



## **REPORT ON THE NEAR FATALITY OF:**

**[REDACTED]**  
**Date of Birth: 6/11/13**  
**Date of Incident: 5/7/15**  
**Date of Report to ChildLine: 5/8/15**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT 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:  
October 7, 2015**

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:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, 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.

Act 33 of 2008 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 Act 33 of 2008 related to this report. The county review team was convened on June 4, 2014

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	06/11/2013
[REDACTED]	Sibling	[REDACTED] 2014
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Half-Sibling	[REDACTED] 2003
[REDACTED]	Half-Sibling	[REDACTED] 2002
[REDACTED]	Half-Sibling	[REDACTED] 1999
[REDACTED]	Biological mother	[REDACTED] 1979
* [REDACTED]	Father	[REDACTED] 1982
* [REDACTED]	Father of [REDACTED] children	[REDACTED] 1977
[REDACTED]	Maternal grandmother	[REDACTED] 1956

\* 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 of Children, Youth and Families (NERO/OCYF) obtained and reviewed all case records pertaining to the family. NERO attended the Act 33 meeting on June 4, 2015. Follow up interviews were conducted with the county caseworker, [REDACTED] and supervisor, [REDACTED].

### **Children and Youth Involvement prior to Incident:**

There was no previous involvement with this family. The family has previously resided in ██████ County and ██████ County. Neither county has any history of previous reports on this family. The family had also resided in ██████ New Jersey for a period of time, and from 2013 to 2014 they resided in ██████, Missouri. No referrals were received by New Jersey or Missouri.

### **Circumstances of Child (Near) Fatality and Related Case Activity:**

On May 7, 2015, the victim child was taken by her mother to St. Luke's Hospital in Bethlehem at approximately 5:00 pm. The victim child presented to the hospital with ██████ and the mother was concerned that she may have ingested ██████, as an empty bottle was found near the child. Medical concern was that the victim child was extremely drowsy and a ██████ needed to be ██████ which was not classic symptoms of ingesting this medication. The victim child was then transferred to St. Christopher's Hospital, Philadelphia. At St. Christopher's Hospital, ██████ determined that the victim child had ingested ██████, she was also determined to have the following items in her digestive system: a nail, screw, button-battery, glass, earring stem, and wire. ██████ reported that the mother was appropriate at the hospital and was compliant with their requests. Dr. ██████ made the referral and certified that due to the type of ██████ swallowed, the victim child could have had fatal consequences, and this was called in as a near-fatality. The victim child ██████ and condition was improving at the time of the call.

Upon leaving to take the victim child to the hospital, the mother requested her cousin attend to her mother and children. The mother's cousin was at the house when the on-call worker arrived to the home. The mother and victim child had been transported to St. Christopher's. The cousin agreed to provide supervision between the mother and the children for the weekend, and the mother, via phone, agreed to have her cousin remain in the home until the investigation could be initiated. A safety plan was implemented that consisted of supervision of the mother with the children. Responsible persons to supervise the mother's contact with her children included her cousin and a friend of the mother's.

Northampton County caseworkers reported that it appeared the mother relies heavily on the oldest three children to help supervise the younger three children. The mother had reported that in the past the victim child had eaten a variety of items, as evidenced by things she had passed through her system and were found in her diaper. The mother reported that she has pictures of a balloon and also a push pin that the child had passed which she showed to the doctor. The mother was concerned that the child may have ██████, which is the ██████ ██████ has since been medically ruled out.

The victim child was ██████ on May 11, 2015.

The investigation revealed that maternal grandmother had moved into the home for care and assistance in recent past few months after [REDACTED]. The family had recently brought belongings over to the home, including [REDACTED]. All of [REDACTED] belongings were placed under the bed and the [REDACTED] did not have safety caps. This is apparently the [REDACTED] that was ingested by child, although the exact [REDACTED] was not clear until the testing came back. At the time of the incident, the mother was upstairs bathing the youngest child. The 5 year old sibling and victim child were finished with their baths and were being supervised by their oldest half-sibling. It was the oldest half-sibling that first noticed and told mother that victim child was not acting right.

The victim child has a history of eating anything she can and her pediatrician is testing her for [REDACTED] and is continuing to follow up from the hospitalization.

The Act 33 Team Meeting was held June 4, 2015. At that time Detective [REDACTED] stated since this was a one-time incident and the mother is cooperative and open to services, no criminal charges will be filed.

The CY48 was filed on July 6, 2015 with an Indicated status with the mother as the perpetrator. The case has been open for ongoing services and monitoring. The mother is compliant with services and has improved the cleanliness of the home as well as applying better safeguards in keeping items away from the toddlers. The father of the youngest three children is assisting with the family supervision. The victim child and sibling are receiving [REDACTED]. The mother and her twelve year old son are receiving [REDACTED].

Prior to the incident the family was not known to Northampton County Children and Youth and they were not receiving services. After the incident occurred the Agency put the following services into place to assist mother while also alleviating the safety risks:

\* [REDACTED] together provided [REDACTED] and also helped to coordinate with [REDACTED]

\* [REDACTED] were provided for the [REDACTED] and [REDACTED] to mother to provide for the [REDACTED] and supervision of the victim child.

\* [REDACTED] for the mother.

\*Referral for [REDACTED] for victim child and her sibling.

\* [REDACTED] was offered for all children not currently attending school - to allow mother time to attend to her own [REDACTED] as well as looking for [REDACTED]

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

Strengths:

Northampton County is in compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;

The agency staff, law enforcement officials and medical team demonstrated a very collaborative effort in investigating and working with this family.

Family resources, friends and relatives were found to implement supports to this mother quickly.

Children were able to remain safely in the home, with supports and services in place.

Deficiencies:

There were no previous referrals on this family, however in working with the family it was discovered that all three school aged children had frequent absences with the oldest half-sibling only attending 11 days of school from March – May 2015, but no referrals were made for truancy. The twelve year old half-sibling also had truancy issues, but also had [REDACTED] in school, and no referral was made for failure to follow through with [REDACTED] services. If either of the above were reported, the family issues would have been discovered upon Agency intervention prior to the incident leading to the near fatality.

Recommendations for Change at the Local Level:

There should be community education regarding mandatory reporting of child abuse in hopes that other agencies will file General Protective Service reports as well as Child Protective Service reports to ChildLine.

Recommendations for Change at the State Level:

No areas were identified.

**Department Review of County Internal Report:**

The Internal County report was received on September 1, 2015. NERO/OCYF concurs with Northampton County's findings and recommendations.

**Department of Human Services Findings:**

County Strengths:

NERO/OCYF determined that the county agency conducted a thorough and comprehensive investigation of this case. The case file was well documented.

NERO/OCYF determined that the county agency was in full compliance with all applicable regulations.

Northampton County demonstrated a very proactive approach in evaluating the circumstances surrounding this near fatality.

County Weaknesses:

No areas were identified.

**Statutory and Regulatory Areas of Non-Compliance:**

No areas were identified.

**Department of Human Services Recommendations:**

NERO/OCYF recognizes the quality and procedural mechanisms currently in place within Northampton County as they relate to the assessment and investigation of CPS cases and recommends their continuation.

NERO/OCYF also commends the county child welfare agency in its collaborative relationship with this office in compiling case specific data and evaluating the overall process of Near Fatalities/Fatalities in an effort to promote consistent, quality services to the children, youth and families involved in this aspect of public child welfare service delivery.