



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 4/14/13
Date of Incident: 1/21/15
Date of Report to ChildLine: 1/21/15

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF
INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Montgomery County Children and Youth

REPORT FINALIZED ON:
August 10, 2015

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. Section 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Montgomery County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on February 18, 2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	04/14/2013
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1987
[REDACTED]	Sibling	[REDACTED] 2010

Notification of Child Near Fatality:

On 01/21/2015 Montgomery County Children and Youth received a report that on the said day the victim child's father found the victim child in a comatose state on the floor. The victim child ingested the mother's [REDACTED] medication [REDACTED] when the mother had fallen asleep on the couch. The medication was in the mother's purse on the floor. The mother reported that the bottle was child proof. The victim child was [REDACTED] while hospitalized and [REDACTED] of Lehigh Valley Hospital certified the case as a Near Fatality.

The family reported that the victim child had a cold and the mother had been up late with the victim child. The mother reported that she fell asleep on the couch and the victim child got into her purse and accidentally ingested the [REDACTED] without her knowledge. The father reported that he kept making 15 minute checks on the mother and the victim child and that the mother was awake during the last check he had made before discovering the victim child passed out on the floor in the family room. The father gave the victim child Red Bull hoping that the high caffeine content would stimulate the victim. When the victim child did not respond, she was taken by ambulance to Grandview Hospital and then transferred to Lehigh Valley Hospital. Both parents have been cooperating with Montgomery County Office of Children and Youth and the caseworker believes they have been quite honest about their past which does include a history of drug use: Marijuana, [REDACTED] Cocaine, [REDACTED].

Summary of OCYF Child Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the county intake supervisor on February 18, 2015. The Regional Office also participated in the County Fatality Review Team meeting on February 18, 2015, where sources of information were shared amongst the ACT 33 review team.

Children and Youth Involvement prior to Incident:

There was no Montgomery County Office of Children and Youth agency involvement prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

The incident occurred on 1/21/15 and the report was made on the same day to Montgomery County Office of Children and Youth. All relevant parties were interviewed and the home was assessed for the safety of the victim child and her 5 year old sibling. The sibling was also medically assessed and there were no concerns. The paternal grandparents and the paternal aunt have been included in the safety plan. The plan stipulates that they will reside at the home with the family on a rotational basis to ensure the safety of the children.

Current Case Status:

The Child Protective Service (CPS) determination was unfounded and the county offered ongoing case management services to the family including in-home services and parenting classes. The safety plan included the paternal grandparents and paternal aunt staying at the home on a rotational basis to care for the children. The safety plan is reviewed every 30 days, amended accordingly and a new plan is mailed to the family.

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

- Strengths:

There was collaboration between the county and the multidisciplinary team during the investigation.

- Deficiencies:

There were no deficiencies by the county and the county was found to be in compliance with regulations and statutes regarding children and families.

- Recommendations for Change at the Local Level:

None

- Recommendations for Change at the State Level:

It is recommended that the State Association of Pharmacologists should issue guidelines around the use of tamper-proof pill containers.

Department Review of County Internal Report:

The Southeast Regional Office of Children, Youth and Families received the county review team report on 06/11/2015 and agreed with the report and its findings with written feedback on July 20, 2015.

Department of Human Services Findings:

- County Strengths:

The county worked collaboratively with the police and the multidisciplinary team members and ensured the safety of [REDACTED] and her sibling.

The CPS was determined to be Unfounded however ongoing services were still offered to the family

- County Weaknesses:

There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency

There were no areas of noncompliance and no LIS was issued to the county agency.

Department of Human Services Recommendations:

The Department did not have any recommendations regarding the monitoring and inspection of the Montgomery County Office Children and Youth. This case was not the result of services not provided by the County. The County completed a thorough investigation.