



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:**



**BORN: 7/11/04**

**Date of Near Fatality Injury: 6/26/10**

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

**REPORT FINALIZED ON: 5/30/13**

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.

**Notification of Child (Near) Fatality:**

On 6/26/10, [REDACTED] received an additional report from the [REDACTED] Hospital, stating that the victim child, who was brought into the hospital unconscious and was recently diagnosed with [REDACTED] ingestion on 06/24/10, also has ligament damage to back of his neck and the kinship parent cannot explain how the child was injured. The ligament damage was diagnosed as serious and life threatening. Additionally, the child was having [REDACTED] from the ingestion of the [REDACTED] medication. Later that day, a [REDACTED] showed an injury to the child's neck.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	victim child	7/11/2004
[REDACTED]	Male sibling	[REDACTED]/2000
[REDACTED]	Cousin / MAU bio son	
[REDACTED]	Cousin / MAU bio son	
[REDACTED]	Kinship Caregiver/ Maternal Aunt (MAU)	[REDACTED]/1978

**Other family members living outside the home**

[REDACTED]	female sibling (resides with MAU [REDACTED])	[REDACTED]/2005
[REDACTED]	Male sibling	[REDACTED] 2007
[REDACTED]	Female sibling	15 years old
[REDACTED]	Female sibling (w/bio mother)	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED]/1979
[REDACTED]	Bio Father of [REDACTED]	[REDACTED] 1969
[REDACTED]	Bio Father of [REDACTED]	[REDACTED] 1969

**Notification of Child Near Fatality:**

On 6/24/2010 [REDACTED] on a report alleging that [REDACTED], Victim Child (VC), was taken via ambulance to the Emergency Room of St. Christopher's Hospital. VC was seizing and [REDACTED] with respiratory failure upon arrival. VC presented as lethargic and had [REDACTED]. The VC had a bruise to the back of the head, mid thigh and suffered a [REDACTED]. He was also going through [REDACTED]. Based on the severity of his injuries, VC was determined to be in critical condition by Dr. [REDACTED]. VC tested positive for morphine ingestion.

The Maternal Aunt (MAU), [REDACTED], called 911 when she noticed on the morning of 6/24/2010 that the victim child was unresponsive and was having difficulty breathing. VC had an [REDACTED] of the head and neck. Tests showed he had injuries to the ligaments of the back of the neck. Dr. [REDACTED], Pediatric Specialist, at St. Christopher's Hospital stated the MAU explained that she lifted the child's head when she found him unresponsive and attempted to perform CPR. According to the doctor, the MAU's story did not correlate with the severity of the injuries to the child's neck. As a result, the report was registered as a Near Fatality [REDACTED] Report. At the time of the incident, the VC was residing with his MAU, along with his biological brother, [REDACTED] and 2 maternal cousins; [REDACTED]

On 6/24/2010, the report was registered to the regional office as a Near Fatality [REDACTED] for investigation and a [REDACTED] to the Department of Human Services.

On 6/26/10 ChildLine [REDACTED] stating that the victim child, who was brought into the hospital unconscious and was recently diagnosed with [REDACTED] ingestion on 06/24/10, also has ligament damage to back of his neck and the kinship parent could not explain how the child was injured. The ligament damage was diagnosed as serious and life threatening. Additionally, the child was [REDACTED] from the ingestion of the [REDACTED] medication.

As a result of the ligament damage to the back of the VC's neck discovered after doing the [REDACTED] on the VC, the Doctor called in the report as she felt that the injuries were inconsistent with the MAU's story and therefore suspicious in nature. On 06/26/2010, the report was registered as a new Near Fatality report due to the additional injuries that contributed to the VC's current critical condition. The report was given to the Regional Office as the second Near Fatality report for investigation on the victim child.

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

The Southeast Regional Office of Children, Youth and Families (SERO) reviewed all records, including medical and case notes, and safety assessment/management In Home worksheet pertaining to the family. Interviews were conducted with the hospital social worker, [REDACTED], on 6/24/2010. SERO also conducted follow up interviews with county caseworker supervisor, private provider caseworker, and St Christopher's Hospital physician, Dr [REDACTED], on 6/26/2010. SERO spoke with an officer

from the Special Victims Unit (SVU) of the Philadelphia Police, [REDACTED] (Mo) and [REDACTED], father. In addition, SERO spoke to [REDACTED] and [REDACTED], both of whom were named as alleged perpetrators (AP #1 and AP #2). SERO also participated in the Act 33 Internal Fatality Review Team meeting on 7/16/2010.

