pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/05/2016
Date of Incident: 09/17/2016
Date of Report to ChildLine: 09/18/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Northampton County Children, Youth and Families

REPORT FINALIZED ON:
03/21/2017

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))

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Reason for Review:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Northampton County completed their investigation under 30 days with an unfounded status therefore the county was not required to conduct an Act 33 meeting.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	09/05/2016
[redacted]	Biological Mother	[redacted]1986
* [redacted]	Alleged Father	1979
[redacted]	Biological Father	1969
[redacted]	Half-Sibling	[redacted]2011

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the prior Child Protective Services (CPS) referral file and the current CPS file.

Children and Youth Involvement prior to Incident:

On 03/03/2016 the agency received a referral with concerns that the victim child's mother did not have custody of her two older children and she was 5 months pregnant with the victim child, [redacted] and using drugs. This referral was screened out because the mother was not living with any children.

On 09/15/2016 the agency received a CPS report with allegations that the victim child's alleged father pushed the mother down the steps while holding the victim

child. This report was registered for "creating a reasonable likelihood of bodily injury." The alleged father was incarcerated and charged with simple assault, endangering the welfare and recklessly endangering another person. This report was investigated and indicated on 10/12/2016 naming the alleged father as the perpetrator.

On 09/15/2016 the agency received a GPS report for inadequate parenting. This report was validated by the agency on 11/10/2016.

On 09/16/2016 the agency received a second CPS report with allegations that the mother was abusing drugs and had been nodding out with needles in her arm and the victim child was hanging off the couch. This report was registered for "creating a reasonable likelihood of bodily injury." This report was investigated and unfounded on 10/17/2016.

The agency responded to both of these referrals on 09/16/2016 and met with the mother and the victim child. The mother had a scheduled appointment with the pediatrician later that same day.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/16/2016 the mother had taken the child to the pediatrician for a well visit. The mother expressed concerns that the victim child was increasingly irritable and was "just not right." The mother was [redacted] during the pregnancy and the victim child was observed in the hospital for 5 days post-delivery and did not exhibit any concerns. The pediatrician referred the victim child to the hospital [redacted] The victim child was admitted to St. Luke's Hospital [redacted]

On 09/17/2016 at approximately 10:45PM while the victim child was at St. Luke's Hospital, the mother was moving the victim child from the bed to the crib when she tripped and fell. The mother held the victim child during the fall and his head struck the edge of a tray table. The victim child cried but was able to be calmed and was taken for an x-ray [redacted] was recommended as the victim child seemed "more quiet" [redacted] than previous to the fall. [redacted] showed that the victim child had [redacted] On 09/18/2016 the agency received a third CPS report identified as a near fatality naming the mother as the alleged perpetrator. The certifying physician did not believe the victim child's injuries were consistent with the incident as reported by the mother and reported that the victim child was in serious condition based on suspected abuse and neglect.

On 09/18/2016 the victim child was transferred to St. Christopher's Hospital for Children. On 09/20/2016 a preliminary safety assessment was completed and a safety plan was implemented. The safety plan was that the mother was to have no unsupervised contact with children under the age of 18. The victim child remained

at St. Christopher's Hospital for Children until 09/21/2016 and was then transferred back to St. Luke's Hospital [redacted]

While at St. Christopher's Hospital for Children the victim child was evaluated by the Child Protection Team. It was determined that the injury the victim child sustained was accidental and witnessed. Due to the age of the child and location of injury, a follow up skeletal survey was recommended to be completed within 2-3 weeks of the victim child's [redacted]

On 10/11/2016 the agency unfounded the CPS investigation stating "The Child Protective Services investigation concluded that the allegations of the bodily injury could not be substantiated in accordance with the CPSL. The alleged perpetrator (AP) did not knowingly, recklessly and/or intentionally cause substantial pain or impairment to the child's physical condition."

The agency continued to assess the family under the General Protective Services intake that was received on 09/15/2016. The mother was compliant [redacted] throughout the first 3 CPS investigations. The mother submitted to random urine screens and only yielded positive results for [redacted]

[redacted] referral was made and services started in the home with the mother on 09/28/2016. The victim child [redacted] at St. Luke's until 09/30/2016. [redacted] the mother and victim child resided with the victim child's 5 year-old half sibling and the half-sibling's father while the mother was looking for more permanent housing.

On 10/19/2016 the victim child was evaluated by the Child Advocacy Center in Allentown, Pennsylvania where the victim child received a skeletal survey. This report confirmed the initial findings of the Child Protection Team at St. Christopher's Hospital for Children and no new injuries were noted on the skeletal survey.

On 10/26/2016 the agency received a fourth CPS report naming the mother as the alleged perpetrator for "creating a reasonable likelihood of bodily injury." The referral stated that the mother had the victim child with her in a hotel while she was smoking crack and using heroine with an adult man. The mother was arrested and a safety plan was completed with the maternal great aunt. While family was able to be identified, no family was able to commit to long term care of the victim child.

[redacted] the victim child was placed in foster care. [redacted]

[redacted]

On 11/08/2016 the mother was detained on a probation violation for admission of using methamphetamine and positive drug screens. The mother remained incarcerated [redacted] The mother was transferred [redacted] on 01/13/2017.

On 11/22/2016 the agency indicated the mother for child abuse stating "The Child Protective Services investigation concluded that the allegations of bodily injury could be substantiated in accordance with the CPSL. The perpetrator did knowingly, recklessly and/or intentionally create a reasonable likelihood of bodily injury to a child through any recent act or failure to act in that the perpetrator admitted to the allegations."

Paternity for the victim child was recently established. Visits have started with the identified biological father. The victim child remains in foster care with a goal of reunification and a concurrent goal of adoption.

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

The CPS report was unfounded in under 30 days and there was no Act 33 meeting held; thus, there was no report completed.

- Strengths in compliance with statutes, regulations and services to children and families;
  Not Applicable

- Deficiencies in compliance with statutes, regulations and services to children and families;
  Not Applicable

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  Not Applicable

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  Not Applicable

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Not Applicable

Department Review of County Internal Report:

The CPS report was unfounded in under 30 days therefore there was no report to review.

Department of Human Services Findings:

- County Strengths:
  The agency completed thorough investigations of all reports. The agency gathered information from service providers and medical professionals.

- County Weaknesses:
  Safety Assessment and identification of appropriate safety actions continues to be a struggle for the county agency. The safety plan actions should be specific and measurable and be sufficient to manage safety.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  Not Applicable

Department of Human Services Recommendations:

- It is recommended that the agency continue to complete timely and thorough child abuse investigations.

- It is recommended that the county safety leads implement safety support sessions as modeled by the Child Welfare Resource Center and NERO.