



REPORT ON THE NEAR FATALITY OF:



BORN: 11/25/2010
DATE OF INCIDENT: 09/14/2012
DATE OF ORAL REPORT: 9/21/2012

FAMILY KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON:
April 25, 2013

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 convened a review team in accordance with Act 33 of 2008 related to this report on October 19, 2012.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	11/25/2010
[REDACTED]	Female Sibling	[REDACTED]/2002
[REDACTED]	Female Sibling	[REDACTED]/2006
[REDACTED]	Male Sibling	[REDACTED]/2011
[REDACTED]	Biological Mother	[REDACTED]/1981

Non-Household Member:

* [REDACTED] Maternal Aunt [REDACTED] 1985
Also Known as [REDACTED]

Non-Household Members, Biological Fathers of the Children:

[REDACTED]	Biological Father of [REDACTED]	[REDACTED]/1965
[REDACTED]	Biological Father of [REDACTED]	[REDACTED]/1960
[REDACTED]	Biological Father of [REDACTED]	[REDACTED]/1977
[REDACTED]	Biological Father of [REDACTED]	[REDACTED]/1982

* [REDACTED] the maternal aunt, was in the home as caretaker of the children at the time of the incident. [REDACTED] was not named as [REDACTED]; however she was arrested for endangering the welfare of a child. She is not incarcerated.

Notification of Near Fatality:

On September 21, 2012, the Philadelphia Department of Human Services (DHS) received a call from [REDACTED] concerning [REDACTED]. It was reported that on September 14, 2012, [REDACTED] was admitted

to the hospital in response to ingesting [REDACTED] and she was in critical condition. It appeared that the ingestion was accidental; however, mother did not seek immediate medical treatment for [REDACTED] was unresponsive in the home for 20 hours. The report was [REDACTED] for medical neglect as mother knew the child had ingested medication; however, she did not seek medical attention. [REDACTED] had significant [REDACTED]. She required [REDACTED]. The doctor reported that the [REDACTED] would have been less if there had not been a delay in receiving medical attention. The incident was determined to be a near fatality. It was noted that [REDACTED] was stable and expected to survive. She will require extensive rehabilitation and may not fully recovery from the [REDACTED].

Summary of DPW Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] Family. The [REDACTED] reports were reviewed. In addition, the In Home [REDACTED] reports from Carson Valley Children's Aid were reviewed. Follow up interviews were conducted with the caseworker, [REDACTED], on October 19, 2012. In addition, the Department interviewed the ongoing social worker, [REDACTED], on December 21, 2012. The Department reviewed previous CPS investigations, Safety Assessments, [REDACTED] and Philadelphia Children's Alliance forensic interviews and assessments. The regional office also participated in the County Internal Fatality Review Team meeting on October 19, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The [REDACTED] family became known to the Philadelphia Department of Human Services (DHS) on June 6, 2005. The family has a history of sexual abuse and homelessness. [REDACTED] have been victims of sexual abuse. The biological father of [REDACTED] has an [REDACTED] report for sexual abuse with [REDACTED] and [REDACTED] as victims. He was also incarcerated for the sexual abuse of [REDACTED]. In addition, [REDACTED] made allegations that her brother exhibited inappropriate sexual behaviors towards her. The family received services from DHS that included [REDACTED] to Children in their Own Home [REDACTED] and [REDACTED] in home [REDACTED]. [REDACTED] has a history of [REDACTED]. She also suffered from [REDACTED] after the birth of [REDACTED]. In addition, Ms. [REDACTED] had a childhood history of physical and sexual abuse.

06/06/2005

This report was concerning [REDACTED]. Mother was [REDACTED] with [REDACTED] at the time of this report. It was reported that, while [REDACTED] was in the care of her father, [REDACTED], her 13 year old half brother exhibited inappropriate sexual behavior with [REDACTED]. The allegation was that [REDACTED] performed cunnilingus (oral stimulation of the clitoris or vulva). [REDACTED] was visiting with her father during this investigation. [REDACTED] did not have stable housing and she was living in a shelter with [REDACTED] at that time. In response to this allegation, [REDACTED] was implemented through [REDACTED]. The [REDACTED] were provided from September 12, 2005 to December 7, 2005. In addition, [REDACTED] received a [REDACTED]. The evaluation concluded that [REDACTED] did not appear to have been sexually abused. She did recant her account of the allegation and instead reported witnessing her father engaged in sexual activity. She presented as a child that was exposed to explicit sexual behaviors. [REDACTED] did not receive any [REDACTED] at this time and she remained in the custody of her mother. DHS closed the case on January 6, 2006.

