pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 9/19/09
Date of Incident: 12/11/13
Date of Oral Report: 12/12/13

FAMILY NOT KNOWN TO:

Northampton County Children, Youth, and Families

REPORT FINALIZED ON:

4/11/14

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))

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. Northampton County has 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 (VC)	9/19/09
[redacted]	Mother/[redacted] (MO[redacted])	[redacted]/81
[redacted]	Father	[redacted]/80
[redacted]	Sibling	[redacted]/99
[redacted]	Sibling	[redacted]/02
[redacted]	Sibling	[redacted]/12

Notification of Child (Near) Fatality:

On December 12, 2013 [redacted] received a report that stated that the Victim Child (VC) was taken to St. Luke's Hospital due to passing out and having a seizure in her home on December 11, 2013. VC had toxic levels of Tylenol in her blood. The doctor thought the high levels of Tylenol caused the seizures. Mother did not witness the child taking pills but earlier in day the child had [redacted] and multivitamins. Child was flown to St. Christopher's Hospital in Philadelphia for further assessment.

A Supplemental report was received by [redacted] on December 12, 2013 while the VC was at St. Christopher's Hospital. The child [redacted]. Child was certified to be in critical condition as a result of suspected neglect. Unknown if child will survive. Child tested positive for barbiturates, benzodiazepines, Tylenol, PCP. At that time, it was noted that the PCP could be a false positive. The investigation was certified a near fatality.

Northampton County Children, Youth & Families (NCCYF) received both reports on December 12, 2013 and began investigating the allegations [redacted].

Summary of DPW Child (Near) Fatality Review Activities: The Northeast Regional Office (NERO) investigation consisted of a review of the [redacted] file, interviews with

NCCYF staff, review of the VC's medical records, and participation in an internal agency meeting regarding the VC.

Children and Youth Involvement prior to Incident:

The family was not known to NCCYF prior to this incident.

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

On December 12, 2013 NCCYF began its investigation. The agency found that the VC ingested medications [redacted] The VC was [redacted] at St. Christopher's Hospital in Philadelphia, PA. The VC [redacted] was awake and continues to be under observation at the hospital.

On December 12, 2013 NCCYF requested a courtesy assessment of the VC from Philadelphia Department of Human Services (DHS) since the VC was at St. Christopher's hospital in Philadelphia County. DHS conducted the 24 hour safety assessment of the VC.

On December 12, 2013 NCCYF investigator attempted to conduct an unannounced home visit but was unsuccessful.

On December 13, 2013 NCCYF met with the VC's family to assess the safety of all of the children in the home. The children were determined to be safe in the home.

On December 13, 2013 the NCCYF investigator interviewed the AP and was told the following:

AP has numerous medications [redacted] that she stores in her night stand/drawer. All of the children are aware of the medication storage location, but have never touched it before. On the day of the incident, AP sent the children to bed at 8PM. AP, dad and the 1 year old stayed downstairs watching television. Shortly after the children were sent to bed, the VC came downstairs and asked for a drink of water. The VC drank the water and returned to bed. AP stated that VC was not acting strange. There were no issues or concerns with her at that time.

The VC's siblings [redacted] share a bedroom. [redacted] typically goes to another siblings' [redacted] bedroom at night because they have more in common. On the date of the incident [redacted] did go to [redacted] bedroom to watch television. He went to the bathroom and when he returned, the VC was coughing. He became concerned and decided to take the VC to his parents.

[redacted] took the VC down to the parents and stated that the VC was shaking. VC was shaking and not blinking. AP thought the VC was choking on something so she tried to put her finger in her mouth, but it didn't work. AP went upstairs and checked the bedrooms to see if anything was wrong upstairs. When AP got to her bedroom she saw

that [redacted] vitamins were on the floor. Mom called downstairs and asked Father to check VC's mouth. Father yelled back to mother that VC passed out. AP went downstairs and found the VC had passed out and started seizing. AP called the ambulance but decided to drive the VC to the hospital instead because the hospital was close.

[redacted]

On December 14, 2013 the NCCYF investigator conducted an announced home visit. The investigator provided the family with a lock box where the AP could store her medications. The investigator instructed the family to store all medications in the lock box. The family agreed.

