



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF:**



**DATE OF BIRTH: 02/13/2009**  
**DATE OF NEAR FATALITY: 02/09/2011**

**THE FAMILY WAS NOT KNOWN  
TO ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY.**

**REPORT FINALIZED ON: 05/16/2012**

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. The county held the Act 33 meeting on March 4, 2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Victim Child	02/13/2009
██████████	biological sister	██████████ 1998
██████████	biological mother	██████████ 1973

**Significant family members relevant to this report:**

██████████	maternal cousin	██████████ 1985
██████████	paramour to ██████████	Adult
██████████	maternal cousin	██████████ 1987
██████████	maternal cousin	██████████ 1990
██████████	maternal cousin	██████████ 1988

██████████ and ██████████ are providing kinship care to ██████████ and ██████████. The paramour of ██████████ is ██████████, she resides in the home with their three year old daughter.

**Notification of Child Near Fatality:**

On February 9, 2011 the Philadelphia Department of Human Services (DHS) received a report from ██████████ concerning 2 year old ██████████. It was reported that ██████████ was ██████████ to CHOP for a ██████████. The ██████████ reported that ██████████ condition was a near fatality. Mother noted that she observed ██████████ being lethargic and blue. Mother reported that she was watching television with ██████████ when he became ill. ██████████ contacted 911 and ██████████ was transported by ambulance to

Children's Hospital of Philadelphia. The case was certified as a near fatality and [REDACTED] for [REDACTED].

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and historical case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the caseworker, [REDACTED], on March 4, 2011. In addition, follow up interviews were conducted with the on-going [REDACTED] social worker, [REDACTED]. The regional office also participated in the County Act 33 Fatality Review Team meeting on March 4, 2011.

**Summary of Services to Family:**

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

The family received [REDACTED] ([REDACTED]) from December 1, 1992 through July 26, 1993. The [REDACTED] services were through Federation of Neighborhood Centers. At that time, [REDACTED] had custody of her maternal cousins [REDACTED] [REDACTED] [REDACTED] and [REDACTED]. It was reported that their mother was unable to parent them.

07/23/2002: [REDACTED] / [REDACTED].

This [REDACTED] [REDACTED] that the home recently had a fire and that part of the home remained damaged. The [REDACTED] was the children constantly appeared to be hungry and that the children would ask the neighbors for food and money. It was reported that the children were dirty and were outside at various hours. It was reported that mother, [REDACTED], might be using drugs. The composition of the family at that time included; [REDACTED] and her child [REDACTED] (2 years old at that time), her cousins [REDACTED] (17 years old at that time), [REDACTED] (15 years old at that time), [REDACTED] (13 years old at that time) and [REDACTED] (12 years old at that time). The children were interviewed and denied the allegations. It was determined that the portion of the home that was burned, was blocked off and the children did not have access to that area. The case was closed 10/3/2002.

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

On February 9, 2011, [REDACTED] was brought into Children's Hospital of Philadelphia for [REDACTED]. Dr. [REDACTED], the treating physician, stated that [REDACTED] was in critical condition and reported the child's condition as a near fatality. Upon examination, it was evident that [REDACTED] had ingested some unknown substance. The toxicology reports were pending; however, his condition was consistent with [REDACTED] ingestion. At this time, mother reported that she had no ideas as to what happened to [REDACTED], but she was sure he did not have access to her medication ([REDACTED]). Mother did report being a former [REDACTED] and she reported that she [REDACTED].



██████████ had drunk the ██████████. She stated ██████████ appeared fine. ██████████ then laid ██████████ on the bed for a nap and a few minutes later she noticed that he was blue and not breathing. She reported that she did perform CPR on ██████████ and then she called 911. It was determined that mother left a container of her ██████████ on a table accessible to ██████████ and he drank the substance which caused an overdose reaction.

- It was determined that ██████████ was in the home of ██████████ at the time of the incident. He reported that he was downstairs watching television and ██████████ was upstairs awake. He reported that ██████████ came down stairs and started playing with him. At this time, ██████████ was upstairs. ██████████ then went back upstairs and mother later laid ██████████ down for a nap in the upstairs bedroom. Shortly after that, ██████████ heard mother scream that ██████████ was not breathing. ██████████ reported that 911 was called and ██████████ attempted to perform ██████████ on ██████████. When the ambulance arrived, ██████████ was transported to CHOP. At the time of the incident, ██████████ was not aware that ██████████ had drunk the ██████████. ██████████ was babysitting ██████████ that day from 9:00a.m. to 11:30 a.m. while ██████████ was at the ██████████. Upon ██████████ return, ██████████ left the home. ██████████ was not in the home at the time of the incident.
- On February 14, 2011 ██████████ and ██████████ were placed in the home of his maternal cousins ██████████ and ██████████ as kinship caregivers. ██████████ paramour also lives in the home with their 3 year old child. The court ordered physical custody of ██████████ and ██████████ to ██████████ and ██████████. To date, the children remain in the home of ██████████ and ██████████. ██████████ is receiving reunification services through ██████████. She continues to attend the ██████████ for ██████████ and ██████████.

### The Safety and Risk Assessment regarding CPS investigation 2/9/2011

The report alleged that ██████████ was ██████████ to CHOP for ██████████ Child ██████████ at the hospital in ██████████.