07/25/2006

This report was concerning [REDACTED]. It was reported that [REDACTED] failed to keep an appointment for [REDACTED] for an evaluation at [REDACTED] on June 8, 2006. [REDACTED] had been exhibiting inappropriate sexual behaviors and reported that mother's former paramour [REDACTED] had "done it." [REDACTED] were living in a shelter. Mother was [REDACTED] and [REDACTED] through the shelter care system. During that time, [REDACTED] was in the care of her maternal aunt, [REDACTED]. [REDACTED] visited with [REDACTED] four to five times a week and would take her to the doctor's appointments. [REDACTED] had agreed to care for [REDACTED] until the [REDACTED] resolved and mother's housing was stable. DHS had visited with [REDACTED] in the home of the maternal aunt, [REDACTED], and she was noted to be safe with no areas of concern. A risk assessment was conducted on August 22, 2006 and determined that overall severity and overall risk for both [REDACTED] was low. The case was closed on August 31, 2006.

11/17/2010

This report was concerning [REDACTED]. It was reported that [REDACTED] was sexually abused by [REDACTED], mother's paramour, and the biological father of [REDACTED]. At this point, mother was pregnant with [REDACTED]. In addition, it was reported that [REDACTED] was taken to the [REDACTED] because she brought a knife to school. [REDACTED] had reported that her mother allowed [REDACTED] to move back into the home and she was feeling uncomfortable. The family was opened for [REDACTED] and [REDACTED] was placed in the home through Carson Valley Children's Aid. [REDACTED] for 6 months through People's Emergency Center. In response to this allegation and the allegation that [REDACTED]

made on November 24, 2010, the children were [REDACTED] at Philadelphia Children's Alliance (PCA) on December 3, 2010.

11/24/2010

This report was concerning [REDACTED]. It was reported that [REDACTED] (biological father) sexually abused [REDACTED]. The safety assessment was conducted on November 30, 2010 and a safety plan implemented. The safety plan was that mother was not to leave the children unsupervised and protect them from access to [REDACTED] was not to come into the home as [REDACTED] had reported that she felt uncomfortable around him. Mother was to take [REDACTED] to visit her father outside of the home and to remain with the father and child during the visit. [REDACTED] for the family were implemented. On 1/11/11, the family began receiving IHPS (In Home Protective Services) through Carson Valley Children's Aid. It was determined that mother had [REDACTED]. It was reported that mother was not ensuring that [REDACTED] was attending school on a regular basis. The mother's explanation for the lack of attendance was a transportation problem. This created a truancy concern for [REDACTED] was on medication at this point in time. She was [REDACTED]. She was also self cutting and was receiving [REDACTED] through [REDACTED]. The [REDACTED] was terminated on 4/27/11 in response to the family stabilization. The mother was providing supervision and ensuring that the children were receiving the necessary services, including education and [REDACTED] were receiving [REDACTED] through [REDACTED]. In addition, the family was receiving [REDACTED] through the [REDACTED] through the [REDACTED]. The investigation was [REDACTED] was arrested and incarcerated for sexually assaulting both [REDACTED] was incarcerated from May 13, 2011 to March 30, 2012.

03/23/2012

This report alleged that [REDACTED] left the children home alone on March 17, 2012. It was further reported that [REDACTED] father [REDACTED] raped Ms. [REDACTED] in the home. The children were asleep during the incident and they were not physically harmed. The mother was referred to Community-Based Prevention Services to assist with [REDACTED] and [REDACTED] related to the rape. Women's Christian Alliance attempted to provide services to mother, but she declined the services.

Circumstances of Child's Near Fatality and Related Case Activity:

On September 21, 2012, the [REDACTED] notified DHS that, on September 14, 2012, [REDACTED] was admitted into CHOP unresponsive. She was determined to be in critical condition as a result of accidentally ingesting medications that she found in her maternal aunt's purse. [REDACTED] had been unresponsive for 20 hours before mother took child to the hospital. The hospital reported that if there was not such a delay in receiving medical intervention, the [REDACTED] and injury would not

have been as serious. As a result of the delay, [REDACTED] brain was deprived of oxygen and she had several [REDACTED] and significant [REDACTED]. The child had a [REDACTED] to relieve the pressure in her brain.

