



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**DATE OF BIRTH: 08/06/2010**  
**DATE OF NEAR FATALITY INCIDENT: 06/02/2011**

**FAMILY KNOWN TO:**  
**Philadelphia Department of Human Services**

**REPORT FINALIZED ON: January 17, 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 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 related to this report on June 17, 2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	victim child	8/6/10
[REDACTED]	mother	[REDACTED] 1985
[REDACTED]	brother	[REDACTED] 2008
[REDACTED]	father (resides elsewhere)	[REDACTED] 1983

**Notification of Child Near Fatality:**

On 6/2/11 at 1:37 pm, the Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging that 10 month old [REDACTED] ingested a potentially lethal dose of [REDACTED] and was [REDACTED] St. Christopher Hospital in critical condition. The child was in the care of her mother's friend, who was residing in the home at the time of the incident.

**Summary of DPW Child Near Fatality Review Activities:**

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child during the [REDACTED]. SERO reviewed DHS's [REDACTED]/assessment, structured case notes, safety assessments and management In Home worksheet and risk assessment. SERO spoke with the DHS social worker, social work supervisor and administrator in the Intake unit. SERO attended the DHS Act 33 Review Team meeting on June 17, 2011.

### Summary of Services to Family:

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

8/26/08 [REDACTED]

DHS received report that mother left [REDACTED] in the care of her mother in NJ while she went to work. Police were called to the home because someone overdosed in the home. The mother returned and took [REDACTED] back home with her in Philadelphia. A courtesy visit was requested to assess his safety. The report was [REDACTED] and no services were provided.

10/11/10 [REDACTED]

DHS received report that mother abandoned [REDACTED] out in the street in her stroller. She returned to the shelter without the child. The child was found outside at the gate in her stroller. The report was [REDACTED] and no services were provided.

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

On 6/2/2011 DHS received a [REDACTED] report alleging 10-month-old [REDACTED] ingested a half tablet of [REDACTED] and was in critical condition at St. Christopher Hospital [REDACTED]. [REDACTED] was in the care of her mother's friend, [REDACTED] who was residing in the home at the time of the incident. When the mother returned home, she noticed the child was groggy. She called poison control, then 911, after learning that [REDACTED] dropped a half [REDACTED] used to treat her [REDACTED], on the floor. She feared [REDACTED] may have swallowed it. The child was transported to St. Christopher Hospital. The [REDACTED] contacted the reporting source who confirmed the allegations.

On 6/2/2011, social worker went to the hospital to interview the mother and see the child. [REDACTED] reported that the child was doing well and had been [REDACTED] for observation. Mother reports that when she left the home, her sister, [REDACTED] who was visiting, and [REDACTED] were in the home. She asked them to keep an eye on both her children while she went to the store. When she returned she found a half wet pill on the floor. She checked the child's mouth but could not determine if she swallowed it. She called poison control who told her to call 911. Mother reported that [REDACTED] claims she and her sister tried to find the pill after she dropped it but were unsuccessful. Mother states she is also currently [REDACTED] and has been [REDACTED]. She reported prior domestic violence with the child's father, [REDACTED] due to her [REDACTED], but states he is great support now. Since mother appeared appropriate with the children in the hospital and reacted appropriately to the incident, a safety plan was not needed at the time.

On 6/2/2011 [REDACTED] conducted a home visit to the home at [REDACTED]. Social worker met with mother, [REDACTED]. The safety assessment deemed the child safe. [REDACTED] was interviewed regarding the incident and supported the mother's statements. An assessment of the home noted the home did not have a fire extinguisher or working smoke detectors. The agency supplied the family with these. The mother returned to the hospital to be with [REDACTED] would temporarily stay in the home with [REDACTED] had since left the home and her whereabouts were unknown. Mother reported that she would try to get that information for social worker.

On 6/8/2011 [REDACTED] worker received a call from [REDACTED]. She acknowledged that it was her pill and that she takes half an 8mg tablet of [REDACTED]. She dropped it on the floor, searched for it, and could not find it. [REDACTED] must have found it. She feels bad and has moved out of the home. She is currently homeless.

On 6/8/2011 social worker contacted mother's [REDACTED] to verify her [REDACTED]. She attended [REDACTED] since January 2011. She has had trouble obtaining childcare however. Intake social worker informed the [REDACTED] program call [REDACTED] for assistance.

On 6/8/2011 social worker contacted the children's PCP, [REDACTED], who stated the children had a prior appointment scheduled for 7/13/2011, however, a follow up appointment for [REDACTED] had been made for 6/27/2011 (sooner).

Attempts to contact the father [REDACTED], had been unsuccessful. The phone is disconnected.

On 6/9/2011 [REDACTED] conducted an unannounced home visit. The children were seen and deemed safe. Mother reported she had an appointment with [REDACTED] and that they have on site childcare which would allow her to attend [REDACTED] while the children are receiving child care.

Based on findings obtained during the [REDACTED] DHS [REDACTED] related to the near fatality to [REDACTED]. The case was then referred to Community Based Prevention Services.

**Current Case Status:**

There were no dependency issues noted during the [REDACTED]. However, the family was referred for Community Based Prevention Services for monitoring and help in obtaining appropriate childcare.

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

- Strengths:
  - The Act 33 team felt that the DHS worker did a thorough job [REDACTED] the case and that all relevant parties were interviewed. Children were seen in a timely manner. The worker referred the mother to appropriate services.
- Deficiencies:
  - The Act 33 team felt that the Department of Public Welfare was not notified timely when the case was upgraded to a near fatality after it left the Hotline
- Recommendations for Change at the Local Level:
  - None identified
- Recommendations for Change at the State Level:
  - None identified

**Department Review of County Internal Report:**

The Department has received and reviewed the report provided by the county. Recommendations include the need for clear guidance for mandated physician reporters regarding near fatalities. DHS has been engaging the hospitals and is having ongoing dialogue in order to clarify the definition of near fatality as per the Bulletin.

**Department of Public Welfare Findings:**

- County Strengths:
  - Although the family was not receiving services at the time of the report, and the report [REDACTED], the county referred the family for Community Based Prevention Services for monitoring and childcare assistance.
  - The county provided clear documentation in the case notes and [REDACTED] report.
- County Weaknesses:
  - The Department of Public Welfare was not notified that the case was upgraded to a near fatality after it left the hotline.

- **Statutory and Regulatory Areas of Non-Compliance:**
  - Upon review of the county file it was noted that the Safety Assessment was not signed by the Supervisor. However, the structured case notes reflect that case conferencing was conducted and that the team was in agreement that no safety plan was needed.

**Department of Public Welfare Recommendations:**

With regards to the need for clear guidance for mandated physician reporters, DHS and DPW are available for assistance to the medical community in understanding the Bulletin and the definition of near fatality.