pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Cassie Montoro

Date of Birth: 08/26/2016
Date of Death: 07/28/2017
Date of Report to ChildLine: 07/27/2017
CWIS Referral ID: [redacted]

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

Northampton County Division of Youth and Family Services

REPORT FINALIZED ON:
01/02/2018

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 08/22/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Cassie Montoro	Victim Child	08/26/2016
[redacted]	[redacted]	[redacted] 2015
[redacted]	[redacted]	[redacted] 1983
[redacted]	[redacted]	
* [redacted]	[redacted]	[redacted] 1971
* [redacted]	[redacted]	[redacted] 1972

* 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.

Children and Youth Involvement prior to Incident:

The county agency received [redacted] on 08/31/2015 regarding [redacted] who would have been [redacted] at the time. The allegations were for creating a reasonable likelihood of abuse and the incident involved [redacted] hitting [redacted] while [redacted] was carrying [redacted]. [redacted] was arrested after this incident.

The agency responded and a safety plan was implemented [redacted] as [redacted] had been drinking alcohol and attempting to secure bail money to bail out [redacted]. The agency also learned that [redacted] had [redacted]. [redacted] was raised by [redacted] and [redacted] were in the care of [redacted] and New Jersey Child Protective Services had prior involvement. [redacted] were also identified as having criminal history including drug and harassment charges.

On 09/04/2015 [redacted] was made to [redacted] and services started on 09/22/2015.

The [redacted] on 10/29/2015. The agency did determine that the family was in need of ongoing services and opened the family for in-home services and parenting as [redacted] was going to be allowing th[redacted] back into the home upon [redacted] release from Northampton County Prison (NCP).

[redacted] was released from NCP on 11/12/2015 and in-home services continued. On 12/14/2016 the agency was advised that [redacted] was arrested due to an incident of domestic violence over the weekend. The agency learned that there were three incidents of domestic violence from the time [redacted] was released from jail and [redacted] was arrested.

[redacted] then obtained a Protection from Abuse (PFA) order against [redacted]; however, [redacted] attempted to withdraw the PFA on 01/07/2016. A Family Service Plan was developed on 12/16/2015 and signed by [redacted]. The goals on the plan included meeting with the agency caseworker, notifying the agency of any change of address, allowing the agency access to [redacted], participating in the development and implementation of safety plans, securing/maintaining a legitimate source of income, participating in in-home services and following through with recommendations, completing random urine screens and ensuring [redacted] medical care is current.

[redacted] was completed on [redacted] on 12/18/2015 and the [redacted].

On 01/11/2016 the agency learned that [redacted] during a home visit.

A referral was made to Northampton County Early Intervention Program for [redacted] on 01/12/2016. [redacted] was assessed and did not qualify for services based on the screening process.

On 02/04/2017 [redacted] was released from NCP and on 02/08/2017 [redacted] withdrew the PFA. [redacted] did not notify the agency of these changes,

however the agency was able to confirm based on information provided to them from the in-home provider, [redacted].

The agency closed the case for services on 05/10/2016 as there were no concerns reported by [redacted] or new [redacted] received since [redacted] release from incarceration.

Circumstances of Child Fatality and Related Case Activity

On 07/27/2017 the county agency received [redacted] for egregious failure to supervise. [redacted] was at the hospital after being found face down in the bathtub by [redacted]. [redacted] was not expected to survive. [redacted] reported that [redacted] had only turned away for a second to get a washcloth. There were suspicions that [redacted] was under the influence of drugs and/or alcohol and law enforcement officials (LEO) were awaiting a warrant for [redacted] on [redacted] was named as [redacted] in the report. Supplemental reports were received and [redacted] due to [redacted] being in critical condition.

The county agency arrived at the hospital and first met with [redacted] did agree to be an [redacted] for [redacted] and [redacted] if determined to be necessary. The county agency then met with [redacted] and was able to smell alcohol on [redacted] breath. It was determined that [redacted] needed to be implemented and [redacted] was [redacted] The county agency did arrange for hospital clergy to meet with [redacted] since [redacted] did not appear to be understanding the severity of [redacted] medical condition. The caseworker and law enforcement official delayed interviewing [redacted] at this time.

On 07/28/2017 at 2:44pm the victim child died. The report then became a child fatality report.

