pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: May 20, 2007
Date of Incident: July 22, 2013
Date of Oral Report: July 23, 2013

FAMILY KNOWN to:
Luzerne County Children and Youth

REPORT FINALIZED ON:
8/28/14

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

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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. On August 13, 2013, Luzerne County convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	5/20/2007
	Brother	[redacted]2008
	Brother	[redacted]2012
	Brother	[redacted]1995
	Mother	[redacted]1978
	Father	[redacted]1983
	Father of [redacted]	[redacted]1976
* [redacted]	Sister	[redacted]1998

*Non-household members: [redacted] is in the custody of a maternal aunt and does not reside in the [redacted] home.

Notification of Child Near Fatality:

On July 23, 2013, Luzerne County Children and Youth received a Child Protective Services Report [redacted]. It was reported that on July 22, 2013, the victim child overdosed on the mother's [redacted] methadone. The child became unresponsive, was taken to the local fire hall where the EMT had to [redacted] the child. The physician certified the child to be in serious condition as a result of suspected child abuse/neglect.

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families received and reviewed all records from Luzerne County Children, Youth and Families pertaining to this family. The case was also discussed with the Child Protective Services Supervisor and Manager. The Regional Office was present at the County Act 33 Review meeting held on August 13, 2013.

Children and Youth Involvement Prior to Incident:

The mother was known to Luzerne County Children and Youth since 1998 after the birth of her first two children. [redacted]

[redacted]

The mother's fourth (victim child) and fifth children (father's second and third), a daughter born in 2007 and a son born in 2008, [redacted] The mother had used Heroin during her pregnancy with the victim child who was born with methadone in her system and suffered withdrawal symptoms for the first month of her life. Both parents [redacted] Subsequently, the case was closed by the agency in January, 2010.

There was a brief period of agency involvement in early 2011 when the mother [redacted]

Circumstances of Child Near Fatality and Related Case Activity:

Upon Luzerne County Children and Youth's receipt of the Near Fatality Report, the child was being transferred to Geisinger Medical Center in Danville. The mother reported that she left the methadone on the dresser in her bedroom. At approximately 7PM, the mother noticed that the child got into the medicine. The mother and father were looking on the internet for advice on what to do. They did not seek medical attention for the child until 11PM. The parents then drove their daughter, unresponsive, to the fire hall where the EMT had to [redacted] the child and she was transferred to Wilkes-Barre General Hospital. From there, she was transferred to Geisinger Medical Center in Danville.

Upon receipt of the report, [redacted] The oldest child was placed with the maternal great grandmother in Hazleton. The other two siblings of the victim child were taken to their paternal grandparents' home in Bethlehem and the victim child remained in the hospital for the night. The victim child was then [redacted] the next day to the care of her paternal grandparents.

On September 17, 2013, the CPS Investigation was concluded. Both parents were INDICATED for the Physical Neglect of their daughter including both Lack of Supervision and Medical Neglect.

Current Case Status:

The three younger children remain in kinship care with their paternal grandparents. Both parents continue to participate in [redacted] Visitation with the youngest child is twice weekly in Bethlehem supervised by the kinship parent. Visitation with the older two children began in September [redacted] The oldest child turned 18 on September 30 and chose to leave care. [redacted] He remains under the supervision of JPO and is in [redacted].

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

- Strengths:

  There were no strengths identified as a result of the Act 33 review.

- Deficiencies:

  There were no deficiencies identified as a result of the Act 33 review.

- Recommendations for Change at the Local Level:

  Determine whether Methadone clinics have a protocol in place for allowing patients with small children to have "take homes" of their methadone and whether they receive education on the dangers of ingestion of the medicine by small children.

  The panel recommended a letter be sent to drug and alcohol providers encouraging education for parents on keeping prescription medications out of the reach of small children.

  The panel also recommended the need for more systems to be represented on the death review team, particularly drug and alcohol providers and the medical community. (It should be noted that, as of the writing of this report, a pediatrician and nurse practitioner joined the Act 33 Team.)

- Recommendations for Change at the State Level:

  There were no recommendations made in regards to State systemic issues.

Department Review of County Internal Report:

The county's internal report was initially received by the Regional Office on October 7, 2013. The regional office concurs with the contents of the report; however, the Act 33 process will be further discussed below.

Department of Public Welfare Findings:

- County Strengths: The agency actively sought members of the medical community to join the Act 33 review team.

- County Weaknesses: None identified as a result of this review.

- Statutory and Regulatory Areas of Non-Compliance: There were no areas of non-compliance identified as a result of this review.

Department of Public Welfare Recommendations:

1. It had been recommended that the agency actively seek a pediatric abuse specialist to join the Act 33 Team. As of the writing of this report, the agency was able to secure the participation of a Pediatric Physician and Nurse Practitioner to join the team. They both attended their first Act 33 meeting on November 7, 2013. They were both active members of the team and it is hopeful that they will continue to participate in future Act 33 meetings.

2. Each Act 33 report submitted to the regional office by the county has been in a slightly different format. It is suggested that the agency revise and adopt a single template format to be utilized for all Act 33 written reports.