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

**11/15/2003** [REDACTED] [REDACTED]

DHS assigned a [REDACTED] to the [REDACTED] report alleging that [REDACTED], the children's mother, forcefully hit [REDACTED] on his back. It was unknown if child sustained injuries and when asked about disciplinary practices; the mother replied she would discipline her child any way she chose. **The case was [REDACTED].** On 3/5/2004, DHS implemented Services to Children in their Own Homes (SCOH) [REDACTED] through a private provider, Tabor Children's Services. Services were discharged 2/23/2005.

**01/06/2007** [REDACTED]

**Open/Accepted for Services**

DHS assigned an [REDACTED] to a [REDACTED] report alleging that VC was observed wearing a long T-shirt as if covering himself and other children in the home were observed similarly dressed. Additionally, it was reported that [REDACTED], the mother's paramour, was indicated as a perpetrator of sexual abuse and that he had admitted to physically abusing his children who did not reside in the home. It was further reported that [REDACTED] was a known perpetrator of sexual abuse and that the children in the home were at risk. DHS completed the assessment of the allegations and determined that [REDACTED]. On 3/28/2007, DHS implemented SCOH [REDACTED] through a private provider, [REDACTED]. The services were discharged on October 15, 2007.

**04/7/2008** [REDACTED]

**05/19/2008** [REDACTED]

DHS assigned a [REDACTED] report alleging that [REDACTED] was complaining of pain in his left hand on 4/7/2008. It was reported that the mother had held [REDACTED] hand high above a flame because [REDACTED] had stolen \$20 from her. DHS implemented Family Preservation Services through a private provider, [REDACTED] on 4/23/2008. Case was [REDACTED] physical abuse against the [REDACTED] as the perpetrator.

**04/29/2009** [REDACTED]

DHS received a [REDACTED] report alleging that there were concerns regarding the care and supervision of [REDACTED] by his mother. It was reported that the home lacked furniture and all of the children were sleeping in one bed. It was also reported that the children did not attend school regularly, did not wear their uniforms, their clothes were dirty and they were not fed regularly. The mother was also reported to be pregnant. **It was determined [REDACTED]**

05/18/2009Closed/not accepted for services

DHS received a [REDACTED] report alleging that in 2006, [REDACTED] had been sexually abused by his father, Mr. [REDACTED]. It was reported that [REDACTED] had been living with [REDACTED] at that time. The mother was functioning appropriately and [REDACTED] whereabouts were unknown. **It was determined** [REDACTED]

The family was still receiving SCOH [REDACTED] services implemented on 4/23/2008 from a previous [REDACTED] report on 4/7/2008. These services were discharged on 6/17/2009. Subsequently, DHS implemented In-Home Protective Services (IHPS) through a private provider on 6/18/2009.

06/29/200907/31/2009 Closed/not accepted for services

DHS received a [REDACTED] report alleging that the mother and [REDACTED] were involved in an argument. It was reported that the mother hit [REDACTED] on the face and additionally she had choked her in the past and that she frequently used corporal punishment to discipline her. No injuries were sustained and the case was closed [REDACTED]. At the time of case investigation closing, the family was still receiving [REDACTED]. A Safety Assessment Worksheet was completed August 27, 2009 during an In-Home-evaluation. It was noted that the mother stated she was overwhelmed with her pregnancy and all of her children. The children began staying with other relatives through a family arrangement. It was noted that [REDACTED] began residing with the MAU, [REDACTED] began living with [REDACTED], Maternal Grandmother (MGM), and [REDACTED] the VC, [REDACTED] began residing with Mr. [REDACTED]

**It was determined** [REDACTED]04/29/201006/17/2010

DHS received a [REDACTED] report alleging that [REDACTED] who had resided with his father, Mr. [REDACTED], during 2006 was inappropriately touched by him and he was afraid of seeing and living with him. On 6/17/2010 the [REDACTED] for sexual abuse against Mr. [REDACTED]

06/24/2010Closed/Accepted for services

On June 24, 2010 DHS received an [REDACTED] report alleging that on 6/24/2010, the VC, [REDACTED] was taken to the emergency room at St. Christopher's Hospital for Children. VC was unresponsive with difficulty breathing. He tested positive for [REDACTED] ingestion. VC had been placed in kinship care in the home of his MAU

since September 2009 through Bethanna. The fiancé of MAU died of [REDACTED] in March 2009 and had been [REDACTED] associated with [REDACTED]. The MAU informed DHS that she placed the pills on top of the china cabinet after her fiancé's death and had not remembered they were still there. She believed that she had gotten rid of them.