On December 16, 2013 the NCCYF investigator referred the family to [redacted] with the goals of parenting education, appropriate medical storage and usage, assistance with accessing community resources and [redacted]

On December 18, 2013 the NCCYF investigator interviewed [redacted] He reported that on the date of the incident VC was in her bedroom with [redacted] VC then went to that bedroom to visit him before bed time. He reported that the VC played with toys in the closet and then laid in his bed for about five minutes. He stated that the VC peed in his bed so he moved the blankets. He stated that he woke VC up and she started coughing. He took VC downstairs. He stated that VC was shaking a lot by the speakers and then she fell. He was not sure what happened to the VC. All he knows is that the VC fell by the speaker then the FA took her the St. Luke's Hospital, then to "Philly". He stated that the FA initially called the ambulance, but ended up driving the VC because the ambulance took too long.

[redacted] stated that the AP keeps all of her medications in her bedroom so VC couldn't touch it. The younger siblings' medications are downstairs. He stated that nobody goes into AP's bedroom except the adults.

On December 19, 2013 the NCCYF investigator interviewed [redacted], She reported on the date of the incident the family was downstairs watching television together. The AP told the children to go to bed. The children went upstairs. [redacted] asked the VC where she wanted to sleep and she reported in [redacted] bedroom. VC went to [redacted] room. [redacted] stated that she fell asleep. She woke up when she heard all of the commotion. When she went downstairs AP was going up the stairs to see what happened. The FA was on the phone calling 911. The ambulance took too long so AP and the FA took the VC to the hospital.

[redacted] reported that the AP keeps all of her medication in her nightstand next to her bed. The AP never gives the children medication to keep in their bedroom. [redacted] stated that she had a bottle of [redacted] in her drawer that she thinks was disturbed because the bottle was empty.

On December 19, 2013 the NCCYF investigator met with FA. He reported that on the date of the incident the parents sent the children to bed around 8pm. VC asked to sleep in her brother's bedroom and the parents said yes. 30-45 minutes later the brother came downstairs and stated that the VC threw up in his bedroom and was shaking. FA just started getting the flu and thought that the VC was catching it too. FA told AP to grab VC a shirt. FA called 911. FA asked VC what was wrong with her. VC didn't respond. VC started coughing. FA took VC to the bathroom to vomit, but she didn't she started pulsing more. FA wrapped VC in a blanket and yelled to AP to leave. They took VC to the hospital.

FA reported that the parents were downstairs the whole time. He stated that you could hear the floor creek when someone walks around upstairs. He denied hearing anyone walking around. He reported that AP keeps track of all of the medication. He stated that he asks her for medication if he needs it.

On December 19, 2013 the NCCYF investigator met with the VC. She reported that she took white pills. VC reported that she drank a lot of water after taking the pills. VC reported that she was throwing up. (It is unclear who gave the VC the pills or if she took the pill on her own because her story changed throughout the interview.)

On December 19, 2013 the NCCYF investigator met with AP. AP reported that she sent the children to bed around 8PM on the date of the incident. She stated that the children were pretty quiet like normal. VC came downstairs for a drink. The AP gave VC some water and sent her back upstairs. She told the VC that she couldn't have any more water because she would pee on herself. [redacted]. brought VC back downstairs and said that VC was shaking. VC was shaking and wouldn't open her mouth. AP tried to put her finger in VC's mouth but couldn't get passed her teeth. AP went upstairs and saw pills on the floor. AP told FA that she thinks that VC took some pills. AP stated that she only takes the pills when she really needs them. AP tried to pick VC up but she was shaking and stiffening. VC closed her eyes and AP smacked VC on the cheek to try to wake her up. VC opened her eyes. AP wrapped VC in a blanket and took VC to the hospital.

On February 4 2014 NCCYF determined that the child's injuries were accidental. No criminal action pending.

On February 2, 2014 the case was accepted for ongoing services.

Current Case Status:

- The case has been [redacted] on February 4, 2014.
- The family is participating in parenting education through [redacted].
- There are no criminal proceedings at this time.

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

- Strengths:
- The agency was in compliance with all statutory and regulatory laws.

- Deficiencies:
- No deficiencies were found

- Recommendations for Change at the Local Level:
- None were made

- Recommendations for Change at the State Level:
- None were made

Department Review of County Internal Report:

The county report was received on February 11, 2014. The Department concurs with the county report's findings.

Department of Public Welfare Findings:

- County Strengths:
- NCCYF conducted announced and unannounced visits during the investigation.
- NCCYF assessed the safety and risk of the children as required during the investigation.
- NCCYF collaborated with the Bethlehem District Attorneys during the investigation.

- County Weaknesses: There are no concerns at this time.
- Statutory and Regulatory Areas of Non-Compliance: The agency was in full compliance with statutory and regulatory requirements.

Department of Public Welfare Recommendations:

NCCYF should continue to contact all collaterals to follow up on areas of concerns that are identified during assessments to ensure that families are receiving the appropriate level of involvement from the agency.