



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

BORN: December 20, 2010
NEAR FATALITY: July 18, 2012

FAMILY KNOWN TO:
Allegheny County Children, Youth and Families

REPORT FINALIZED ON: June 3, 2013
DATE OF ORAL REPORT: July 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. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim child	December 20, 2010
[REDACTED]	Mother	[REDACTED] 1994
[REDACTED] *	Father	[REDACTED], 1993
[REDACTED]	MGM	[REDACTED] 1973
[REDACTED]	MGM paramour	[REDACTED]
[REDACTED]	PGM	[REDACTED] 1979

*Indicates that this individual lives in a different household

Notification of Child (Near) Fatality:

The near fatality report related to [REDACTED] was initially reported to Childline by [REDACTED] and relayed to Allegheny County on July 18, 2012.

According to the report, the mother left her child in the care of the alleged perpetrator, (babysitter), while she went to the store. When she returned home approximately 1 hour later, she found the child had vomited and was unresponsive. The alleged perpetrator told the mother that the child had tripped and fallen over a fan. The mother contacted paramedics who transported the child to [REDACTED]. It was determined by [REDACTED] that the child had [REDACTED]. Upon further examination, it was found that the child also had a [REDACTED]. The child [REDACTED] and transferred [REDACTED]. The examining physician reported that the child's injuries were not consistent with the explanation that the alleged perpetrator had provided to the mother, i.e. the child had tripped and fallen over a fan.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth, and Families attended a pre-conference review of the case on 8/31/2012, and also attended the MDT meeting for [REDACTED] on 9/27/2012. The Western Region Office of Children, Youth, and Families also reviewed all written materials submitted by Allegheny County DHS pertaining to the [REDACTED] family. In addition, the Department spoke with the Family Group Decision Making unit caseworker to discuss the present situation with the child and family to include ongoing services to the family and the estimated time frame for case closure.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had not received services from the county agency prior to the child near fatality event. The mother, father and mother's paramour had previous involvement with CYF as children. There were three referrals made to the agency regarding the family on the following dates: 7/29/99, 3/4/09, and 3/8/12. All three referrals were screened out at the intake level. The review also noted that mother had significant involvement with the [REDACTED]. Father was on probation through [REDACTED] at the time of the near fatality of his child. Mother's paramour had been supervised by probation for delinquent acts not associated with the near fatality event, and [REDACTED] had closed his case shortly after the child's injuries, as he had not been charged for inflicting those injuries.

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

[REDACTED] is the only child of the 18 year old mother. On the date of the incident, 07/18/2012, the mother and child were residing in the home of the maternal grandmother, the MGM's paramour and mother's three younger siblings. According to the mother on the date of incident she needed to go shopping and since none of the other household members were able to babysit the child, the mother contacted the alleged perpetrator who is a neighbor and mother's paramour. According to the mother, she had done the same thing on one occasion in the past and the alleged perpetrator had cared for the child without incident. When the alleged perpetrator arrived in the home the mother went upstairs to do her hair before going shopping; while upstairs the mother heard a noise but did not think anything of it at the time. The mother then left for the store and was gone for about an hour. Upon her return she found the child had vomited and he was unresponsive. The alleged perpetrator told the mother that the child had tripped and fallen over a fan. The mother immediately contacted paramedics who arrive in approximately 20 minutes and transported the child to [REDACTED] where the injuries described above were documented.

The county agency commenced an investigation immediately and determined that it would be unsafe for the child to be returned to the mother's care upon discharge from the hospital. The agency obtained [REDACTED]

██████████ placement for the child with a resource family, when he was discharged on 7/24/2012, and while assessments of relative homes were completed. ██████████

██████████ to place with relatives upon completion of home evaluations.

Current Case Status:

Subsequent to the near fatality incident, the father came forward to express his interest in caring for the child. He was evaluated and determined to be an adequate caretaker. On 9/19/2012 the agency placed the child with his father in the home of the paternal great-aunt.

The CPS abuse report was indicated against Mother and her boyfriend as perpetrators on 9/14/2012, as each admitted to being in a caretaking role at time when injuries occurred. Interviews also confirmed that Mother had prior knowledge that her intimate partner was not a suitable caretaker and may have injured the child previously, yet continued to use him as a caretaker.

On 9/25/2012, law enforcement arrested the mother and charged her with Endangering the Welfare of a Child, Reckless Endangerment of Another Person, and Aggravated Assault. The mother's partner, a minor, ██████████ for charges of Aggravated Assault, Reckless Endangerment of Another Person, and Endangering the Welfare of a Child. Those charges remain pending at this time.

CYF has instituted Family Group Decision Making interventions with the family, working with mother and father and extended kin to address issues of safety, ██████████ and parenting services.

The child received a ██████████ after the event and continues to receive ██████████ services on an outpatient and in-home basis from ██████████ and the pediatric hospital's intervention team.

The father received services to address his ██████████ and need for enhanced parenting skills. Mother plans to ██████████ and parenting classes while awaiting criminal court proceedings.

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

Allegheny County Department of Human Services conducted its multi disciplinary review team meeting of this near fatality on 9/27/2012. The findings from the meeting included.

- Strengths:

County CYF responded immediately to the CPS report, conducted a thorough investigation of the incident, and instituted an appropriate safety plan for the victim child.

- Deficiencies:

No noted deficiencies

Recommendations for the reduction of the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect at the local level:

- Review of [REDACTED] provider's policy regarding non-compliance by consumer with [REDACTED] as well as provider policy related to provision of [REDACTED] to consumers based upon a number of [REDACTED] [REDACTED] prior to scheduling a [REDACTED]
- Development of a monitoring system across criminal courts and between magisterial district courts and juvenile courts to ensure consistency of language and communication of any conditions, including visitation restrictions, imposed by respective courts.
- Review of prenatal services policy to determine whether screening is offered to identify [REDACTED] and referrals to appropriate services, including parenting skills.
- Review of supervisory and staff development supports needed to enhance assessment and understanding of domestic violence by caseworkers and providers with direct case management responsibilities.

Recommendations for Change at the State Level:

- None noted

Department Review of County Internal Report:

The Department received the Allegheny County Department of Human Services Fatality/Near Fatality Review Report. The Department is in agreement with both the strengths and recommendations made by this team in regards to this report.

Allegheny County Children and Youth Services acted appropriately and responded timely to the CPS report. The agency completed a thorough investigation of the incident and instituted appropriate safety measures for the child. Children and Youth instituted Family Group Decision Making interventions with the family and placed the child in the care of the father, and his extended family member. The agency also assured that both the child and parents did and will receive appropriate follow up services to ensure both the safety and well being of the child.

The Department also is in agreement with the report's recommendations to reduce the likelihood of future child fatalities/near fatalities to include a thorough review of their prenatal services policy, to determine whether screening is offered to identify [REDACTED] needs, and referrals are made for appropriate services, including parenting skills.

Department of Public Welfare Findings:**County Strengths:**

- Prompt county follow up to the CPS report which included a thorough investigation of the incident and appropriate safety planning for the child.
- Follow up activities related to the near fatality incident by agency staff were thorough and well documented. The child has been placed in the custody of the father at the paternal great aunt's home with appropriate follow up services to both child and father. The child will be followed up by the [REDACTED].

County Weaknesses:

- None noted

Statutory and Regulatory Areas of Non-Compliance:

- No areas of statutory or regulatory non-compliance.

Department of Public Welfare Recommendations:

As noted above the Department's assessment of the county's response to the near fatality incident was positive, there are no additional recommendations.