pennsylvania
DEPARTMENT OF PUBLIC WELFARE

# REPORT ON THE NEAR FATALITY OF:

[redacted]

**Date of Birth: 11/1/07**
**Date of Incident: 7/8/13**
**Date of Oral Report: 7/8/13**

## FAMILY KNOWN TO:

Northampton County Children, Youth, and Families

## REPORT FINALIZED ON: 9/25/13

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 did not convene a review team because the county agency completed its investigation within 30 days and determined the report was Unfounded.

## Family Constellation:

| Name: | Relationship: | Date of Birth: |
|---|---|---|
| [redacted] | Victim child (VC) | 11/1/07 |
| | Mother (MO) | [redacted]/83 |
| | Father (FA) | [redacted]/83 |
| | Sibling (Sib.) | [redacted]/04 |
| | Sibling (Sib.) | [redacted]/08 |
| | Maternal uncle (MU) | [redacted]/86 |
| | Maternal uncle's paramour (MUP) | [redacted]/88 |
| | Cousin/HHM (CO) | [redacted]/11 |
| | Cousin/HHM (CO) | [redacted]/06 |
| | Cousin/HHM (CO) | [redacted]/05 |
| | Maternal grandfather (MGF) | [redacted]/58 |
| | Maternal grandmother (MGM) | [redacted]/63 |

## Notification of Child Near Fatality:

Northampton County Children, Youth & Families (NCCYF) received the report of the near fatality related to the victim child (VC) on July 8, 2013 at 11:41P.M. The VC was last seen awake by the family around 2:30P.M. The mother found the VC unresponsive; he appeared to have vomited pills. The VC was brought to Easton Hospital [redacted] at 11:05 P.M. by ambulance. [redacted] the VC had overdosed on some kind of opiate. VC was [redacted] was not breathing on his own. [redacted] certified that the VC's condition was [redacted] VC was then sent to Lehigh Valley Hospital at Cedar Crest in Allentown. [redacted]; it was unclear if father was at the home at the time. [redacted] the VC was last seen awake 9 hours prior [redacted].

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

The Northeast Regional Office (NERO) investigation consisted of a review of the CPS 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:**

NCCYF had previously received a referral on this family on March 17, 2010 stating that: the children live in filth, the family has a kitty litter box that is over flowing, the MO only cleans the litter box when CYS calls and says that they are coming to the home. [redacted] the mother, her paramour, her three children, and another couple with children are all living in a three bedroom house. [redacted] recently one of the other children in the home had the runs and was running around the home without a diaper; there was feces all over the floor and the children were walking in it; MO doesn't have any parenting skill; the VC got out of the house and ran down the street.

NCCYF conducted an investigation. The agency determined that the allegations could not be substantiated. The agency did not provide any services to the family at that time. The case was closed at intake.

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

As described above the victim child was brought to Easton hospital by paramedics and police, following a suspected overdose of opiates; [redacted] the attending physician certified the child as critically ill [redacted].

On July 9, 2013 NCCYF began a CPS investigation. The investigator spoke to [redacted] the alleged perpetrator/mother (AP/MO) is [redacted]. It appears as though the VC took the [redacted] medications. On the same date, the NCCYF investigator went to the hospital. The NCCYF investigator spoke to [redacted] prior to meeting with the family. [redacted] reported that the VC is [redacted]. On July 9, 2013, the NCCYF investigator also spoke with the VC's family. The investigator spoke to the [redacted] that he went to work at 1:30 P.M. that afternoon. He stated that he works in Flemington, NJ. He works from 3-11 P.M. He reported that when he left for work VC was fine. FA provided the investigator with information on the household composition. He reported that he, MO, VC, VC's 2 siblings, MU, MUP and three minor cousins reside in the home. He also reported that MO/AP has [redacted] that the medication was locked in a box until last week when the lock box was stolen. [redacted] reported that the lock box has not been replaced due to the family not having the

finances to replace it. He stated that MO/AP has been keeping her medication in her purse since the lock box was stolen. When the investigator met with [redacted] VC complained of a headache so she gave the VC some Tylenol. MO/AP then told VC to go to bed since he was not feeling well. VC asked to lie on the couch instead of going to bed. MO/AP allowed VC to lie on the couch. VC reported that his head hurt so much so MO/AP placed an icepack on his head. VC fell asleep. MO/AP allowed VC to sleep through dinner, but around 10PM she decided to get VC up. When the VC would not wake up after several attempts, MO/AP called the ambulance. The ambulance and police arrived and took VC to the hospital.

On July 9, 2013, the NCCYF investigator went to assess the VC's home. She met with MUP and VC's sibling, [redacted] she saw the VC the morning of the incident. [redacted] MU was trying to wake the VC for dinner, but was unsuccessful. She reported that there was a bowl in front of VC that was filled with mucus from his nose. [redacted] MO/AP's meds were kept in a lock box until it was stolen a week prior to the incident. Now MO/AP keeps her medications in her purse. She reported that she takes her medication 1-2 times a day and believes she is coherent after taking her medication.

