



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823
Fax: (215) 560- 6893

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 1/25/2003
Date of Near Fatality Incident: 11/08/2010

FAMILY NOT KNOWN TO:
Any Public or Private Child Welfare Agency

REPORT FINALIZED ON: 06/15/2012

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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, 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 [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia Department of Human Services (DHS) 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	1/25/2003
[REDACTED]	sister	[REDACTED] 2006
[REDACTED]	mother	[REDACTED] 1986

Other family members

[REDACTED]	maternal grandmother	Adult
[REDACTED]	father	Adult

Notification of Child (Near) Fatality:

On 11/10/2010, Philadelphia DHS received a call from [REDACTED] concerning seven year old [REDACTED] was brought to St. Christopher's Hospital after [REDACTED] an overdose of [REDACTED]. The mother had sent [REDACTED] to bed, but [REDACTED] had gotten up during the night to get a glass of milk. The mother realized that the child was taking too long, and went to check on her. The mother found [REDACTED] with pills in her hand and in her mouth. She thought she had removed the medication from her mouth, and sent the child back to bed. Shortly after this, she heard a thump. [REDACTED] had fallen out of bed and was unconscious on the floor. The mother brought [REDACTED] to St. Christopher's Hospital. The child was certified in critical condition when brought to the hospital, and [REDACTED] but was expected to survive.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the family. An interview was conducted with the [REDACTED] from DHS. The SERO also participated in the Act 33 Review Team on 12/3/2010.

Summary of Services to Family:**Children and Youth Involvement prior to Incident:**

No previous involvement with any child welfare agency.

Circumstances of Child Near Fatality and Related Case Activity:

[REDACTED] and her sister were diagnosed as [REDACTED] (having an unusually small head) and [REDACTED] when they were very young. The mother secured services for both girls without the assistance of other agencies and in a timely manner. Prior to DHS involvement, the mother had services in place for the girls through the [REDACTED] [REDACTED] Elwyn, Childlink, and Kencrest.

On 11/08/2010, the mother had put her daughters to bed, and also went upstairs for the night with them. During the course of the [REDACTED], the mother reported that she had left [REDACTED] out on a table downstairs. The bottle did not have a childproof cap. On previous occasions, the daughter was able to open this type of bottle. The mother heard the victim child get out of bed and go downstairs to get a glass of milk. When it seemed that the victim child was taking too long, the mother went downstairs to check on her. Upon going downstairs, the mother found the victim child holding the open bottle and had pills in her mouth. The mother took the pill bottle from the victim child and cleaned her mouth of pills. The victim child was sent back to bed. Shortly afterward, the mother heard a thump (which was later determined to be the victim child falling out of bed). The mother found the victim child unconscious on the floor. The mother took the victim child to St. Christopher's Hospital.

On 11/10/2010, the [REDACTED] called the [REDACTED] [REDACTED] report in to [REDACTED]. The [REDACTED] was concerned because the mother did not seem overly distressed by the incident, and did not seem to be taking responsibility for leaving the bottle of pills where the child could find them knowing that in the past the victim child had opened the bottle and taken pills out. The mother did not attempt to determine how many pills the victim child had taken before putting her back to bed. This was the victim child's second overdose since May 2010. The May 2010 overdose was of [REDACTED] when the mother had measured the wrong amount of medication the victim child was to

take. The physician had changed the medication from liquid to pills at that time to prevent a repeat of inaccurate dosage.

The DHS worker interviewed family members, and found this mother to have a large supportive extended family. The maternal grandmother was included in the Safety Plan, as she agreed to assist the mother in the administration and storage of medication. All family members appeared well-bonded to the children.

During the [REDACTED], the DHS [REDACTED] contacted the father [REDACTED], who was aware of the child's [REDACTED], but acknowledged that he was not very involved in his daughter's lives.

On 11/18/2010, DHS [REDACTED]. The mother has entered an [REDACTED].

Current Case Status:

As a result of this [REDACTED] the DHS worker will focus on developing interagency collaboration with current agencies (Elwyn, Childlink, and Kencrest) and other community agencies such as [REDACTED] and Department of [REDACTED] services.

The children remain in the home. The mother is in school full time to become a medical assistant.

A [REDACTED] evaluated the victim child and identified community resources to assist the family. [REDACTED] was seen at the [REDACTED] for routine medical follow up on 11/5/2010. DHS is [REDACTED] to monitor the mother's medication administration and to assist in identification of methods to safely store medication.

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

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 [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia DHS convened a review team in accordance with Act 33 of 2008 on 12/03/2010.

Compliance with statutes and regulations

- Thorough [REDACTED] which included consultation with [REDACTED] and legal departments, as outlined in DHS protocol.
- Safety Plans completed in timely, thorough manner
- Implementing [REDACTED] for family

- Suggestion that DHS should review how Hotline reviews the handling of ingestion cases to determine if consistent practice is occurring
- Review team engaged in a great deal of conversation about this report being upgraded from [REDACTED] based on [REDACTED] determining this case to be a near fatality. Concern was that while the child's condition was near fatal, perhaps it did not meet the criteria of [REDACTED].

Recommendations for Change at the Local Level:

None identified.

Recommendations for Change at the State Level:

None identified

Department Review of County Internal Report:

During the Act 33 Review, the medical professionals reported that they saw frequent ingestions of medications and toxic substances, but only a very small percentage was ever reported to [REDACTED]. Some determinants of which cases would be reported included: the very young age of the child, the severity of the impact of the overdose on the child, and if narcotics were involved.

Team members focused on the [REDACTED] report of Near Fatality perhaps being [REDACTED] since the overdose was accidental. However, Dr. [REDACTED] clearly identified the reasons why she believed that the mother was negligent, which would warrant [REDACTED] call. [REDACTED] made the determination of Near Fatality based on the information provided to them by Dr. [REDACTED]. The underlying theme of this discussion was that this incident was believed to have been an accident, and should not have been [REDACTED]. However, the [REDACTED], meaning that it was determined to be [REDACTED].

Department of Public Welfare Findings:

County Strengths:

- [REDACTED] Timely and thorough [REDACTED]
- Consultation with medical professionals, including [REDACTED]
- Need for cross system collaboration was identified during Act 33 Review

County Weaknesses:

- None identified

Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendations:

None identified