



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR FATALITY OF



BORN: January 31, 2010
Date of Near Fatality Incident: July 13, 2010

**The family was not known to
Allegheny County Children, Youth and Families.
The family was not known to
other public/private social service agencies.**

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 No. 1147, now known as Act 33 was signed by on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Circumstances of Child's Near Fatality:

On July 13, 2010, the child was with her father when he noticed she was having difficulty breathing. The father contacted emergency medical services, who transported the child to UPMC – McKeesport Hospital. The child was then transported to Children's Hospital of Pittsburgh on the same evening due to "[REDACTED] CT scan".

The child required an immediate [REDACTED], and was admitted to the [REDACTED] with a [REDACTED]. The child was certified in critical condition at this point, after it was determined the child suffered from [REDACTED] and [REDACTED].

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/31/2010
[REDACTED]	Mother	[REDACTED]/1986
[REDACTED]	Father	[REDACTED]/1985
[REDACTED]	Maternal Grandmother	[REDACTED]1965
[REDACTED]	Paternal Grandfather	[REDACTED]/1948
[REDACTED]	Paternal Grandmother	[REDACTED]/1949
[REDACTED]	Maternal Aunt	[REDACTED]1987

Documents Reviewed and Individuals Interviewed:

The OCYF Regional Program Representative reviewed the case file provided by County CYF for the intake investigation on this family. The file included the investigation summary, demographic information, risk/safety assessment and safety plan, and progress notes. Interviews were conducted with Allegheny County CYF staff, including the intake caseworker and the current intake supervisor. Also reviewed were the medical and forensic records provided by the Children's Hospital of Pittsburgh.

Case Chronology

The child was with her father on July 13, 2010, when he noticed she was having trouble breathing. The father contacted emergency medical services, who transported the child to UPMC – McKeesport Hospital. The child was then transported to Children's Hospital of Pittsburgh on the same evening due to [REDACTED]

The CT scan showed a [REDACTED] [REDACTED] was present and required [REDACTED]. There were no other injuries noted.

In the days leading up to the hospitalization, the child had multiple caretakers, including parents, maternal and paternal grandparents, paternal aunt and a paternal cousin. According to reports from family members, the child began to exhibit "fussy" behaviors, which were attributed to teething, on July 12, 2010. The mother dropped the child off at the father's home on July 13, 2010 at 4:30pm, the day of the incident. The mother reported that she remained at the father's home for 10-20 minutes. The mother states that prior to leaving the father's residence, she witnessed the child "gasping for air" and "trying to cry". According to the mother's report, she thought the baby was trying to throw up through her nose (Mother reports the child has had chronic vomiting through the nose for 3-4 months). The mother then left the father's home, proceeding to a retail store, then to her maternal great-grandmother's home in Monroeville.

At approximately 7:30pm, the father called the mother and told her the child was having trouble breathing, prompting the father to contact emergency services. It should be noted at the time of the incident, the father was on electronic home monitoring pending sentencing in the death of an ex-girlfriend's child in 2007.

After being transported to UPMC – McKeesport Hospital, it was determined that the child was suffering from [REDACTED]. A CT scan showed abnormalities, and once the child was stable, she was transported to [REDACTED]. A head CT and brain MRI on July 14, 2010 [REDACTED]

[REDACTED] The child required an immediate [REDACTED], and was admitted to the [REDACTED] with a ventilator. The child was certified in critical condition at this point.

Allegheny County CYF was notified of the [REDACTED] on July 14, 2010 and immediately began the investigation along with Allegheny County Detectives.

The Children's Hospital of Pittsburgh – Child Advocacy Center report notes the child had [REDACTED]

[REDACTED] Due to the evidence of old blood and a history of vomiting over past months, it was determined the trauma was sustained over a period of time. Dr. [REDACTED] report noted that the injury could have occurred from a couple of hours prior to the emergency call to 2-3 days prior to the emergency call. Finally, the report noted that the child's injuries were consistent with recurrent shearing/shaking of the child's head, and the injury pattern could only have occurred through continual trauma.

While the Child Advocacy Center was able to determine the child's injuries were a result of [REDACTED], the [REDACTED] and law enforcement investigations were not able to determine the [REDACTED], as there were several individuals who were responsible for the child leading up to the emergency call. The [REDACTED] investigation determination was [REDACTED], and to date, no one has been charged criminally for the child's injuries.

On July 20, 2010, [REDACTED], giving Allegheny County CYF permission to place the child in an appropriate transitional setting or with relatives. The child was [REDACTED] on July 26, 2010 and placed with the maternal uncle and his live-in girlfriend.

