



## **REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: 02/08/2011**  
**Date of Incident: 06/03/2014**  
**Date of Oral Report: 06/03/2014**

**FAMILY KNOWN TO:**  
**Philadelphia County Department of Human Services (DHS)**

**REPORT FINALIZED ON: 02/27/2015**  
**August 25, 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, 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 County has convened a review team in accordance with Act 33 of 2008 on June 20, 2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Child	02/08/11
[REDACTED]	Sibling	[REDACTED]/09
[REDACTED]	Biological Mother	[REDACTED]/92
[REDACTED]	Biological Father	[REDACTED]/87
[REDACTED]	Maternal Grand Mother (AP)	[REDACTED]/67

**Notification of Child Near Fatality:**

[REDACTED] was transported by the paramedics to Einstein Hospital on 06/03/14. He was taken to the hospital due to ingesting [REDACTED] that belonged to his maternal grandmother. The victim child was [REDACTED]. He was then transferred to St. Christopher's Hospital for Children for further observation. [REDACTED] was awake and alert before leaving Einstein Hospital. The victim child was certified to be in serious condition as a result of neglect [REDACTED].

**Summary of PA DHS Child Near Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SEROCYF) obtained and reviewed all case documentation, and documents pertaining to the victim child. Contact was made with the Philadelphia Department of Human Services (DHS) case worker to obtain the documents listed below. The SEROCYF participated in the Act 33 meeting on June 20, 2014. On June 7, 2014 the victim child was [REDACTED] and he was placed in foster care.

**Records and Documents Reviewed:**

- Court Documents
- Safety Assessment

Medical Records  
Structured Case notes  
CY48

**Children and Youth Involvement prior to Incident:**

DHS did have prior involvement with the family as a result of several General Protective Services, (GPS) reports on the family as noted below:

February 9, 2011, the report was classified as a [REDACTED] when [REDACTED] and his mother both tested positive for marijuana at his birth. The report was assessed and the family agreed to receive services. Services were provided by [REDACTED]. Service goals were not met. The case was closed at that time.

January 14, 2013, DHS received a GPS report alleging that the biological mother was not supervising the victim child's older sibling, and that the mother used drugs and alcohol on a daily basis. The report was assessed and findings were present. The mother and family were referred for preventive services. Services were provided by [REDACTED]. Service goals were not met. The case was closed as this was a voluntary service.

July 10, 2013, DHS received a GPS report alleging that the biological mother was not supervising her children. The report was assessed and findings were present. Prevention Services were already in place based on the referral received in January.

March 2, 2014, DHS received a GPS report that the children were found outside unsupervised, and the whereabouts of the mother was unknown. Contact was made with the mother; she reported that she was with the children at home. The report was rejected by DHS hotline.

**Circumstances of Child Near Fatality and Related Case Activity:**

On June 3, 2014 DHS received a Child Protective Services report that the victim child was transported to the emergency room by the paramedics; and that he had ingested [REDACTED] that belonged to his maternal grandmother. The victim child was [REDACTED]. The victim child was certified as being in serious condition as a result of neglect, but was expected to survive.

The biological mother was not at home at the time of the incident. The victim child was in the primary care of the MGM.

The MGM stated that she was babysitting the victim child, his older sibling and a three year old grandchild, when the incident occurred. The MGM stated that she laid her [REDACTED] on the television stand, and then took the children outside to sit on the front steps. When the MGM went back into the house and into the bathroom, her [REDACTED] bottle was missing and the victim child was acting strange. She reported that the victim child could not stand up and

kept falling. The victim child's sibling told the MGM that she found the [REDACTED] bottle outside.

The MGM did not know how many pills were in the bottle and could not explain how the victim child could have gotten the top off of the bottle. The MGM stated that at 4:00pm she called 911 and later called the biological mother and informed her about the incident.

After learning there was a sibling at the home with the father and maternal grandmother, the DHS social worker attempted to visit the home, but was not able to get inside. As such, notification letters were left at the home at both apartments. The biological mother and maternal grandmother live in the same apartment building but in separate apartments.

The investigating DHS social worker conferenced with her supervisor and put together a list of immediate actions that were required to take place. The initial steps were to continue to gather information on regarding the incident, visits were made to the hospital to see the victim child; obtain further information on medical treatment; assess the safety of the sibling in the home; and to interview the biological mother, assessing for protective capacities and assess the safety of the family home.

A Safety Plan was put into place on June 4, 2014 by the DHS social worker and signed by the biological mother. The plan stated specific directions for the biological mother to follow related to the victim child and his sibling. The biological mother was to remain [REDACTED]; she would need to notify DHS if she left [REDACTED]; and complete appropriate paper work [REDACTED]. The biological mother would have to ensure that her older child receives a medical evaluation and that the victim child would remain in the hospital until he was [REDACTED].

The biological mother and her older child reported to the DHS office to meet with the SW. The SW made contact with the older child's father, but he was unable to provide care for him, because he did not have his own housing. The father refused to give his address. The biological mother identified other housing resources but they were not appropriate.

The older child was interviewed by the DHS SW, he reported that on the day of the incident, the MGM took two pills and then fell asleep. He also stated that he saw the victim child chopping up the MGM's medication with a fork and then took the pills. He could not say how the victim child got the top off the medication bottle, but he did say that the victim child kept falling after he took the pills. He woke up the MGM and told her that the victim child had taken the pills at which time the MGM beat the victim child and then said he was going to see the doctor.

[REDACTED]

[REDACTED]

The victim child [REDACTED] St. Christopher's Hospital for Children on 6/7/14, and placed through [REDACTED].

The older sibling was placed in a [REDACTED] Foster Care home. The two siblings were not placed together because the foster home placement did not have the capacity to accept the two siblings.

CY48 completed on 6/21/14 with the determination as indicated due to neglect.

**Current Case Status:**

The victim child and his sibling are placed together in the same foster home through [REDACTED] Foster Care. After the victim child's [REDACTED], there were no other medical concerns or appointments regarding the incident. The victim child had a forensic interview in June regarding this incident that took place [REDACTED].

The cousin of the victim child, who also lived in the home, was placed in foster care on 06/05/2014.

[REDACTED] will assume case management services for the family.

The biological mother was referred by [REDACTED].

The victim child's biological father will be referred for [REDACTED].

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

- **Strengths:** The team felt that the MDT worker at Philadelphia DHS did an excellent job investigating the case and conferencing with the chain of command.
- **Deficiencies:** The team has a number of concerns regarding the family's history with DHS. There were repeated referrals for voluntary prevention services, and the rejected report on March 2, 2014. The team felt that the report should not have been rejected, but that an investigation should have occurred.

- **Recommendations for Change at the Local Level:** The team recommended that DHS should review its policy regarding the DHS hotline's handling of reports, including a review of DHS standards for accepting or rejecting reports.
- **Recommendations for Change at the State Level:** In agreement with local level recommendation.

**Department Review of County Internal Report:**

County reports were received June 25, 2014; documents were requested at the Act 33 meeting held on June 20, 2014.

**Department of Human Services Findings:**

- **County Strengths:** The county continues to do an excellent job with investigations and providing required materials to the PA DHS in a timely manner.
- The county proceeded with this near fatality timely; appropriate services were provided to children and other family members.
- **County Weaknesses:** DHS should evaluate its current process of reviewing rejected reports for appropriateness and revise as needed to increase the number of reports that are reviewed by the hotline administrator.
- **Statutory and Regulatory Areas of Non-Compliance:**  
None identified

**Department of Human Services Recommendations:**

None identified