On 07/29/2017 [redacted] was interviewed by the county agency caseworker and law enforcement official. [redacted] initially reported to only leaving the child alone for a second and found the child face down upon [redacted] return. As the interview continued, [redacted] did admit to drinking alcohol all day and also taking [redacted]. [redacted] did recall feeding [redacted] dinner between 5:00pm and 6:00pm before giving [redacted] a bath. [redacted] reported that [redacted] had left the bathroom for about five minutes while [redacted] was texting [redacted] who [redacted] was in a fight with earlier in the day. [redacted] reported that [redacted] called [redacted] name, [redacted] heard a sound and went into the bathroom at which time [redacted] said' "uh oh, baby." The victim child was face down in the tub. [redacted] took the victim child out of the bath and made three phone calls prior to contacting emergency officials via 911. The victim child was taken to a local hospital prior to being transferred to a trauma center.

The county agency and law enforcement collaborated together to complete the investigation. Through review of text messages and phone calls, it was determined that [redacted] were unsupervised in the bathtub between five and ten minutes.

[redacted] was referred to [redacted] and was accepted into [redacted]. [redacted] entered [redacted] on 08/10/2017 and [redacted] on 08/15/2017.

On 08/21/2017, during an agency staffing, the agency determined that [redacted] for egregious failure to supervise should also be registered for [redacted] as [redacted] was also in the bathtub during the same time period.

On 08/24/2017 the agency [redacted] the case naming [redacted] for causing serious physical neglect of a child and for causing the death of a child through an act or failure to act.

On 08/29/2017 the agency also [redacted] the case on [redacted] naming [redacted] for causing serious physical neglect of a child.

The agency [redacted] of [redacted] and [redacted] on 09/21/2017. The [redacted] is receiving speech therapy and occupational therapy through Early Intervention and is also involved with ongoing [redacted] due to [redacted] fear of being near a bathtub.

[redacted]. The family was referred to the agency's Family Group Decision Making unit to coordinate a meeting and plan for [redacted]

[redacted] has been referred to [redacted] and has been requested to [redacted]. [redacted] has also been Court Ordered to attend a [redacted], offender's assessment, and compliance with [redacted].

[redacted] has been Court Ordered to comply with [redacted] parole instructions and [redacted] which can be started while incarcerated.

Criminal charges for [redacted] are pending the outcome of [redacted].

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

  The [redacted], the [redacted] and [redacted] have coordinated the interviews and kept each other up to date on where the case is standing throughout the case. The Agency was able to find [redacted]

[redacted], in order for [redacted] to have familiar faces in [redacted] life.

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

  The Act 33 review team questions if this family "should have been watched closer" when the Agency was aware [redacted] at the time of the case closing. Team members agree that at the time of closing [redacted] was [redacted], and had been compliant when completing in home services.

- 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 recommendation of the team is to find/determine a better way to obtain [redacted] from other states. The Agency had requested records during the first case referral and while working that case, never obtained the records. The Agency knew from [redacted] reports that [redacted] that [redacted] are not involved with. The Agency was not aware when first closing the case that [redacted] in another state, due to [redacted] and domestically violent choice of paramours.

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

  N/A

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

  The team questions how to get family and relatives to "make the call" and refer families when there are concerns. The team hopes that some of the public service commercials will help. The team members were asking how we can effect change on the local level.

  Team suggested that if a parent obtains PFA against more than one paramour, or tries to revoke a PFA in short timeframe, finding a way for the Court to order non-offender/protective counseling, enhancing the awareness of the effects on the children, prior to lifting the PFA Order.

Department Review of County Internal Report:

The NERO received the county report timely on 11/17/2017. 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 gathered information from law enforcement, witnesses and the hospital. The Act 33 meeting focused on issues of concern and why reports were not made to the county agency regarding drug and alcohol use and supervision by [redacted] despite learning of these concerns during the investigation.

- County Weaknesses: Although the agency met minimal regulatory requirements in regards to making contact with the family and completed a family service plan, best practice standards could have enhanced services to the family. Best practices should be for child welfare workers to ensure that the planning process is ongoing and revised as family dynamics change and that goals should be clear and measurable and meet the needs of the family.

  It is recommended that the agency complete Safety Assessments within 72 hours of receiving information that suggests a change in child safety. Although the safety of the child may not have changed, [redacted] release from incarceration and [redacted] withdrawing the PFA are all factors which suggest a possible change to the child's safety.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency: N/A

Department of Human Services Recommendations:

It is recommended that the Department ensure that child welfare workers are trained to have a better understanding of complex family dynamics such as substance abuse, domestic violence and criminal history and how to recognize when these factors represent red flags.

It is further recommended that workers understand the importance of consulting with community agencies when case planning with families.