident. a residential youth counselor, reported that he witnessed the youth enter David's room, and an argument ensued regarding the stolen iPod. reported that he entered David's room with a therapeutic behavioral counselor, and then escorted the other youth back to his own room. then questioned David about the iPod. David denied having the iPod, but stated that they were going to search the room. reported that he found the iPod and it was returned to its owner. stated that he then heard loud noises coming from David's room. entered the room and placed David in a restraint because he was acting aggressively. entered the room shortly thereafter. reported that he tried to speak with David, but David would not listen so staff left him alone in the room.

stated that, a few minutes later; he heard glass breaking and furniture being thrown in David's room. reported that David had barricaded his door with furniture so he forced his way into the room with . David was swinging, kicking, and breaking the ceiling lights. then placed David in a restraint. reported that, during the restraint, punched David in the ribs. reported that put David in a headlock, with his forearm on David's neck. stated that it seemed like David was not breathing so removed his arm. stated that David was gasping for air so he started chest compressions. Both called the staff nurse from their personal cellular telephones. By the time a second call was made to the nurse, approximately two to three minutes after the restraint ended, David reportedly lost consciousness. denied that anyone had called 911 at that time. reported that he was trained in CPR but that he only did chest compressions. He alleged that was also doing chest compressions but that, at one point, grew physically tired so he began doing chest compressions with his foot. reported that, when the nurse entered the room reported that David hit his head. stated that he felt pressured to agree, but that he later told police that David had not hit his head. The nurse checked for David's pulse but could not find it. The nurse called 911 stated that he believed David was dead and reported that first responders did not arrive until 30-40 minutes after the nurse called 911.

The PA-DHS investigators met with the Wordsworth Director of Nursing and several of the nurses. The Director provided the PA-DHS staff with a copy of Wordsworth's Emergency Medical Plan. The plan provided direction for staff, including procedures for contacting onsite nursing staff and notifying the on-call physician if an incident occurs after hours. The Plan also clearly noted that, if there was a medically emergent situation, then 911 should be contacted. During a previous interview, the PA-DHS investigators learned that the first call to the Wordsworth

nursing staff went unanswered. Neither the on-call physician nor the Wordsworth Medical Director was contacted on the night of the incident.

Nurse was present on the night of the incident. She stated that she received the call that David was in an Emergency Safety Intervention. stated that she was administering medications so she told nurse to go to the floor. immediately went to the floor and then, a few minutes later, she contacted for a blood pressure cuff. reported that she ran to the room. When she arrived was performing CPR. then asked someone to get an oxygen tank. and ran to get the tank. When they returned, they put the mask on David and staff continued CPR. stated that she could not remember who was performing CPR or who was in the room at the time. stated that she did not know what time 911 was called but that made the call. She stated that they worked on David for more than an hour, but they could not revive him.

Two additional nurses who were not present on the night of the incident were also interviewed. One of the nurses reported that David had no serious medical issues. She stated that David's behavior had recently improved and she attributed the improvement to a new medication. The other nurse reported that nurses are required to report to the floor when a restraint occurs. She also noted that Wordsworth provides the nurses with cellular telephones.

Several other Wordsworth staff members were interviewed as collateral witnesses. was also re-interviewed a residential counselor, reported that he was not aware of any issues that David had with staff or with other residents. He noted that during a meeting that evening, David left the room without permission and "went off" for several minutes. confirmed statements and added that was upset because he thought it was disrespectful of David to leave the meeting without permission. also stated that, during the conversation between and the resident who owned the iPod, joined the conversation but it was not clear to him why became involved. also stated that he did not know why went into David's room because was not assigned to David's unit that night. stated that he did not see the restraint but reported that he saw staff's hands on David. Neither knew if staff had enough space to do a proper restraint since there were many things on the floor. the team leader, reported that he had worked at Wordsworth for less than one month. He stated that he did not feel as if he had been properly trained on his responsibilities. stated that he gave no instructions that evening because he did not know what to do. He stated, however, that staff should have notified him when they needed to force their way into David's room.

The PA-DHS investigators contacted the Director of Nursing to obtain information regarding activities in the nursing department, such as shift logs. It was reported that the nursing department does not keep record of activity that occurs on a shift. A review of telephone records would be the only way to determine when the nurses received calls.

The PA-DHS investigators received a report from the Philadelphia Fire Department. When in route to Wordsworth, the dispatcher informed emergency medical services that it was a "code blue" call. After they arrived at Wordsworth, the responders were delayed in getting to David because Wordsworth security did not know the floor where the emergency was occurring. David's room was disheveled. Someone reported that David had destroyed his room after being confronted about the stolen iPod. Staff stated that they tried to restrain David but that he hit his head on the floor, took a deep breath, and then coded. Police were then dispatched to the scene.

The PA-DHS investigators interviewed several other Wordsworth staff members but they did not have first-hand knowledge of the incident. They could only provide information that they had been given by other staff and residents. The PA-DHS investigators attempted to interview a residential counselor, but he retained an attorney and refused to be interviewed. were not interviewed prior to the Act 33 meeting. resigned from Wordsworth on October 20, 2016; resigned on October 21, 2016. Both were employed as residential counselors at the time of the incident.

