



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA¹ REPORT

In the Matter of
Natalie Sampson
Minor Child²

9-03-2009-00006

November 20, 2009

¹ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission (“CDNDSC”) was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child’s death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Natalie Sampson is considered a near death incident. At the time of the incident, the child was approximately two years and seven months old and residing with the mother and mother’s paramour.

At the time of the incident, the mother and her paramour had dropped the child off at the paramour’s aunt’s home for child care while the couple went shopping. The paramour’s aunt was caring for the child in her home that day. The aunt left the child unattended momentarily in the afternoon in order to go to the bathroom. Upon her return, the relative apparently found the child eating Zyprexa tablets. The aunt apparently called 911 and reported the child ate approximately 5 Zyprexa tablets and was having difficulty breathing. EMS brought the child to the Emergency room with no adult, as the aunt had fled the scene once the ambulance had arrived. In the Emergency room, the child was noted to have waxing and waning mental status with periods of agitation and drowsiness. Due to her altered mental status and in order to protect her airway, she had a breathing tube placed, was placed on mechanical ventilation and transferred to the intensive care unit. At the hospital, the child’s mother and mother’s paramour smelled of alcohol and either marijuana or cigarette smoke. The child improved quickly and was able to breathe on her own the next day. The parents were noted to be inattentive, leaving side rails down on crib with child attended and sleeping with child in cot when told it was unsafe.

Upon further review the child was found to have not seen her primary medical care provider in over one year and was behind on her immunizations. There were previous allegations of neglect by the mother, however, at that point in time, there was not enough information to warrant a DFS investigation.

The police conducted an investigation on this incident and intake with the appropriate agency. No charges were filed as it was determined that this incident was an accidental overdose.

Additionally, two years prior to this incident, at the age of 2 months the child was taken to the Emergency room for minor head/body contusions and lip contusions. It was

reported by the mother that the child had fallen from her stroller onto the sidewalk. The child was vomiting, had an abrasion/contusion on the upper right lip, and had bleeding from the gums. No history as to why and under what circumstances this incident occurred were recorded in the medical history, No report or concern was raised regarding how a 2 month old fell out of a stroller face first if the infant was buckled in appropriately and the stroller was being used appropriately. No report was made or suspicion raised by medical personnel.

System Recommendations

The following recommendations were put forth by the Commission:

- (1) Based on community behaviors that could minimize and/or prevent another near death, the panel recommends a community outreach effort to educate parents on keeping their child safe while in the care of a babysitter. Specifically, parents should thoroughly investigate the homes in which they are leaving their children to ensure a safe environment that is free of hazards, where medications and toxins are out of reach and should always ensure that any caregiver can reach a parent easily by phone in case of emergency.

The facts of the case indicate that the child was under the supervision of her aunt at the time that the medication was ingested. If the child was properly supervised this near death incident would have been prevented.

Ancillary Factors³

The following ancillary factor was identified and will be evaluated by CDNDSC for possible action:

- (1) Lack of primary medical care follow up.

There was poor follow up with regard to medical care as the child had not seen by her primary medical care provider in over one year.

- (2) Education for medical professionals regarding proper documentation of incident information and injuries.

At two months of age, the child presented to the emergency room after reportedly falling out of a stroller. The most likely scenario for this event, if the infant did indeed fall out of the stroller face first, is that the mother was not strapping the child in appropriately or

³ In some cases there may be no system practices or conditions that impacted the death or near death of the child; however, if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.

using the stroller as intended. The incident was poorly documented in the medical records and it does not appear as though a hotline report was made.