pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Mason Blum

Date of Birth: 05/12/2015
Date of Death: 11/01/2017
Date of Report to ChildLine: 11/02/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Northampton County Children, Youth and Families Division

REPORT FINALIZED ON:

04/10/2018

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:

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/28/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Mason Blum	Victim Child	05/12/2015
[redacted]	Biological Mother	[redacted]1983
	Half-Sibling	[redacted]2006
	Biological Father	[redacted]1991
	Sibling's Father	[redacted]1983

* 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 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 agency history with the family and current [redacted] file. NERO attended the Act 33 meeting convened on 11/28/2017.

Children and Youth Involvement prior to Incident:

The Northampton County Children, Youth and Families Division (NCCYFD) had minimal involvement with the family prior to the incident. The agency was able to determine that there was a referral in March 2010. The agency records indicate that the report was assessed and closed as [redacted] and [redacted] were residing in [redacted] with a relative and that [redacted] had numerous family supports. All other information regarding this incident has been expunged.

The agency had received and screened out a referral in February 2015. The allegations report that [redacted] is using drugs [redacted]. [redacted] did not have any kids in [redacted] custody at the time and [redacted] was involved with probation.

There was also a [redacted] report regarding the victim child's sibling and [redacted] The allegations involved physical abuse with [redacted] as the alleged perpetrator and the victim child's sibling as the victim child [redacted] obtained primary custody after this incident. At the time of the report [redacted] compliant with the probation department. Upon conclusion of the investigation the case was [redacted] The report was [redacted] and [redacted]

Circumstances of Child Fatality and Related Case Activity:

The agency received a [redacted] report on 11/02/2017 with allegations that [redacted] caused the death of the victim child [redacted] on 11/01/2017. The referral states that the half sibling had visitation with [redacted] and [redacted] failed to pick up the half sibling at the conclusion of visitation. The half sibling's [redacted] went to the home and was unable to make contact with [redacted] proceeded to contact law enforcement to complete a welfare check on the victim child in the home. When law enforcement accessed the apartment [redacted] was found on the couch and the victim child was found deceased in the bathtub. Drug paraphernalia was found in [redacted] home and blood test had been taken. [redacted] was charged with involuntary manslaughter, endangering the welfare of a child and possession of drug paraphernalia.

NCCYFD began an investigation upon receipt of the report. The agency had been advised [redacted] that [redacted] was currently incarcerated, would not speak with the police and had requested an attorney. Law enforcement had learned from initial interviews that the child had some physical disabilities, was receiving services and was unable to put himself into the bathtub. [redacted] did tell the coroner [redacted] must have been the one to put the child into the bathtub.

With permission [redacted] the agency met with [redacted] at the correctional facility. [redacted] reports that [redacted] had an argument with the victim child's [redacted] and [redacted] had left the home. [redacted] recalls taking the victim child's sibling to visitation, returning home and feeding the victim child. [redacted] could not recall the events for the rest of the evening. [redacted] admitted to arguing with [redacted] paramour about stealing money and using the money to purchase methamphetamines. [redacted]

The agency completed an interview of the victim child's sibling's [redacted] The victim child's sibling's [redacted] had already applied for full custody on 11/02/2017 and was in the process of setting up [redacted]. The victim child's sibling's [redacted] reports [redacted] was concerned [redacted] had relapsed when [redacted] didn't show for pick up based [redacted] speech and demeanor when dropping off [redacted] son.

The victim child's sibling was also interviewed and reported that [redacted] was saying things that did not make sense after school on the date of the incident. The victim child's sibling did report that [redacted] and [redacted] were fighting about money, that [redacted] paramour left the home, and [redacted] fed the children dinner prior to visitation.

The agency then attempted to interview the victim child's [redacted] at the residence. Upon arrival [redacted] was packing some items and was planning on leaving the home. [redacted] advised that he worked full time while [redacted] stayed home. [redacted] reported that [redacted] was very involved in [redacted] for their son. [redacted] did admit that [redacted] and argued over [redacted] concerns of [redacted] and missing money. [redacted] did leave to go to a friend's home and was not allowed back into the home when [redacted] returned. [redacted] would not provide the caseworker any other information, including the address of where [redacted] was moving. [redacted] did allow the caseworker to have a photograph of the victim child and take photos of the layout of the home. Several family members were assisting [redacted] and were willing to discuss family resources but not provide an address of where [redacted] was planning on going.