On 6/23/2010 at approximately 3:00 PM, VC gave a bottle containing the [REDACTED] pills to his MAU stating that he found the bottle in [REDACTED] (son of MAU) tote. MAU stated to DHS that she did not know who removed the [REDACTED] label from the bottle nor did she remember how many pills were in the bottle. The investigation revealed that VC appeared fine at dinner and he went to bed at 9:00PM. VC's brother, [REDACTED], observed that VC was experiencing difficulty breathing the next morning and could not be awakened. He called to his MAU and when she arrived she noticed that he was attempting to wake up VC. She noted there was something on his face and he was not breathing well. She picked him up and carried him to her room, laid him on the bed in front of the fan, and then contacted 911. She stated that she did not know her son, [REDACTED] used drugs until he tested positive for marijuana at the hospital on 6/24/2010 (see more detailed information in the section below). The investigation further revealed that MAU's son knew the pills were on the china cabinet and that he removed them about 2 months prior to the incident. He reported that he did not intend to sell or use the pills and kept them hidden in his tote.

[REDACTED] reported that he observed VC going through [REDACTED] belongings on other occasions and on 6/24/2010 when he attempted to wake VC he noted vomit and "snot" on VC's face. He stated that he pulled VC out of the bed and tried to stand him up; however VC did not wake up or stand up on his own, so he put VC down on the floor and called his MAU.

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

On 6/24/2010, SERO visited the Hospital to see the VC and was able to interview the Hospital Social Worker, Mother and the VC's Father. VC was unconscious at the time and according to the Hospital Social Worker was questionable as to whether he would survive. SERO also spoke with the county supervisor and provider case worker to discuss case status, child's medical condition and safety planning for the VC and his brother who was also in the care of the MAU. On 6/25/2010, SERO contacted Dr. [REDACTED], attending physician. According to the physician, the VC was still unconscious and his vital signs were deteriorating. She also stated that he was in critical condition and certified his status to be a Near Fatality. On 6/26/2010, [REDACTED] informed SERO that a 2<sup>nd</sup> [REDACTED] report was [REDACTED] on the VC. On 6/28/2010, SERO visited the Hospital to see the VC who was still unconscious. SERO discussed the case with Dr. [REDACTED], [REDACTED] at St. Christopher's, who stated that as a result of the extensive ligament damage to the back of his neck discovered during the [REDACTED], was inconsistent with the explanation given by the MAU. MAU explained that she only administered regular emergency care before he went to the hospital. The physician

stated that both the [REDACTED] ingestion and the ligament tearing are both contributory factors to the child's Near Fatality status.

On 6/28/2010, SERO contacted the hospital to check on the status of the VC who was showing signs that he might awaken however was still unconscious. SERO provided details of the current investigation with the SVU officer who then began a criminal investigation. SERO also spoke with the private provider caseworker regarding the safety plan, which provided for VC to remain in hospital and his brother to remain in respite care. On 6/10/2010, SERO received a call from [REDACTED] St. Christopher's Hospital who informed her that VC was awake, but was experiencing some [REDACTED]. He was still unable to be interviewed.