The report was received a week after her admission as the hospital was not sure of the cause of her condition until the toxicology results were obtained. The toxicology report indicated that [REDACTED] had ingested [REDACTED]-also known as [REDACTED] medication. It was also determined that the child had ingested [REDACTED]. The [REDACTED] did not show up in the toxicology report, as according to the medical staff, [REDACTED] does not always show up in the toxicology report. However, based on her medical condition, it was determined that multiple medications had been ingested. The doctor reported that the pill that hurt [REDACTED] was the [REDACTED] also known as [REDACTED]. This is the medication that decreased her heart rate and blood pressure, which resulted in her suffering from multiple [REDACTED] and [REDACTED]. The hospital reported that [REDACTED] had a burn on her foot which was later determined to not be a burn; instead, she had cut her foot on the bed frame and she picked the sore.

On September 13, 2012 [REDACTED] along with her siblings, were in their home under the supervision of the maternal aunt, [REDACTED]. The incident occurred when [REDACTED] went out to the apartment balcony to smoke a cigarette. The balcony door locked and she was unable to get back into the apartment. She called the children's mother while on the balcony to inform her that she was locked out. She was locked out of the apartment for about 20 minutes. She regained entry by breaking the glass to the balcony door. During that time, [REDACTED] went into her aunt's pocketbook and ingested her medications, [REDACTED]. The investigation determined that the ingestion of the medication was accidental. The children's mother was not in the home at the time of the incident. She was out shopping at the [REDACTED] making purchases for the children when the incident occurred. The maternal aunt informed mother that when she was able to get back into the apartment, she found [REDACTED] playing in her pocketbook where her medication, [REDACTED] (also known as [REDACTED]) was. According to the maternal aunt, at this point, [REDACTED] appeared to be fine. She was not aware at this point that [REDACTED] had ingested any of the medication.

The mother stated that she arrived home about an hour and a half after receiving the call from her sister. Her sister informed her that she had been locked out of the apartment and was on the balcony. She informed mother that [REDACTED] was playing in her pocketbook where her medication was. [REDACTED] was not aware that [REDACTED] had ingested the medication and she reported that [REDACTED] appeared fine. There were no changes in [REDACTED] behavior and she continued to play. When mother arrived home, she observed [REDACTED] and she was her normal self-playing and showing no signs of distress. Neither mother nor maternal aunt knew that [REDACTED] had ingested the medication. It was not until bedtime, around 8:00pm, when her behaviors began to change. She became sleepy and lethargic. At this time, mother and maternal aunt checked [REDACTED] for residue in her mouth.

████████ counted the medication and realized that a ██████ was missing. They did not count the ██████ as there were numerous pills. With the change in her behavior and the missing ██████ pill, they realized ██████ had ingested the medication. The maternal aunt recommended that mother take the child to the hospital. Mother made the decision to let ██████ sleep it off. Mother did not call 911 as she felt that the ambulance would not take ██████ to CHOP and she did not want her to be taken to the neighborhood hospital. The maternal aunt encouraged mother to take her to the hospital, mother elected not to and thought she would sleep it off. At this point, both mother and maternal aunt were aware of the ingestion.

On September 14, 2012, upon waking up in the morning, ██████ observed that ██████ had slept later than her usual 7:00am. ██████ was covered with vomit and still appeared sleepy. She gave ██████ a bath and gave her a bottle. At this point, ██████ was lethargic and mother thought she needed to go to CHOP. Mother did not take ██████ to the hospital until around 7:00pm. She reported that the reason for her delay in taking ██████ to the hospital was she did not want DHS in her business. She also reported that she was going to wait until ██████ and ██████ returned home from school, and then she was going to take ██████ to the hospital. When mother decided to take ██████ to the hospital, she went to take the bus. While waiting for a bus, a neighbor offered them a ride to the hospital. Mother had a broken ankle with ██████. She required the use of crutches in order to walk. It was reported that she had an accident stepping down from a public bus. Upon arrival to CHOP, ██████ was immediately taken into the operating room, where she received ██████ to reduce the ██████.

