



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: [REDACTED], 2006
Date of Near Fatality Incident: April 9, 2010

**The family was known to
Montgomery County Office of Children and Youth**

Date of Report: October 28, 2010

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. Montgomery County has convened a review team in accordance with Act 33 of 2008 related to this report on March 4, 2010.

Family Constellation

<u>Name:</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	[REDACTED]/2006
[REDACTED]	Mother	[REDACTED]/1981
[REDACTED]	Sibling	[REDACTED]/2001
[REDACTED]	Sibling	[REDACTED]2009

Other Family Member

[REDACTED]	MGM	Adult
[REDACTED]	Father	[REDACTED]1980
[REDACTED]	Father of [REDACTED]	[REDACTED]/1977

Notification of Child Fatality

On April 9, 2010 Montgomery County Office of Children and Youth received the [REDACTED] stating the victim child (VC), age three, was brought into the ER at 7:30 pm by his mother and was unresponsive and severely hypoxic. The mother stated that she couldn't wake him up. The VC presented with an [REDACTED]. The mother is in a [REDACTED] program for [REDACTED]. The mother stated that she keeps her [REDACTED] in a locked box. VC was given [REDACTED] and immediately responded to it. Initially his respiration was a three (normal rate for toddlers and children one-five years is 20-30 breaths/min). The doctor certified that the victim child was in critical condition and would consider the incident as a near fatality due to lack of supervision on someone's part. The VC was transferred to Children's Hospital of Philadelphia (CHOP). The mother stated that she was not missing any of her [REDACTED]

Summary of DPW Child Fatality Review Activities

For this review, the Southeast Regional Office (SERO) reviewed the county's investigation reports, spoke with assigned Montgomery County investigative worker, reviewed the In-Home Safety Assessment and Risk Assessment work tools, interviewed the Montgomery County caseworker, and reviewed the prior case record and medical records from CHOP. SERO attended the Act 33 review on March 4, 2010

Summary of Services to Family

Children and Youth Involvement Prior to Incident

Referral/Assessment 08/26/05 thru 12/05/05; On August 26, 2005 Montgomery County Office of Children and Youth received a referral regarding the family concerning the children's hygiene, shelter and supervision. At the time of the report, the mother was primary caretaker for the oldest child. This referral/assessment was closed out on December 5, 2005. No other information is available for this report because the family was not accepted for services.

Referral/Assessment 6/30/09 – 09/17/2009 Low Priority; On June 30, 2009 Montgomery County Office of Children and Youth received a report from . The reporting source stated that the mother delivered a female child, , through at 34 weeks gestation. The child was premature and tested . The mother is in a program for an . The mother tested positive for . She admitted to usage during her pregnancy, most recently the mother admitted to using on June 7, 2009. She stated that the helped decrease her nausea and helped her to eat. At the time of the report, the mother and the children were residing in Conshohocken, Pennsylvania. The child's father is a and is on probation. He is not allowed to reside in the home with as a condition of his probation.

Montgomery County Office of Children and Youth family for in-home intensive services due to the child being premature and having ongoing medical needs. The initial was developed on September 17, 2009. The concurrent goal listed on the plan was placement with a relative. In-home services were developed to help the mother keep all medical appointments and to ensure that the family was linked to appropriate community services. Montgomery County conducted monthly visits to the family home, maintained ongoing contact with the family via phone, and made collateral contacts with the schools. The clinic confirmed that mother's urine tests had been negative, that she had been approved for three take-home doses, and was in the process of stepping down the dose. Reports from doctors and school personnel involved with the children were positive and Montgomery County had no on ongoing concerns. On March 2, 2010 at the case closing, the in-home safety assessment determined that all the children were safe at home with their mother as their needs were being met and there were no signs of abuse or neglect. The father's probation officer confirmed that he is fully cooperative with probation and treatments. He will be required to enter therapy with the children's mother prior to being permitted to live in the home. There are no restrictions on the father

residing with his other children while residing at his mother's home in Ambler, Pennsylvania.