The child thrived while placed with the maternal uncle and live-in girlfriend, gaining weight and regaining strength on the right side. The mother was permitted to have supervised visitation with the child. These visits were arranged informally between the mother and maternal uncle. Unfortunately, the maternal uncle requested the child's removal from their care due to feeling overwhelmed in meeting the child's and their own children's needs. The child was moved to a foster family home, who is also a family friend to the mother, on September 1, 2010.

Currently, the mother has unsupervised visitation with the child daily from 1:00pm to 7:30pm at the home of the maternal grandmother (where the child's mother lives). The child is involved with the Family Foundation for developmental issues. The mother is involved with parenting at Family Resources, and is voluntarily attending [REDACTED]. The family is also involved with Family Group Decision-Making.

As noted earlier, the father was on electronic home monitoring pending sentencing in the death of his 13-month old son he had with an ex-girlfriend in

2007. He has since plead guilty to Involuntary Manslaughter (18§2504) and Endangering the Welfare of Children (18§4304). He is currently incarcerated with the Pennsylvania Department of Corrections at SCI – Retreat located in Hunlock Creek, PA serving a 1-3 year sentence.

Previous CY involvement

While the mother and child were not previously known to Allegheny County Office of Children, Youth and Families, the father was previously known through three previous referrals.

The first referral for the father was November 19, 2006 when he and his then girlfriend burned his girlfriend's 8 year old brother on the leg and chin with a curling iron. The girlfriend held the brother down while the father to the current review burned him. The 8 year olds mother was out of town for the weekend, and upon return failed to seek medical attention. The 8 year olds maternal aunt took the child to the hospital and acted as the emergency caregiver. Allegheny County CYF involvement did not continue with the family after December 2006.

The second referral was June 15, 2007, when the father was named as the [REDACTED] in the death of his 13-month old son to his girlfriend (the same girlfriend with whom the father burned a sibling with a curling iron). The cause of death was ruled blunt force trauma of the trunk and the child's death was ruled a homicide. Additionally, the medical examiner found the child had suffered from blunt force trauma to the head, multiple trunk contusions, posterior fractures to ribs 5, 6, 7, and 8 on the right side and posterior fractures to ribs 5, 7, 8, and 9 on the left side, deep liver lacerations, pancreas contusions and hemorrhages to the abdominal and kidney area. As noted earlier, the father plead guilty to involuntary manslaughter and endangering the welfare of children, and is serving 1-3 years at SCI – Retreat for this incident of abuse.

The third referral was on July 28, 2010 alleging that father had unsupervised access to his older son, who was 3 years of age. This investigation was closed as the mother and paternal grandmother of the 3 year old child noted they make arrangements so the father is not alone with the child, as it would be a violation of his house arrest.

Compliance with Statutes and Regulations

The review did not identify compliance issues with statutes and regulations; however a best practice issue arose out of the review. There was a conflict with transcripts and court orders, as well as a conflict between Court Orders issued by Family and Criminal Court. The Criminal Court ordered that the father was to have no contact with children, and the transcript from the same hearing noted he was to have no unsupervised contact with children. Family Court ordered that the father was to have supervised visitation with children. Neither Court was

aware of the activity in the other's Court nor were the Courts aware of the stipulations surrounding the father's involvement with children. Allegheny County Children, Youth and Families conducted all reviews as required.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

- 1) Inconsistency between father's court- ordered no contact with children and transcript that allowed supervised contact with children (note: father violated either order, as EMS noted that father was alone with [REDACTED] at time of ambulance's arrival)
- 2) Probation to review court orders and transcripts to ensure consistency in language- Human Services Director to address at next Judges' Roundtable
- 3) Ensure communication for cases that traverse Family and Criminal Court- need to develop protocol between courts

Findings and Recommendations

After reviewing the case record and interviewing stakeholders, the Western Regional Office of Children, Youth and Families has concluded Allegheny County Children, Youth and Families was in compliance with statutes and regulations related to the investigation of [REDACTED] and providing services to the family, following appropriate protocol in regards to the investigation of the aforementioned referrals.

Of grave concern in this case is the father's criminal status and the conflicting Court Orders between Family and Criminal Court. Family Court ordered that the father could have supervised contact with his children, and the Criminal Court ordered no contact with children, given the fact that the father was on electronic home monitoring for the death of his 13-month old son in 2007. The county must develop a protocol to address the disconnect between family and criminal court, as well as open the lines of communication between the family and criminal courts to ensure consistency with court ordered stipulations.

The Department is in agreement with the County recommendations, and believes it is of utmost importance to immediately develop a plan to address the inconsistencies in Court Orders for cases that are active in Family and Criminal Court.