Collateral contacts were made to the agencies providing [redacted] All agencies report that [redacted] was involved and diligent in providing services to the victim child. The appointments were rarely cancelled and when they were they were rescheduled timely. [redacted] The agencies involved did attend the Act 33 meeting and discussed being aware of [redacted] drug and alcohol history. They report that [redacted] was engaged in services and it was evident [redacted] worked with the victim child between visits based on his progress.

The agency learned that a urine drug analysis conducted at the correctional facility yielded positive results for [redacted], Meth, [redacted], THC, [redacted] A preliminary autopsy shows no signs of trauma and it appears that primary cause of death is drowning.

[redacted] has a prior criminal history of burglary and theft as well as mental health and substance abuse issues [redacted] had been involved in [redacted] and the agency obtained records dating back to June 2017. [redacted] openly discussed [redacted] concerns and [redacted]

regarding [redacted] older son. [redacted] did have a positive [redacted] screen in August 2017 and [redacted]

On 12/01/2018 the agency filed [redacted] status naming [redacted] as the perpetrator for causing the death of a child through recent act or failure to act and for causing serious physical neglect, failure to supervise.

[redacted] remains incarcerated and the criminal investigation is ongoing. [redacted] has moved to [redacted] and does not wish to have contact with the agency.

The agency completed a [redacted] report on the victim child's sibling's [redacted] home. The intake was received on 12/07/17 with concerns that [redacted] had previously lost custody due to a domestic violence incident that occurred a few years prior. The agency met with the victim child's sibling on several occasions and was able to ensure that the family is receiving [redacted] and has various family resources. [redacted]

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

Strengths in compliance with statutes, regulations and services to children and families;

- A strength for this case was the coordination with law enforcement and District Attorney's office throughout the case that continued even after case closure by the Agency. [redacted] was also forthcoming in information pertinent to the case.

Deficiencies in compliance with statutes, regulations and services to children and families;

- There was a delay in reporting the abuse to Childline, however no deficiencies were discussed related to regulation and protocol.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

- The team discussed at length how to improve communication between [redacted] and CYF, [redacted] regulations make it very difficult for Children and Youth staff to obtain specifics in updates [redacted]. In this case, the question is: "if [redacted] staff was aware that [redacted] and was the primary caretaker for the 2 year old child with physical disabilities, would a call to the agency have changed anything?" The recommendation is [redacted] staff

to make a Childline report if there are young children in the home and an adult caretaker [redacted]

- [redacted]The team on state and higher level would like to recommend that the level of confidentiality between human services teams be relaxed to some extent. As mandated reporters, [redacted] staff should be able to tell involved agency workers that a parent [redacted]

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

- None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

- [redacted]The team discussed that when the referral was received due to [redacted] drug use [redacted]
- Team also discussed that all in home service providers should be better trained on drug and alcohol symptoms, to better be able to spot signs [redacted]. While even in hindsight, the providers do not think they missed signs, knowing what to look for could possibly help in the future.
- Locally the team is going to reach out to [redacted] providers, to start a discussion regarding how to better support parents of young children. When should [redacted] include having an adult to watch the children if [redacted] plans to use. Can agencies better work jointly to improve support systems?
- In this case [redacted] of the victim was aware [redacted] had [redacted], but because [redacted] was not high when [redacted] left [redacted] to care for the child. The [redacted] was also aware [redacted] was using and allowed [redacted] to drive the child from the meeting place back to the house. The team members will talk to [redacted] teams to see if family could be brought in to [redacted] to discuss this type of information, so family is more aware to not leave their own children at risk.

Department Review of County Internal Report:

The NERO received the county report timely on 03/01/2018. The NERO does concur with the findings in the county report.

Department of Human Services Findings:

County Strengths:

- The agency completely a timely investigation and worked collaboratively with law enforcement. The agency gathered information

from community providers and the Act 33 meeting focused on potential changes to collaboration between agencies.

- The agency ensured safety of the victim child's sibling and completed a [redacted] assessment of his home.

County Weaknesses:

- There was a delay in reporting the fatality by one day. This was discussed at the Act 33 meeting.

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

- None

Department of Human Services Recommendations:

DHS concurs with the Act 33 team's recommendation that "The team discussed at length how to improve communication between [redacted] providers and the agency [redacted]. Currently [redacted] regulations make it very difficult for agency staff to obtain specifics in updates [redacted]"

DHS further recommends ongoing training for mandated reporters regarding when to report allegations of suspected child abuse and/or neglect.