



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: 06/01/05
Near fatality: 04/02/2010

FAMILY KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON: 01/12/2011

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 convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	06/01/2005
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father	[REDACTED]
[REDACTED]	Sibling	[REDACTED]

Notification of Child (Near) Fatality:

On 4/2/10 the Department of Human Services (DHS) received a [REDACTED] [REDACTED] alleging that the victim child, [REDACTED] took an unknown pill while in the care of mother and father. When [REDACTED] did not wake up in the morning of 4/2/10 at 9AM this morning, the child's mother went to [REDACTED] bedroom and found her unresponsive. Mother carried [REDACTED] to Germantown Hospital which is a few blocks away from her home. The child's father was at work and was notified to meet them at Germantown Hospital for emergency treatment. The report alleged that the pills [REDACTED] ingested were an older [REDACTED]. Mother reports that the pills were thrown in the trash. It was unknown whose prescribed pills were in the trash. Reporter believes parents neglected to seek immediate care for [REDACTED] after ingesting the medication. [REDACTED] was thought to be at increased risk because she had a history of [REDACTED]. [REDACTED] was deemed to be in critical condition. The report alleged that [REDACTED] was expected to survive and she was transferred to St. Christopher's Hospital. The case was certified as a near-fatality.

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. Follow up interviews were conducted with the Caseworker [REDACTED]. The regional office also participated in the Act 33 Review Team meeting on April 16, 2010.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

3/2/2007

Child [REDACTED] had been brought to St. Christopher's Hospital for Children on 2/26/2007. Child had ingested [REDACTED] an old medication that had been [REDACTED] to the father for his [REDACTED]. Father claimed that he had used the child syringe used for liquid Tylenol for Child and may not have cleaned out the equipment as good as he thought. Child was discharged from the hospital on 3/2/2007.

The child's mother was pregnant and was also not taking her [REDACTED] to her for her [REDACTED] treatment. The case was [REDACTED] but was open and referred for SCOH services through Juvenile Justice Center from 5/3/2007 through 6/18/2008. An FSP was in place for the parents. Goals were to attend parenting classes from Intercultural Family Services and to be compliant with the treatment for their [REDACTED] through [REDACTED]. The mother gave birth to her second daughter on 11/23/2007. The mother resumed [REDACTED] after giving birth to her second child. The family completed their goals in the FSP and according to the Family and Child Tracking System, the case was closed on 10/2/2008.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 4/2/10 the Department of Human Services (DHS) received a [REDACTED] Report alleging that the victim child, [REDACTED] took an unknown pill in the care of mother and father. When [REDACTED] did not wake up at 9AM this morning, mother went to [REDACTED] bedroom and found her unresponsive. Mother walked [REDACTED] to the hospital and father met her there. The report alleged that the pills [REDACTED] ingested were an older [REDACTED]. Mother reports that the pills were thrown in the trash. Reporter believes parents neglected to seek immediate care for [REDACTED] after ingesting the medication. [REDACTED] was thought to be at increased risk because she had [REDACTED]. [REDACTED] was deemed to be in critical condition. The report alleged that [REDACTED] was expected to survive and she was transferred to St. Christopher's Hospital. The case was certified as a near-fatality.

The drug that [REDACTED] ingested was [REDACTED]. The child's mother and father gave conflicting stories on how they thought [REDACTED] could have obtained the medication. It was discovered, through [REDACTED] interview at Philadelphia Children's Alliance, that [REDACTED] retrieved the medication from her father's bag while her mother was sleeping. Mother confessed to being intoxicated and passed out, leaving the children unsupervised when the incident occurred. The father was at work.

The Safety Plan for [REDACTED] was to have her stay with neighbor, [REDACTED]. All parties agreed with this plan. All visits with the parents and their children would be supervised by [REDACTED] clearances were completed and she was approved to have [REDACTED] and [REDACTED] in her home.

On April 3, 2010, [REDACTED] was [REDACTED] to Ms [REDACTED] home. Child, mother, and the DHS worker went with the child to Ms [REDACTED] home. The Safety Plan was reviewed with all of them and they agreed that all visits with the mother and her children would be supervised by [REDACTED].

Current Case Status:

- The mother and father were [REDACTED] for lack of supervision resulting in a physical condition.
- [REDACTED] An order of protective custody was obtained for both [REDACTED] and her sibling. The Children are now placed with a maternal aunt who was referred for kinship care. The parents will be referred to the Achieving Reunification Center for services. The parents have also been referred for [REDACTED] through the court and will be subject to random [REDACTED]. DHS will monitor both parents participation in [REDACTED].

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

Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report on April 16, 2010. (Within 30days of the report)

- Strengths:
 - The agency placed [REDACTED] and her sibling in the same household.
- Deficiencies:
 - None identified.
- Statutory and Regulatory Areas of Non-Compliance:
 - None identified

Department of Public Welfare Findings:

- Strengths:
 - The agency placed [REDACTED] and her sibling in the same household in kinship care.
- Deficiencies:
 - None identified.
- Statutory and Regulatory Areas of Non-Compliance:
 - None identified

Department of Public Welfare Recommendations:

- Increase education about the effects of child abuse on its victims. Counties and OCYF should continue to explore and institute alternative ways to educate the community on child fatalities/ child abuse and the damaging effect on families and communities. Public service announcements could be utilized to provide information on Planned Parenthood and the Safe Haven Law.

- County children and youth agencies should provide staff with education on the appropriate storage of medication so that staff can then review this with families, and educate parents how to keep their children safe.
- OMHSAS should educate clinical staff who work with parents on the need for safe storage of their medications. When [REDACTED] consumers receive medications at clinics, they should be given education on how to safely store their medications if they have children in their homes.
- When parents are involved in the [REDACTED] system and discontinue treatment, their children may be placed at risk. Collaboration should occur between the mental health and child welfare systems to ensure that these families are being assessed, and that children are not being placed at risk.