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The CPS report determination is pending the conclusion of the criminal investigation. The police investigation is ongoing.

HISTORY OF FAMILY'S INVOLVEMENT WITH DHS

had no prior history with Philadelphia DHS. family

David's family was known to Lebanon County Children and Youth Services.

AREAS ADDRESSED BY THE ACT 33 REVIEW TEAM:

STRENGTHS and DEFICIENCIES:

1. Compliance with statutes and regulations.

- The Act 33 Team discussed training regulations for residential staff. The Team noted that Wordsworth needed to better develop its staff through coaching and a comprehensive staff development program. The Team questioned if training that staff received, such as crisis intervention and the use of physical restraints, was sufficient.
  - Wordsworth leadership noted that refresher trainings, such as how to deescalate situations and how to do physical restraints, are provided annually. There is no regular practice, however, in non-emergent situations nor do the residential teams always practice together.
    - The Act 33 Team felt that trainings needed to occur more regularly and include sessions where staff could practice responding to situations. During emergency situations, staff must respond quickly and appropriately. They need to automatically know what to do in a situation.
  - The Act 33 Team questioned if the alleged use of a headlock during David's restraint was an anomaly or if the practice was a common occurrence during other restraints. The Team asked what policies and procedures could be put into place to ensure that no other staff members would engage in improper restraint practices.
    - It was reported that the restraint training includes the directive that nothing should be put on a youth's neck during a restraint. The Act 33 Team stressed that training should also clearly prohibit punching a resident while employing a restraint.
    - The Act 33 Team stressed that the use of restraints needs to be practiced regularly and must be supervised by high level staff who can provide redirection as necessary.
    - The Act 33 Team also noted that, when an employee is disciplined for violating a procedure or protocol, they must receive further training in that area before they are returned to their position. For instance, an employee suspended for improper use of restraint should receive remedial training in restraint use before returning to employment.
  - The Act 33 Team noted that, while staff was attempting to deescalate the situation, someone should have concurrently called the nurse.

- The Act 33 Team recognized that CPR was not done correctly by any of the Wordsworth staff. Although several staff members reported giving CPR, through interviews, it was learned

that staff had performed only chest compressions and that no one gave David rescue breaths.

- Wordsworth leadership reported that that American Red Cross provides CPR training to its staff.
- The Act 33 Team noted that there is a "mental barrier" that needs to be overcome in order to provide mouth-to-mouth rescue breaths. Though Wordsworth was not required to have breathing masks, the team noted that this relatively inexpensive piece of equipment may have helped to overcome compunctions that the staff may have had.

- The Act 33 Team did not understand why Wordsworth does not require that nurses keep shift logs to document their activities. This information could have been important in understanding why staff had difficulty contacting the nurses when David became unresponsive.
  - Wordsworth leadership reported that notations are put into individual files and that the document is provided at the end of the shift. There is not a summary document with the notations for all of the residents, however.

- The Act 33 Team felt it was unacceptable that emergency medical responders were delayed in getting to David. In addition to Wordsworth staff's failure to call 911 in a timely manner, when the first responders arrived at Wordsworth, security personnel did not know on which floor the emergency was occurring. This further delayed emergency medical care for David.
  - Wordsworth leadership noted that, when 911 is called, policy dictates that the supervisor notifies security of the emergency.

- The Act 33 Team felt that it was not clear if Wordsworth was able to meet David's behavioral health needs. Wordsworth leadership noted that they had agreed to accept David into their program in spite of the fact that he had been denied by numerous other programs. They also reported that Wordsworth often accepts such clients into their facility.
  - Wordsworth leadership noted that, in the past, youths with a need for such a high level of care were often sent to facilities in other states. Other states are permitted to use different types of treatment and different restraint methods. When this practice stopped, many of these children ended up being placed at Wordsworth.
    - The Act 33 Team noted that, if Wordsworth could not meet David's needs, he should not have been admitted into the program. Children must be admitted to the therapeutic environment that will best meet their individual needs. The Act 33 Team stressed that keeping children closer to their homes can be counterproductive and should not outweigh the need for appropriate behavioral health treatment.
  - Wordsworth leadership noted that their current Residential Treatment Program accepts youths with mental health issues some of whom also have delinquent issues. Since youths in these two very different groups often need different types of treatments, additional services are necessary. Wordsworth leadership reported that they had preliminary conversations with PA-DHS to discuss creating two programs to separate the populations.

- The Act 33 Team felt it was inappropriate that the decisions to confront and then restrain David were made by an employee who had little training and experience. Proper protocols were clearly not followed. The decisions should have been made by supervisory staff that had additional experience and training.

  - Wordsworth CEO Debra Lacks reported that the funding for the youths that they service needs to be increased in order to attract more experienced applicants who are better able to meet the needs of the youths. Wordsworth line staff earns approximately $13.00 per hour. She also stated that the prospective staff is often young and comes from the same troubled neighborhoods as the youths Wordsworth serves.
  - DHS Commissioner Cynthia Figueroa noted that line staff spend the most time with the youths and they often have the highest turnover rates in Residential Treatment Facilities. In these types of situations, supervision and support are critical.