On February 9, 2011 a safety assessment was conducted by the Philadelphia Department of Human Services social worker. The safety assessment was conducted in the home of ██████████. The identified safety threats were #3 and #9. Safety threat #3: Caregiver cannot or will not explain the injuries to a child. Safety threat #3 Caregivers in the home were not performing duties and responsibilities that assured child safety. It was determined the children were unsafe and a safety plan was developed. ██████████ was placed in the home of ██████████ and ██████████, and ██████████ was hospitalized at CHOP. The safety plan was for the hospital to ensure ██████████ safety, meet his medical needs and not ██████████ without notifying DHS. DHS was to monitor the safety plan. This plan was for 48 hours. ██████████ and ██████████ signed the plan.

On February 9, 2011 a present danger assessment was conducted. Present danger was identified as [REDACTED] was hospitalized for an apparent [REDACTED] overdose. The maltreatment was identified as mother being unable to explain [REDACTED] injuries.

On February 14, 2011 a safety assessment was conducted. The identified safety threats were #3; Caregiver cannot or will not explain the injuries to a child.; #6; Caregiver cannot or will not control their behavior; #9; Caregivers in the home are not performing duties and responsibilities that assure child safety; #10; Caregiver lack of parenting knowledge, skills and/or motivation presents an immediate threat of serious harm to a child and #11; Caregivers do not have or do not use resources necessary to meet the child's immediate basic needs which presents an immediate threat of serious harm to a child.. The safety decision was unsafe. It was determined that the mother's protective capacity was diminished at the time of the incident; as she left the [REDACTED] accessible to [REDACTED]. Safety plan was that upon discharge from the hospital [REDACTED] would be placed in the home of [REDACTED] and [REDACTED] and for [REDACTED] to remain in the home.

On February 17, 2011 the risk assessment was conducted. It was determined that the overall severity and overall risk was high. For overall severity, [REDACTED] left her [REDACTED] on a table where [REDACTED] had the ability to access it. The ingestion of the [REDACTED] resulted in a near fatality.

**Current Case Status:**

- The [REDACTED] was determined [REDACTED] for [REDACTED] naming biological mother, [REDACTED], as perpetrator.
- This family continues to be an open case with DHS. The family receives kinship [REDACTED] through Lutheran Family Services.
- The DHS social worker reports that mother is compliant with [REDACTED] goals.
- [REDACTED] and [REDACTED] reside in the kinship home of their maternal cousin, [REDACTED] and [REDACTED], and his paramour, [REDACTED].
- [REDACTED] was [REDACTED] from the [REDACTED] on February 14, 2011 with the expectation that he would make a full recovery. He was [REDACTED] with no side affects of the [REDACTED]. He was immediately placed in the home of [REDACTED] and [REDACTED] and [REDACTED] were implemented.
- [REDACTED] take [REDACTED] were revoked as a result of [REDACTED] ingestion. She continues in [REDACTED] through the [REDACTED].
- [REDACTED] is functioning well with no medical complications from the [REDACTED] ingestion. According to [REDACTED] social worker, he is talking and walking at an appropriate age level.
- [REDACTED] has supervised weekly visits with the children.

**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 has convened a review team in accordance with Act 33 of 2008 related to this report. The Act 33 meeting was held on March 4, 2011

**Strengths:**

- The team felt that the DHS Social Work Services Manager did a thorough job [REDACTED] the case.
- The safety plans were completed in a thorough and timely manner.
- The team felt that DHS acted properly by obtaining an Order of Protective Custody and placing both children in kinship care.

**Deficiencies:** None were identified

**Recommendations for Change at the Local Level:** none were identified

**Recommendations for Change at the State Level:** none were identified

**Department Review of County Internal Report:**

SERO is in receipt of the Act 33 report. The report was reviewed by SERO. SERO concurs with the strengths that were identified.

**Department of Public Welfare Findings:**

**County Strengths:**

- Collaboration with the medical team and social work team at St. Christopher's Hospital for Children.
- DHS made immediate contact with extended family to obtain clearances so that kinship would be made available for [REDACTED] and [REDACTED]. This is a connected family, as [REDACTED] raised her cousins. [REDACTED] reported she treated them as her own children. [REDACTED] and [REDACTED] are bonded to [REDACTED], [REDACTED], [REDACTED] and [REDACTED].
- Timely and quality safety assessments and safety plans were completed.
- Appropriate referrals for [REDACTED] and [REDACTED] were made. [REDACTED] was referred to ChildLink and he is closely monitored by his pediatrician.

County Weaknesses:

- There are none identified.

Statutory and Regulatory Areas of Non-Compliance:

- There are no statutory or regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

- There have been several reports of children ingesting [REDACTED] prescribed to their parents. As a result there is significant need for the collaboration and integration of services for substance abuse programs and children and youth services. Also, there is a need for public service announcements to inform the public of the dangers of children being exposed to and ingesting medication that has not been prescribed for them and the ingesting of illegal drugs.
- When counties have received a [REDACTED], there should be some type of monitoring, protocol or procedure to ensure the on-going safety of the children. The 7/23/2002 [REDACTED] alleged that mother ([REDACTED]) might be using drugs. The [REDACTED] also [REDACTED] and [REDACTED] issues of the home as a result of a house fire. The monitoring could be through private provider agencies that would collaborate with the educational, medical, mental health and drug and alcohol programs.
- When poverty creates issues with housing and utilities, there should be resources and referrals available to families so that they do not have to suffer in housing that is not fit for human habitation. There should be some type of allowances made when families have children and they are unable to afford basic human utilities in their homes. At the time of the 2/9/11 near fatality of [REDACTED], it was reported that the home lacked gas and heat. According to the county worker, the home continues to need repairs and rehabilitation.