



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF:



BORN: JANUARY 8, 1994
DATE OF NEAR FATALITY INCIDENT: July 27, 2010

FAMILY NOT KNOWN TO COUNTY AGENCY

REPORT FINALIZED ON:
January 28, 2011

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 by Governor Edward G. Rendell. 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 not convened a review team in accordance with Act 33 of 2008 related to this report due to the case being unfounded within 30 days.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	01/08/1994
[REDACTED]	Mother	1962
[REDACTED]	Father	1959
[REDACTED]	Sibling	1993
[REDACTED]		1994

Notification of Child Near Fatality:

On July 27, 2010, a referral was received by DHS stating that [REDACTED] who is [REDACTED] and [REDACTED], suffered a [REDACTED] while he was a patient at Children's Hospital of Philadelphia (CHOP). [REDACTED] was admitted to CHOP on 07/21/2010 with "back pain." On 07/23/2010, [REDACTED] stopped breathing was resuscitated and was taken to [REDACTED]. Bottles of Medicine prescribed to [REDACTED] mother were found in his room. [REDACTED] tested positive for [REDACTED] which is the same type of medicine that was found in his room. [REDACTED] was taking [REDACTED]. The [REDACTED], in [REDACTED] with the [REDACTED], caused [REDACTED] to stop breathing. The mother admitted that she had given it to him; however, after further investigation, this statement proved to be misinterpreted. The mother also admitted that she did it at home as well because [REDACTED] was in pain. [REDACTED] was certified to be in critical condition by Dr. [REDACTED] but was expected to survive.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the current case record pertaining to the [REDACTED] family. A follow up interview was conducted with the Caseworker, [REDACTED] Philadelphia Department of Human Services (DHS).

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

There was no prior Children and Youth involvement with the [REDACTED] family prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 07/23/2010, [REDACTED] overdosed, stopped breathing and was [REDACTED] while he was a patient at Children's Hospital of Philadelphia (CHOP). [REDACTED] who is [REDACTED] had been admitted to CHOP on 07/21/2010 due to back pain. [REDACTED] mother, [REDACTED] said that [REDACTED] was in an automobile accident about 3 months ago and he also fell about a week after the accident. Since then, [REDACTED] has been experiencing back pain.

On 07/28/2010, [REDACTED] DHS Social Worker, interviewed [REDACTED] Nurse [REDACTED] Doctor [REDACTED] and observed [REDACTED] at CHOP. [REDACTED] asked [REDACTED] how she could tell [REDACTED] was in pain. She replied that he makes certain noises, puts his hands on his back and paces. Earlier in the month, under the direction of [REDACTED] PCP, Dr. [REDACTED] was taken to Doylestown Hospital [REDACTED] seeking relief for his pain. [REDACTED] was sent home with [REDACTED]. [REDACTED] later brought [REDACTED] to CHOP [REDACTED] on 07/21/2010 because his pain continued. She had [REDACTED] medication and her medication in her purse. [REDACTED] is a [REDACTED] who is prescribed [REDACTED] for pain. [REDACTED] asked [REDACTED] about the allegation that she gave [REDACTED] while he was in the hospital. [REDACTED] clarified that she told hospital [REDACTED] staff that she gave [REDACTED] of a 15mg of [REDACTED] about 3-5 weeks ago. She denied that she gave him any medications while he was in the hospital. [REDACTED] also denied any other incidents of giving [REDACTED] non-prescribed medications. [REDACTED] said that they (she and [REDACTED] have been under constant supervision by hospital staff since they've been at the hospital and that she thinks [REDACTED] may have gone into her purse on 07/23/2010 when she left his room to use the bathroom. [REDACTED] went on to say that she is not sure if [REDACTED] is even capable of opening the pill bottle and taking the pills himself. She added that she has never seen him open a pill bottle before. [REDACTED] said that she first questioned whether hospital staff had given it to him. She said that a hospital staff named [REDACTED] was in charge of the one-on-one supervision that day; she denies that she had been left alone with [REDACTED] in his room since they've been there.

[REDACTED] spoke with Nurse [REDACTED] the nurse in charge, who told [REDACTED] that the hospital now has [REDACTED] medications locked away. [REDACTED] asked the nurse about [REDACTED] reaction to the incident. The nurse said that [REDACTED] first blamed the hospital staff and then said that [REDACTED] must have gone in her purse when

she left the room. The nurse went on to say that she is not sure if ~~F~~ is capable of opening the bottle himself.

spoke with Dr. the doctor in charge, who said that the pill bottle was found open on the window sill in room and that first blamed hospital staff. After ~~ter~~ tested positive, then said that he must have gone into her purse when she left the room. Dr. said that he is not sure if is capable of opening a pill bottle, but that he has seen operate a remote control and a CD player. Dr. also clarified that the one-on-one supervision is due to behavior, and not due to anything concerning ; is active and requires staff supervision. verified that no hospital staff saw . give medication.

On 08/02/2010, spoke with Philadelphia Special Victims Unit (SVU), Detective who informed her that he had determined that is capable of going into his mother's purse, taking out the pill bottle, and opening it to take pills. The detective said that they directed to do this in his hospital room and that did as directed. gave the same account (to Detective of the events of that day as she had given to . Detective also said that the staff member assigned to room the day of the incident was currently on vacation; however, he was able to interview hospital staff, via telephone. denied seeing take pills out of purse or seeing give him pills. He also said that he did not remember if left the room at all. did say that does get up and walk around the hospital room.

contacted the District Attorney's (DA) office and was told that no one will be pursuing prosecution; SVU would be closing the case.

Current Case Status:

A Safety Assessment was completed by SW DHS on 08/03/2010 with a Safety Decision of "Safe" for .

A Safety Assessment was completed by SW Bucks County C&Y on 08/03/2010 with a Safety Decision of "Safe" for siblings .

returned to his family's home on 8/03/2010. There were safety measures put into place within the home including keeping medicine in locked cabinets so that the children can not have access to the medications and poisons. New locks were placed on the cabinet doors to assure safety when he is in the home.

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

There was no Act 33 Review Team convened due to the case being completed within 30 days and [REDACTED]. The county agency completed their investigation on 08/24/2010 concluding that there was no evidence that a caregiver gave the child [REDACTED]. The case was [REDACTED].

- Strengths:
DHS completed a thorough investigation.
- Deficiencies:
None identified.
- Recommendations for Change at the Local Level:
No recommendations at this time.
- Recommendations for Change at the State Level:
No recommendations at this time.

Department Review of County Internal Report:

There was no Act 33 Review Team convened; the case was [REDACTED] within 30 days; case was received 07/27/2010 and [REDACTED] 08/24/2010.

Department of Public Welfare Findings:

- County Strengths:
 - DHS completed thorough interviews with the mother which helped to clear up the misconception/allegation that mother gave victim child medication while he was in the hospital.
 - DHS collaborated with Bucks County Children and Youth, the county where the [REDACTED] family resides, to have a Safety Assessment completed and to determine the appropriateness and safety of the [REDACTED] home for [REDACTED] to return.
- County Weaknesses:
None identified.
- Statutory and Regulatory Areas of Non-Compliance:
None identified.

Department of Public Welfare Recommendations:

None at this time.