- The Act 33 Team questioned if there was a cultural norm at Wordsworth which discouraged the reporting of incidents. The Team was worried that an institutional culture such as this could prevent staff and youths from providing information that impacts the well-being and safety of Wordsworth residents. The Team also questioned if residents felt safe reporting their issues with staff.
  - The Team discussed the alleged prior incidents of staff hitting David. There appeared to be an antagonistic relationship between David and
    - Wordsworth leadership denied that any of these incidents had been previously reported to them.
    - One of the alleged incidents reportedly occurred in the cafeteria. There are no cameras in the cafeteria or in the residents' rooms. There are video cameras in the common areas and in the school.
  - Wordsworth leadership noted that there are ongoing conversations with staff regarding accountability. Staff is encouraged to report incidents and is permitted to submit concerns anonymously.
    - Wordsworth leadership stated that, if the prior incidents had been reported, their protocol dictated a review of any available video footage, a review of David's clinical history and any factors which may have contributed to the situation, removing staff from David's unit, and retraining the staff in proper procedures.
  - Wordsworth leadership stated that there is a Child Advocacy Group at the facility and also a grievance policy. They noted that residents often confide in their therapists who are then mandated to report the incidents.

2. Services to David and the extended family:

- At the time of the report, David was placed at Wordsworth via Lebanon County. There are no other minor children in his family.

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RECOMMENDATIONS FOR CHANGES AT THE STATE AND LOCAL LEVELS:

1. **Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.**

   - The Pennsylvania Department of Human Services should consider amending its regulations regarding first aid supplies for residential treatment programs and other congregate care facilities. Current regulations do not require facilities to have access to life-saving equipment such as CPR barrier masks and automated external defibrillators (AEDs). Staff should also receive regular training on how to properly use the equipment.
   - The Philadelphia Department of Human Services should consider amending its contractual requirements for congregate care providers to mandate that facilities have access to life-saving equipment such as CPR barrier masks and automated external defibrillators (AEDs). Staff should also receive regular training on how to properly use the equipment.

2. **Monitoring and Inspection of county agencies.**

   - There were no recommendations.

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ACT 33 REVIEW TEAM:	Dr. Sam Gulino, Chief Medical Examiner, City of Philadelphia Cynthia Figueroa, Commissioner, DHS Jessica Shapiro, First Deputy Commissioner, DHS Kimberly Ali, Deputy Commissioner of Child Welfare, DHS Gary Williams, Chief Learning Officer, DHS Laurie Dow, Divisional Deputy City Solicitor, City of Philadelphia Law Department Jennifer Good, Act 33 Program Manager, DHS James Carpenter, District Attorney's Office, City of Philadelphia Dr. Joanne Wood, Physician, CHOP Dr. Maria McColgan, Director, St. Christopher's Hospital Child Protection Program Cpl. Shirley Murray, Philadelphia Police Department, Special Victims Unit Jeannine Lisitski, Executive Director, Women Against Abuse Rachel Holzman, Deputy Chief, Office of Student Rights and Responsibilities, Philadelphia School District Dr. Sara Kinsman Director, Maternal, Child and Family Health, Department of Public Health Gina Weal, DHS Nurse Bert Harris, DHS Psychologist
PA-DHS Office of Children, Youth and Families – Southeast Regional Office:	Raheemah Shamsid-Deen Hampton, Director Mark Davis, Program Representative Sherri Irvis-Hill, Program Representative Pat Wolff, Program Representative Shelly Neptune, Program Representative Karen Knellinger, Program Representative Lynda Moore, Program Representative Emilio Pacheco, Program Representative
PA-DHS Office of Mental Health And Substance Abuse Services:	W. Jerome Burton, Program Representative
Wordsworth Staff:	Debra Lacks, President and Chief Executive Officer Jennifer Herrmann, Deputy Executive Director Samara Speakes, Program Director Alyssa Tosi, Compliance Officer Dr. Mark Novitsky, Psychiatrist William L. Banton, Attorney Adam Yanoff, General Counsel
Lebanon County Probation:	Sally Barry, Director Susan Christner, Deputy Director

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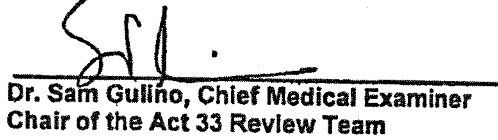
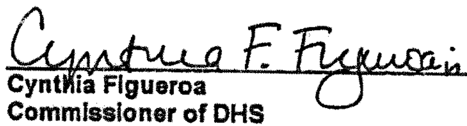
Approved by the Act 33 Team:



Dr. Sam Gulino, Chief Medical Examiner
Chair of the Act 33 Review Team

DATE: 1/31/2017

Reviewed and Approved:



Cynthia Figueroa
Commissioner of DHS

DATE: 2/1/17

Forwarded to The Honorable James F. Kenney
Mayor of the City of Philadelphia

DATE: 2/1/17

Forwarded to Raheemah Shamsid-Deen Hampton
Pennsylvania Department of Human Services

DATE: 2/1/17