pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 12/02/2017
Date of Incident: 12/22/2017
Date of Report to ChildLine: 12/22/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Northampton County Children, Youth and Families Division

REPORT FINALIZED ON:
06/14/2018

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 01/22/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	12/02/2017
	Mother/ Perpetrator	[redacted]1987
	Father/ Perpetrator	[redacted]1990
	Maternal Grandmother	[redacted]1964
	Maternal Uncle	[redacted]2001

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 agency history with the family and current Child Protective Services (CPS) file. NERO attended the Act 33 meeting convened on 01/22/2018.

Children and Youth Involvement prior to Incident:

Northampton County Children, Youth and Families Division (NCCYFD) received a General Protective Services (GPS) referral on the family on 11/03/2017 with allegations that the mother [redacted], has [redacted] and admits to [redacted].

NCCYFD did complete an assessment and met with the mother on 11/14/2017. The mother did admit to using and is currently on [redacted]. Mother also reported that she is on parole. The agency had completed a home visit and a collateral contact to the parole officer prior to the victim child's birth.

Upon birth, the agency met with the mother and the victim child at the hospital. The victim child was born healthy on 12/02/2017. The mother initially [redacted] however the [redacted]. The victim child's [redacted].

The agency completed additional home visits upon victim child's discharge. The agency did receive concerns from a community provider that they thought the mother was overwhelmed. During the assessment, the agency was able to determine that the mother had [redacted] for her parole office. The mother did report that she attended [redacted] and planned to follow through with recommendations. The GPS report was validated and closed on 12/22/2017 citing family and community supports.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/22/2017 the agency received a Child Protective Services (CPS) report alleging serious physical neglect of a child. The allegations report that the child presented to the emergency room with a low glucose level, lethargic, shivering, dehydrated and gray in appearance. The mother reported that the child was checked on at 3:00am and then again at 11:00am. There were also concerns reported for possible drug trafficking in the home. The reporter felt that it was neglectful that the child was left in the crib for approximately 8 hours without being checked on.

The agency caseworker arrived at the hospital and learned that the victim child had [redacted]. At this visit the worker met with the mother, father, maternal aunt and maternal grandmother to review the allegations. Both parents were interviewed separately and both admit to being the sole caretaker at the 3:00am feeding. When the child woke up at 11:00am the mother stated he was not responding like he usually does. At this time, the mother contacted the maternal grandmother who contacted emergency officials to respond to the home. A [redacted] was requested of both parents during this visit.

The victim child was evaluated by the [redacted] and on 12/26/2017. It was learned that the specific [redacted]. It is estimated that the child would have ingested [redacted] within 6-8 hours of the [redacted] A supplemental report was received and the CPS report upgraded to a near fatality with allegations of Causing Bodily Injury to a Child, specifically poisoning.

The agency completed an emergency staffing and implemented a safety plan whereby the victim child would be discharged to his maternal aunt and the parents would have supervised contact. The parents were unable to provide a plausible explanation for how the victim child ingested [redacted]. Several stories had been provided however the attending physician stated that the child would have needed to come into direct contact and this was not transferred by accidental means or breastmilk.

On 12/28/2017 the agency made a referral to [redacted] to provide further support to the family. The family was cooperative with this service. The agency continued to complete an investigation and conducted interviews of the father and maternal grandmother. The mother was however refusing to be interviewed at that time. The agency amended the safety plan on 01/12/2018 to include the grandmother as a responsible party to the plan allowing the child to move into her home and having the maternal grandmother supervise all contact.

Throughout the remainder of the investigation, the agency continued to monitor the safety plan. The father was refusing to comply with [redacted] but agreed to a [redacted]. The mother had missed [redacted] during that time.

On 01/30/2018 a GPS referral was received alleging parent substance abuse. The report alleges that the mother admitted to relapsing earlier in the month of January 2018. This report was validated.

On 02/01/2018 the agency filed an indicated status naming both of the parents as perpetrators of abuse as neither parent was able to provide an explanation of how the child ingested [redacted] and both parents admitted to being a caretaker during the time frame in question. The case was accepted for services and the safety plan was to remain in effect. The family was accepted for services on 02/02/2018.

On 02/12/2018 the agency [redacted]. The [redacted] scheduled for 02/21/2018 however was continued due to both parents [redacted]. The safety plan was ordered to remain in effect until the [redacted] which was scheduled for 04/04/2018.

Both parents had [redacted]. The father [redacted] and the mother [redacted]. Mother also [redacted] during [redacted]. The agency also received reports from in-home providers that there were concerns the safety plan was not being followed while in the care of the maternal grandmother. Based on this information the agency filed [redacted] victim child. [redacted] was granted and [redacted] was scheduled for 03/26/2018.

At [redacted], the judge [redacted] maternal grandmother provided the mother moved out of the home. The safety plan remained in effect that the father could only have supervised contact. The [redacted] was continued to 04/05/2018 to ensure the same judge would hear the case.

At [redacted] on 04/05/2018 the child was [redacted]. The mother was ordered supervised visitation by agency staff and the father's visits are supervised by the paternal grandmother. Further orders of the court included that both parents receive an [redacted], submit to [redacted] and cooperate with the

in-home nursing service. The mother was also ordered to complete [redacted] and continue [redacted].

On 04/17/2018 the mother was [redacted].

This remains an active investigation with law enforcement.

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

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

  Law enforcement, the District Attorney's Office are working jointly with Children and Youth staff, charges are pending.

  The family was offered multiple Family Group meetings to help determine a plan to keep the child safe. There are many family resources on both maternal and paternal side that are willing to help.

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

  None

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

  There is a recommendation to change regulations at the federal, state and local levels surrounding [redacted], [redacted] and medical records information in cases specifically where there children not yet school age and parents are not compliant with [redacted]. It is recommended that a referral be made in all cases where a parent relapses or is not medication compliant. In this case the mother was able to produce [redacted] for parole, but she was also not using the [redacted] as prescribed and the D&A treatment staff could not share the specifics of the mother's relapse without signed consent meeting all the requirements of D&A regulations.

- 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.

  Dr. from CAC reports [redacted], but the CYF referral says [redacted]. Team has concern that CYF did not have the full info

from the hospital about the child [redacted]. Suggestion for better communication between teams, if there is a definite concern, ensure it is verbalized to a staff member, and not just in written report.

Multiple cases this team reviewed recently where there has been a drug issues and then something major happens. Can D&A providers be reporters when mothers of young children relapse? At what point of relapse or what age of children should they make referrals as mandated reporters? Provide education and improve collaboration between D&A staff and CYF staff.

Recommendation for Hospitals to refer mothers that have [redacted] to community in home nursing program. Eyes in the home to help monitor stress level for first few months, which are trying for new mothers.

Recommendation for more rehab inpatient beds for mother with child programs. Local inpatient programs verses programs far away from family resources.

Department Review of County Internal Report:

The NERO received the county report timely on 04/20/2018. The NERO concurs with the findings in the county report.

Department of Human Services Findings:

- County Strengths:

  The agency completed 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 utilized family supports to ensure safety of the child during the investigation and [redacted].

- County Weaknesses:

  The agency completed a GPS investigation of the family upon the victim child's birth. The agency obtained appropriate releases of information and completed fax requests for information. The agency did not wait until information was received from those providers or follow up via phone to gather more information before closing the case.

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

  The agency did complete a Family Service Plan, however, it was not completed within the required 60 days of being accepted for services.

Department of Human Services Recommendations:

DHS recommends coordination between [redacted] providers and children and youth agencies when treating parents of young children, specifically when a parent is at greater risk of relapse.