On September 21, 2012, a safety assessment was conducted; no safety threats were identified and it was determined that the children were safe with their mother. The maternal aunt was interviewed and it was determined that she would not be named as an alleged perpetrator. The investigation revealed that the ingestion of the medication was accidental. Maternal aunt was locked out of the apartment when the incident occurred. ██████ went into her pocketbook and obtained the medication and ingested the medication. At the time of the ingestion, the maternal aunt was on the balcony of the apartment and the balcony door was locked. She was unable to gain access back into the apartment. She did regain access to the apartment by breaking the glass door. Once in the apartment, she did see ██████ playing in her pocketbook with the pills on the floor. She did not count the pills to see if any were missing. At that time, she was not sure if ██████ had ingested any of the medication. At this time, ██████ behavior had not changed and she continued to play with her brother, ██████. Mother and maternal aunt did check in ██████ mouth to see if she did ingest any of the medication. During the ██████ investigation, the maternal aunt reported that she has ██████; she also has nerve damage in the back and neck. As a result of these conditions, she is unable to work and she receives ██████ due to a learning disability and

She also has a [REDACTED], which is why she takes the [REDACTED]

On October 5, 2012, the [REDACTED] investigation was [REDACTED]. There was a 20 hour delay in mother seeking medical intervention. It was determined by medical staff that [REDACTED] remained unresponsive for over 20 hours before mother sought medical treatment. According to the medical reports, her [REDACTED] would have been less if there had not been a delay in seeking care. Mother reported that her reason for not seeking medical care was she did not want [REDACTED] to be taken to the neighborhood hospital. She preferred that she would be taken to CHOP. She also provided an explanation as she did not have anyone to take care of the other children if she took [REDACTED] to the hospital.

Current Case Status:

[REDACTED] was [REDACTED] on October 5, 2012 and placed in foster care through Friendship House. [REDACTED] was arrested on October 26, 2012 and charged with Endangering the Welfare of a Child and she is presently incarcerated at the [REDACTED]. Upon the arrest and incarceration of [REDACTED], the siblings were placed into the same foster home as [REDACTED] has made significant improvement and progress with her rehabilitation. She does not require continued inpatient rehabilitation. She has the ability to walk, she eats orally and she is learning how to talk. She receives [REDACTED] through [REDACTED].

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

- **Strengths:**

Compliance with statutes and regulations.

The Team felt that the MDT social worker did an excellent job with the investigation of the case.

The Team praised the MDT social worker's proactive approach by referring the mother and the maternal aunt for parenting capacity evaluations.

Services to [REDACTED] and the extended family

The family did not have an open case at the time of the incident. Upon the [REDACTED] of [REDACTED], she was placed in foster care through Friendship House. [REDACTED] receives [REDACTED] services. The mother and maternal aunt were arrested on October 26, 2012 and [REDACTED] were placed in the same foster home as [REDACTED].

- **Deficiencies:**
There were no deficiencies identified
- **Recommendations for Change at the Local Level:**
There were no recommendations identified
- **Recommendations for Change at the State Level:**
There were no recommendations identified

Department Review of County Internal Report:

The Department is in receipt of the county report dated January 16, 2013. The report is comprehensive and describes the DHS history of the [REDACTED] family. The report also contains detailed information regarding the investigation of the near fatality.

Department of Public Welfare Findings:

County Strengths:

- The collaboration with the medical team and child abuse team at CHOP.
- The sensitivity used during the Act 33 Team meeting regarding the decision of the SVU to arrest mother and maternal aunt. There was detailed conversation regarding having the children witness their mother and aunt being arrested. It was decided to have DHS notified and DHS to be present during the arrest to ensure the safety and well being of the children.
- The CPS investigator and the ongoing social workers demonstrated best practice while investigating the allegations, as well as ensuring that the siblings were placed in the same foster home.

County Weaknesses:

- There are none identified

Statutory and Regulatory Areas of Non-Compliance:

- There are no areas of non-compliance.

Department of Public Welfare Findings and Recommendations:

- The Department recommends public service announcements to foster public awareness about medication safety and keeping medication out of reach of young children. The ingestion of medication by young children

has been a trend with near fatality and fatality reports within the past five years.

- The Department recommends that counties provide additional supports to parents who become known to them who suffer from post [REDACTED] [REDACTED]. This mother had a history of childhood physical and sexual abuse and required additional case management services, especially after [REDACTED] on November 24, 2012.
- The Department recommends more collaboration between the systems of public housing and other community social service agencies. Landlords of public housing should be held liable when children are injured due to inadequate and poor conditions of the home. The public housing was aware of the broken patio door. The fact that the patio door locked and maternal aunt could not gain access to the children was a safety problem. The door was repaired after the incident.
- The Department recommends more collaboration between the community mental health systems and the public child welfare agencies when parents are receiving treatment for depression.
- The Department recommends more collaboration between the homeless shelter systems and public mental health and child welfare agencies, as mother and children had an extensive history of homelessness.