



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Mason Gallagher

BORN: 1/12/2011

DIED: 2/14/2011

FAMILY KNOWN TO:

Bucks County Children and Youth Social Services Agency

REPORT FINALIZED ON:

04/18/2012

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 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, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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 child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Bucks County was not required to convene a review team in accordance with Act 33 of 2008 related to this report as the report was [REDACTED]

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Mason Gallagher	Victim child	1/12/2011
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Father	[REDACTED] 1984
[REDACTED]	Mother	[REDACTED] 1986
[REDACTED]	Paternal grandfather	[REDACTED] 1949
Other family members:		
[REDACTED]	Maternal great grandmother	[REDACTED] 1930

Notification of Child Fatality:

On 2/15/2011, Bucks County Children and Youth Social Services Agency (BCCYSSA) receive a ChildLine report concerning one month old Mason Gallagher. On 2/14/2011, Mason was taken to Lower Bucks Hospital Emergency Room after his father found him cold, blue and not breathing. The mother had gotten up with him during the night and fell asleep sitting up on the couch with him cradled in her arms. When the father found the mother and baby on the couch, the mother was sleeping with her head forward. Mason's knees were up to his chest, and his arm was over the top portion of his face. The father did not believe that the arm was obstructing the airway. (The mother is of light to average build.)

Mason was transferred to Children's Hospital of Philadelphia (CHOP) on 2/14/2011 after being [REDACTED] at Lower Bucks Hospital.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. Follow up interviews were conducted with the caseworker, [REDACTED]

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

9/8/2010

Family became known to Bucks County C&Y when the mother, [REDACTED], was involved in an automobile accident and taken to the hospital. [REDACTED] was determined to be 18 1/2 weeks [REDACTED] Lower Bucks Hospital alerted BCCYSSA of the positive drug test. The county began their investigation. The other child [REDACTED] (dob [REDACTED]/2009) was examined and determined to be in good health. A conversation with his pediatrician revealed that [REDACTED] was current on medical appointments. BCCYSSA completed a Safety Assessment and did not identify any safety threats. The county agency chose to keep the case open because of the [REDACTED] there were no services other than case management to the household. The mother was enrolled in a [REDACTED] program in northeast Philadelphia. BCCYSSA made contact with the clinic; it was reported by the clinic staff that the mother was compliant with [REDACTED]. Clinic staff had observed mother interacting with [REDACTED] during some appointments, and reported her to be caring and affectionate.

BCCYSSA made monthly home visits. Family consisted of Mason, sibling [REDACTED] mother, father and paternal grandfather. [REDACTED] was developed 12/3/2010 after being [REDACTED] on 11/5/2010. The goals on the [REDACTED] included: to meet with the social worker, to [REDACTED] needs of [REDACTED] to provide necessary medical care for [REDACTED] to provide appropriate supervision of [REDACTED] to sign releases of information for BCCYSSA to access other agency reports, and to ensure that [REDACTED]

When Mason was born 1/12/2011, BCCYSSA was still providing services. He had tested positive for methadone, and was hospitalized for 3 weeks after his birth. At delivery, the mother's [REDACTED].

Circumstances of Child Fatality and Related Case Activity:

On 2/14/2011, BCCYSSA received a ChildLine report concerning one month old Mason Gallagher. The initial report was that the father woke up to find the baby in bed with them. When the [REDACTED] investigator met with the family, she was told that the father had found the mother asleep on the couch with Mason curled up on her chest and with their one year old son, [REDACTED], sleeping on the couch next to the mother. The father noticed that the baby was positioned strangely, and that the baby was cold, blue and not breathing. The father immediately grabbed the baby to begin CPR and shouted for the mother to call 911. The mother could not find her cell phone, so went to the room of the paternal grandfather and shouted for him to call 911. The father rode in the ambulance with the baby while the mother stayed at home waiting for a relative to come to the home to stay with [REDACTED]. Lower Bucks Hospital was able to revive the baby. The baby was [REDACTED] at Lower Bucks Hospital then transferred to CHOP via medi-vac. When the parents were told that Mason was not going to survive, the parents had a

chaplain perform last rites and baptize the baby. Once this was done, the machines were turned off and the baby died.

On 2/15/2011, the [REDACTED] worker implemented the Safety Plan that stated that the parents would be supervised by the paternal grandfather until the results of the drug screenings were received by BCCYSSA. The parents went for drug testing on 2/17/2011.

On 2/22/2011, the Safety Plan for the father was lifted as his drug test was negative. The Safety Plan for the mother would remain in effect as she tested positive for methadone. This decision was made as the [REDACTED] worker had spoken with the mother's treatment provider that she had tested positive for benzodiazepines and purchased methadone off the street in the past two months.

On 4/14/2011, the county filed this report as [REDACTED]. The preliminary autopsy results showed no signs of [REDACTED].

Current Case Status:

- The Bristol Township police investigated this case. After consultation with the District Attorney's office, it was [REDACTED]. The child's cause of death was determined to be accidental suffocation.
- The mother currently attends [REDACTED] at [REDACTED]. The [REDACTED] is for her to be [REDACTED]. She is currently receiving [REDACTED] a day. Her plan is to begin use of [REDACTED] once she can [REDACTED] down to [REDACTED] day.
- Since the Safety Plan was implemented on 2/15/2011 for the paternal grandfather to be the supervisor of the mother, the paternal grandfather was killed in a motorcycle accident on 4/14/2011. When the agency became aware of his death, two new family members were found to be supervisors of the mother. The paternal grandmother and paternal aunt moved into the home with the parents.
- The family requested that the step father be the supervisor rather than the aunt and grandmother. The agency agreed to this plan and approved him as supervisor. [REDACTED] The father was seeking [REDACTED]. The county has offered resources for other family members for [REDACTED].

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Bucks County has not convened a review team in accordance with Act 33 of 2008 because the investigation was [REDACTED] 4/14/2011 within 30 days of receipt of the report.

Department of Public Welfare Findings:

- County Strengths:
 - The county opened this case for services after the [REDACTED] referral to ensure the health and wellbeing of the one year old, as well as the healthy birth and delivery of Mason.
 - Collaboration with [REDACTED] resources.
 - Timely safe and risk assessments

- County Weaknesses:
 - None identified
- Statutory and Regulatory Areas of Non-Compliance:
 - None identified

Department of Public Welfare Recommendations:

- When parents face the loss of infants and young children, the county agency should make [REDACTED] services available to immediate and extended family members