On 6/30/2010, SERO spoke to the Pediatric Specialist at St. Christopher's who expressed her concern with the MAU's version of events leading up to the Near Fatality. In one version, the MAU stated that VC was fine before going to bed and another version of events was that he appeared very fatigued and may have shown signs of being under the influence. She felt the explanations surrounding his neck injuries were not consistent with her picking him up from the bed while he was unresponsive and laying him on her bed in front of the fan before calling 911. SERO received a call from the SVU who felt that VC may have taken [REDACTED] pills because of the number of pills remaining in the bottle. The Officer stated that the most accurate account of events came from the VC's brother, who stated that the incident started as a result of the VC wetting the bed. As a result the VC was confined to his room for punishment. During that time the VC went through his cousin [REDACTED] tote and found the pills. The VC's brother stated that the VC took the pills to his MAU who took them and placed them on the cabinet. After that the VC went to his room to bed. The next morning, the VC's brother got up from the top bunk and noticed that the VC was [REDACTED]. He tried to pull the VC from the bed where the VC could have hit his head on a metal frame. This is where the VC may have received the torn ligament to the back of the neck, which was consistent with the medical information from the hospital. The VC's brother stated that his MAU came in, sees what is going on and lifted the VC from the bed and put him in her bed and turned on the fan. The cousin, [REDACTED], stated that he took the pills to the hospital and gave them to the private provider case worker, who then informed the hospital of what may be in the child's system. Both the VC's brother and cousin were tested for drugs. The cousin tested positive for marijuana, not morphine, and the VC's brother was found not to have any drugs in his system.

On 7/8/2010, SERO conducted a visit to the home of the MAU to interview her and her son (AP#1). She was unable to secure any other information other than what had already been provided. The cousin confirmed that he had removed the [REDACTED] pills from the top of the china cabinet 2 months ago and that the VC retrieved the [REDACTED] pills from his tote. He denied intent to sell or use the [REDACTED]. SERO also visited the hospital to see the VC. He had been receiving [REDACTED] and appeared to be in extreme discomfort and crying. He has [REDACTED] and is [REDACTED].

On 8/20/2010, the [REDACTED] with ChildLine. SERO [REDACTED] [REDACTED] While the VC suffered serious bodily injuries, severe pain and [REDACTED], both APs and a witness who was present at the time of the incident stated that the child accidentally found and ingested a pill while rummaging through his cousin's tote. The investigation ruled out physical abuse by the cousin and lack of supervision as he was not in a caretaker role. The VC took the pills to the MAU and denied taking any of the pills and continued on with his routine. The police investigation concluded without charges being pressed.

**Current Case Status:**

On 6/30/2010, the VC's [REDACTED], but he continued to experience difficulty moving his right side. [REDACTED]. The duration of his hospitalization was uncertain.

On 7/1/2010, the county held a Multi-Disciplinary Team (MDT) review meeting to discuss the 2 [REDACTED] reports from 4/7/2008 and 4/29/2010. The Team recommended paternity tests, obtain results from mother's [REDACTED] on [REDACTED] to determine the need for [REDACTED] services, prepare for reunification with the children with the mother, parenting skills for the mother, determine the mother's current need for educational services and refer [REDACTED] to a provider to address his domestic violence issues.

On 7/5/2010, DHS case notes indicated that the VC was in no condition to be transferred to another facility and that he remained in the [REDACTED]. He was no longer [REDACTED]. It was further noted that he was unable to comprehend, interact, or communicate. He also suffered [REDACTED] and would still need to undergo further testing.

On 8/2/2010, VC was placed at the [REDACTED] at the Children's Hospital of Philadelphia. He had become verbal and using profanity which doctors believed was due to [REDACTED]. He continued to have [REDACTED] but was progressing. [REDACTED]. After his [REDACTED], on 9/23/2010 the county identified a medical foster care home for him where he continues to remain.

The police are not charging the kinship caregiver with any criminal act. The kinship caregiver's 15 year old son who had the medication in his bedroom is receiving [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 social worker did a good job assessing the needs of the family. The collaboration between DHS Social Worker Services Manager, the hospital and Bethanna enabled the systems to provide the appropriate services to meet the family's needs in a well coordinated and effective manner.

Deficiencies:

- None identified.

Recommendations for Change at the Local Level:

- The team recommended that information on medication safety/storage could be shared with other social workers to improve case practice with families.

Recommendations for Change at the State Level:

- The team requests that DPW issue a bulletin about the disposal of old medications and how to secure medications in foster homes.

**Department Review of County Internal Report:**

The Department has received and reviewed the report provided by the county and is in agreement with the county findings.

**Department of Public Welfare Findings:**

County Strengths

The county provided clear documentation in the case notes and investigation report. The county referred the family to appropriate services.

County Weaknesses

There were no areas of concern.

**Department of Public Welfare Recommendations:**

- The team requests that DPW issue a bulletin about the disposal of old medications and how to secure currently used medications in foster homes.
- The County should collaborate with other county agencies to increase the amount of public service announcements addressing the issue of drug overdosing.