Circumstances of Child Fatality and Related Case Activity

The mother stated that she took the victim child and his two younger siblings to McDonalds for lunch that day after getting her [REDACTED]. She put the children down for a nap when they got home from McDonalds and noticed that the victim child had difficulty waking up and he kept falling back to sleep. The victim child was initially taken to Montgomery Hospital and transported to Children's Hospital of Philadelphia (CHOP) the same day, April 9, 2010, at approximately 10:30 pm. He was in respiratory distress and the doctors believed that he [REDACTED]. He was [REDACTED] from CHOP on April 11, 2010. While at Montgomery Hospital, he was given [REDACTED] and responded immediately. The child's mother attends a [REDACTED] clinic and was given a [REDACTED] the same day, April 9, 2010. According to the mother, the victim child accompanied her to the clinic that day. They were separated at the clinic. The mother attended to her appointment and he was taken to a staffed play area. There are no children allowed in the [REDACTED]. The patients are educated on the effects [REDACTED]. The [REDACTED] are regulated and must have DEA approval. The mother stated that she keeps her [REDACTED] in a locked box at home. The mother's statement about keeping her [REDACTED] treatments in a locked box was confirmed by the children and youth caseworker during a safety assessment home visit on April 10, 2010. The mother was reported to be overwhelmed with the care of the three children. The victim child was residing with his mother and two of his siblings at the home of his maternal great grandmother. The victim child's half sibling is residing with her grandmother. The siblings are [REDACTED], and [REDACTED]. [REDACTED] are full siblings and are residing together.

On May 10, 2010, the report was [REDACTED] on the mother based on medical evidence. It was determined that if not for the mother's lack of supervision, the child could not have or even been exposed to the [REDACTED]. The mother had been compliant with her treatment and a [REDACTED] showed that the child had [REDACTED] in his system within range of a onetime dosage. All the tops on the [REDACTED] containers were closed and there were child proof tops on all the medication bottles. All the medication was accounted for during the course of investigation. It is unknown as to how the child got into the medication. There were no criminal charges filed against the mother because law enforcement determined that no criminal activity had occurred.

Current Case Status:

The case was [REDACTED] due to the fact that it meets the [REDACTED]. The medical evidence supports that the child did ingest [REDACTED]. The incident occurred under the mother's supervision. The county did not take custody of the children. The family accepted services and the case was transferred to in-home services. The services were focused on supportive services for the mother to ensure that the children maintained all medical appointments and met all educational milestones. The mother and two younger children are residing with the maternal great

grandparents. The safety plan is that the mother is not to be left alone with the children. The older child resided with her maternal grandmother who resides within the child's school district. The mother was in compliance with her [REDACTED] and attended parenting class. The family was connected to community resources to help with the utilities and child care. The father was not residing with the family.

On September 20, 2011, the mother gave birth to another child, [REDACTED]. At the time of birth, the mother was residing in an apartment with the two younger children. The newborn child remained in the hospital until she was [REDACTED] to the mother's home on November 1, 2011. The child was found unresponsive by the mother and declared dead on November 30, 2011. The family was not active with the county at this time. The county referred the family to a support group for families [REDACTED]. The family was also referred to the [REDACTED].

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

Act 33 of 2008 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 May 7, 2010 a near fatality review was convened in Montgomery County.

- Strengths: None noted in Act 33 report.
- Deficiencies: None noted in Act 33 report.
- Recommendations for Change at the Local Level:
 1. OCY has an internal review risk assessment for children under the age of five years who become known to OCY for drug-related issues. This review is convened by the director of social services; in all cases, caseworkers will be required to be alerted to assure appropriate handling of take-home doses of [REDACTED]. The case worker will check the lock boxes during the home visit to assure they are located out of the reach of the children and secured.
 2. The fatality team's drug and alcohol representative provides information to the OCY staff regarding drug overdoses.
 3. The [REDACTED] clinics should take extra measures to assure that parents have safety controls in place to avoid such events occurring in the future. It is further recommended that [REDACTED] doses be contained in a child proof or sealed vessel.
- Recommendations for Change at the state level: None noted in the Act 33 report.

Department Review of County Internal Report

The Department reviewed the county's internal report and agrees with the findings as noted in the report. The Near Fatality of the child was the result of the lack of supervision of the parent which resulted in the child being able to ingest the parent's outpatient [REDACTED] prescription treatment which led to the child's near fatality condition.

Department of Public Welfare Findings

- County Strengths: The Montgomery County Office of Children and Youth completed a comprehensive [REDACTED] investigation. The county obtained all necessary documentation that included police reports, medical examiners reports and medical/hospital reports. The county interviewed all individuals pertaining to the investigation.
- County Deficiencies: No deficiencies were identified.
- Statutory and Regulatory Areas of Non-Compliance: No statutory or regulatory areas of non-compliance were identified.

Department of Public Welfare Recommendations

SERO recommends that the Department continue to encourage public Methadone treatment clinics to issue take-home lock boxes with their take-home prescriptions and to increase monitoring of take-home doses where there are children in the home five years old and under.