pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 10/30/2009
Date of Incident: 01/29/2013
Date of Oral Report: 01/29/2013

FAMILY NOT KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON: 1/17/14

Office of Children, Youth, and Families, Southeast Region
801 Market St, 6th Fl., Ste. 6112, Philadelphia, PA 19107 | 215.560.2249/2823 | F 215.560.6893 | www.dpw.state.pa.us

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 February 15, 2013.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Victim Child	10/30/2009
[redacted]	Mother	[redacted]/1998
[redacted]	Sibling	[redacted]/2007
[redacted]*	Mother's Paramour	Adult
[redacted]	Maternal Great-Grandmother	Adult

* Not in Household

Notification of Child Near Fatality:

On January 29, 2013, the Department of Human Services (DHS) received a Child Protective Services (CPS) report alleging that three year old [redacted] ingested the [redacted] medications, [redacted] was taken to Children's Hospital (CHOP) on January 28, 2013. She was in respiratory failure and in critical condition. [redacted] accidently swallowed the medications that were left in her reach. The maternal great-grandmother (MGGM) delayed seeking medical attention despite suspecting that [redacted] ingested the medications.

The mother, [redacted], reported that [redacted] was in the care of her MGGM when she injected the medications. The mother was not aware that [redacted] had taken the medication until after the mother brought [redacted] home. [redacted] looked drowsy and unresponsive. [redacted] [redacted] sibling, reported that [redacted] had taken the pills but that [redacted] denied it when questioned by the MGGM. The mother stated that she called 911 approximately 10 minutes after [redacted] arrived home. The MGGM reported that she usually keeps her [redacted] medication locked away until she gives it to [redacted]. The MGGM did not supervise him on this day and he left the medications in the bathroom. The MGGM reported that she asked [redacted] several times if she took the medications and each time [redacted] denied it. The MGGM did admit that she found one pill that was wet and appeared as if it were chewed. She did not think [redacted] ingested the medications as she was still running around and playing. [redacted] did not appear sleepy until later. The MGGM reported that [redacted] had been sick and thought [redacted] lethargy was due to her illness.

Summary of DPW Child Near Fatality Review Activities:

The Southeast Region Office of Children Youth and Families obtained and reviewed all current records pertaining to the [redacted] family.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had no prior history with DHS.

Circumstances of Child Near Fatality and Related Case Activity:

On 01/29/2013 [redacted] was in the care of her maternal great grandmother. [redacted] mother, stated that her boyfriend, [redacted] picked up the children from her MGGM, [redacted]; he arrived approximately 7:10 pm. When he arrived, [redacted] was up playing and was upstairs in MGG room asleep. MGGM was trying to wake her up; 25 minutes later, [redacted] woke up, ran downstairs and started yelling "Daddy, Daddy." [redacted] stated that [redacted] helped with redressing; she had to put her jeans back on. She was able to put her own boots on. [redacted] stated that the child walked out the door on her own. [redacted] stated the child walked to the EL train at [redacted] on her own, which was approximately two blocks. Once on the train, [redacted] went back to sleep. He stated they got off the train at [redacted] and went to the [redacted] store to buy mussels for dinner. While at the store [redacted] was leaning on the crisp lay and was a little bit out of it. [redacted] stated that it was about the same time as she was coming home and saw her boyfriend and children walking towards home, he said to her that [redacted] looked drowsy (she was walking funny). She stated that she immediately picked [redacted] up and carried her home. Mother said when she got home, child was unresponsive; she called her name, talked and pinched her but got no reaction. Mother stated [redacted] had a cold and had been sick. [redacted] asked sibling [redacted] if anything happened at MGGM home. [redacted] said that [redacted] was in the bathroom after [redacted] (another child in the home) was in there and [redacted] thought it was candy and put the pills in her mouth. [redacted] said that at MGGM home, [redacted] will check on her sister and she followed her after she went into the bathroom. [redacted] told MGGM "I think [redacted] took some pills." MGGM asked [redacted] if she took the pills and she denied taking them. Ms. [redacted] stated that within 10 minutes or so of arriving home, she called 911. Ms. [redacted] stated that MGGM is a panic freak and she usually calls her for everything and she doesn't understand why she didn't call her and tell her that [redacted] had gotten hold of [redacted] medicine.
The CPS investigation was completed on 03/01/2013 with the CY48 submitted as unfounded.

Current Case Status:

The mother is currently taking a leave of absence from her job to provide care for her children. MGGM is no longer providing care for the girls.
[redacted] Medication safety measures have been instituted in the home of the maternal great grandmother where the incident occurred.
The report was unfounded and the case at DHS was closed because no safety threats were identified. The family has been referred for [redacted] for assistance with community resources. The Police Department investigated this case and decided not to file criminal charges against the MGGM.

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

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 2/15/2013.
Strengths:
Documentation of the investigation
DHS was assessing the service needs of the family to determine the appropriate referral to make.
Deficiencies:
None
Recommendations for Change at the Local Level:
None noted
Recommendations for Change at the State Level:
None noted

Department Review of County Internal Report:

The Department has received and reviewed the county's report. The report was concise and well documented.

Department of Public Welfare Findings:

County Strengths:
Documentation of actions
DHS was assessing the service needs of the family to determine the appropriate community referral(s) to make.

County Weaknesses:
None noted

Statutory and Regulatory Areas of Non-Compliance:

Department of Public Welfare Recommendations:

None noted