[redacted], thinks that VC bumped his head. VC was playing by himself. VC gave MO/AP her wallet out of her purse. [redacted] reported that after breakfast VC had a migraine. VC reported that he was dizzy. MO/AP gave the VC 2 teaspoons of liquid Tylenol. [redacted] sat next to VC while he slept. VC wouldn't wake up. VC had white stuff coming out of his nose. The family tried everything to wake VC up, cold water, shook him, tried to stand him up, but they were unsuccessful. [redacted] thought that VC had a migraine and a heat stroke. [redacted] that MO/AP kept the medicine in the lock box until it got stolen. [redacted] that MO/AP keeps the medicine in her purse or the closet now because the VC steals from MO/AP's purse. VC goes into MO/AP's purse a lot. MO/AP is aware of VC going into her purse. VC has given MO/AP her medicine to make her feel better.

On July 9, 2013 the NCCYF investigator also interviewed: [redacted] maternal great aunt. (MGA), [redacted] (sibling), [redacted] (HHM/cousin), and [redacted] (HHM/cousin).The MGA and the children listed were not at the home at the time of the incident. [redacted] she often takes the children to assist the parents out. [redacted] the VC is a handful and she often takes him by himself in order to keep up with him. [redacted] that MO/AP would never do anything to harm her children. [redacted] MO/AP has [redacted] VC took the medication out of his mother's purse because he knows she takes medicine when she is sick. [redacted] believes this was an accident. [redacted] would not put it past the VC to go in MO/AP's purse and take out her medication.

On July 10, 2013 [redacted] VC was doing well [redacted] VC was able to first start talking, he admitted he went into his mother's purse and took the medication. The doctors are only concerned about the mother being more careful with her medications. [redacted] it is reasonable to allow a child to sleep for long periods of time especially if they are not feeling well. [redacted] did not test the VC's blood [redacted]

On July 11, 2013 [redacted] he doesn't have much information to add to what happened. [redacted] when he got home from work the VC was still sleeping. He tried to wake the VC up around 9ish and that's when everything happened. [redacted] VC had a white substance coming from his mouth. [redacted] mother told him she gave the VC Tylenol because he complained of a headache. He said the VC rarely gets sick or sleeps during the day, and that the VC has never touched the mother's pills. He did acknowledge the VC has gone in the mother's purse for gum or other small items.

On July 11, 2013 the [redacted] parents care.

On July 17, 2013 a NCCYF caseworker conducted an unannounced home visit and found MO/AP's purse on a chair in the living room with the medication visible. The caseworker was concerned with MO/AP's inability to secure her medication.

On July 18, 2013 [redacted] the MO/AP a lockbox to store her medication.

On July 31, 2013 the NCCYF investigator [redacted] the day of the incident he got up in the morning and had cereal for breakfast. [redacted] playing with his brother. [redacted] his mom asked him to get her cigarettes in her purse and when he went to get them, he heard a shaking noise. [redacted] he turned around and saw [redacted] (his little cousin/HHM) shaking the pill bottle. [redacted] his little cousin/HHM had the bottle because early in the morning, The MU asked MO/AP if he could have one of her pills. [redacted] he doesn't know how his little cousin/HHM got the bottle. VC took the bottle from his little cousin/HHM. [redacted] he had a really bad headache so he wanted to see if it will help with his headache. [redacted] he took 1 pill with a bottle of water. [redacted] it helped with his headache but made him tired. [redacted] he went to bed. [redacted] he doesn't remember anything after that. [redacted] waking up with a [redacted] he wasn't able to talk. [redacted]

was laying down in the living room. [redacted] before he took the medicine he tried to go to sleep but that didn't work. [redacted] he goes in his mother's purse lots of times. [redacted] his mother knows he goes into the purse because she yells at him for taking things. [redacted] his mother used to keep her medicines in a lock box in the cabinet on the top shelf. [redacted] the only medicine mommy keeps in her purse is [redacted] takes Aleve when he has a headache because he is a big boy. [redacted] now mommy keeps all her medicines in the lockbox on top of the shelf.

On August 1, 2013, NCCYF concluded the investigation. The report received an Unfounded status. NCCYF determined that the AP's actions did not constitute serious physical neglect as defined under the CPSL 6303 (a)(b) which defines neglect as prolonged or repeated lack of supervision resulting in a physical condition. No criminal action is pending.

**Current Case Status:**

- The case has been accepted for services
- The family is participating in parenting education through [redacted]
- The family has been referred to [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:**

Northampton County did not convene a review team meeting or submit a Near Fatality Report because the investigation of the abuse report pertaining to this near fatality was concluded within 30 days of receipt and based on the available information was determined to be unfounded.

**Department Review of County Internal Report:**

N/A

**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 areas of concern at this time.
- Statutory and Regulatory Areas of Non-Compliance:
- NCCYF was in full compliance with statutory and regulatory requirements during this investigation.

**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.