pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

BORN: March 24, 2014
DATE OF INCIDENT: June 4, 2014
DATE OF ORAL REPORT: June 4, 2014

FAMILY KNOWN TO:
Allegheny County Department of Human Services
Office of Children Youth and Family

REPORT FINALIZED ON:
June 10, 2015

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))

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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, DHS 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:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted] 1991(23)
	Father	[redacted] 1993 (20)
	Focus Child	03/24/2014 (11mths)
	Half- Brother	[redacted] 2014 (4)
	Father of [redacted]	[redacted] 1987 (27)
	Maternal Grandmother	[redacted] 1968 (47)
	Maternal Cousin	unknown
	Maternal Aunt	unknown

Notification of Child (Near) Fatality:

Allegheny County Children, Youth and Family (CYF) received a Near Fatality report [redacted] in the early hours of June 4, 2014 at 4:58 am. The referral source was a [redacted] reported that [redacted], DOB 03/24/2014, was brought by medics to [redacted] Children's Hospital Pittsburgh in cardiac arrest. He was allegedly found to be unresponsive by his father when he tried to give him his 2:00 am feeding. Lifesaving efforts were continued in the emergency room and medical staff was able to regain a heartbeat. The child was then admitted to [redacted]. He was listed in critical condition. The prognosis was grave. The child's condition was suspicious for non-accidental trauma; however, [redacted] reported that there was no evidence that the incident was intentional or occurred as a result of unsafe sleep practices. It is unknown if he was face down in the bassinet or if parents were co-sleeping with him.

It was reported that the mother last saw the child at about 10:00 pm, when the father was feeding him. Mother reportedly went to bed and did not see the child until approximately

1:00 am when father woke her up because the child was unresponsive when the father tried to give him his 1:00 am feeding.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Region Office of Children Youth and Family Services obtained and reviewed all current and past case records pertaining to the family. Follow-up interviews were conducted with the intake caseworker and Family Service caseworker on June 23, 2014. The regional office also participated in the County Internal Fatality Review Team meeting on June 23, 2014 where copies of Child Advocacy Center Medical Records were presented.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family was most recently referred to CYF on April 7, 2014, when [redacted] presented to Children Hospital of Pittsburgh with a [redacted]. The child's mother initially indicated that she thought that she had caused [redacted] to the leg while she was swaddling the child in a blanket and "heard a pop." She later indicated that she may have caused [redacted] after falling asleep with the child while breastfeeding. She thought that she may have rolled onto him. The mother stated that she remembered that the child was very difficult to console when they woke up. The medical staff at CHP believed the injuries to be consistent with mother's story. The Child Protective Services investigation was unfounded and the family was accepted for services. There were no services provided to the family at this time. Collaterals were completed at which time there were no concerns, therefore the case was closed; with the plan for mother to continue her involvement with regard to all medical recommendations. The case was closed on May 6, 2014.

PREVIOUS HISTORY WITH MOTHER AS A YOUTH:
The mother had a CYF record as a child dating back to 1993. As a youth she received independent living services. From 2003-2005 she participated in family support services [redacted]

ADDITIONAL INFORMATION ON PARENTS PRIOR TO BIRTH OF CHILD:
As an adult, the mother filed a Protection from Abuse order against the child's father in both October 2013 and on January 24, 2014. Father has been arrested on multiple occasions on assault charges. There is one date of service listed for the father [redacted].

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

On June 4, 2014, Allegheny County Children, Youth and Families received the report at which time the child had reportedly presented to Children Hospital of Pittsburgh in full

cardiac arrest. Allegheny County CYF completed an unannounced home visit at the family home. The child's 3 year old brother was observed and appeared well cared for by the caregiver. There were no concerns in regard to the home conditions. Mother and Father were at the hospital with the child during this visit. Allegheny County CYF then proceeded to CHP to visit the child, mother and father. CYF met with the [redacted] who informed them that two homicide detectives were also present at the hospital. The hospital reported that mother and father were both present at the hospital and mother was appropriately tearful. It was also reported that [redacted] doctor had spoken to the family. CYF spoke with [redacted] doctor who reported that it was too early to determine the prognosis of the child. There were no broken bones found under examination. The doctor felt that the incident was suspicious for a "roll over" injury sustained from "unsafe sleeping conditions". The doctor suspected that the child was in the bed with another adult, and the adult rolled onto him and smothered him. The doctor reported at that time that the child was [redacted] The doctor was unable to determine if the injury was from intentional suffocation or if it resulted from an unsafe sleep situation.

Allegheny County CYF was able to observe the child [redacted]. He reportedly did not appear responsive to outside stimulus, but per the hospital this was expected based on his condition. The child was deemed safe in his current environment.

On June 6, 2014 it was reported that he was still unresponsive, but sedated and [redacted]. On June 10, 2014, Allegheny County CYF spoke with the detective who stated that based on the [redacted] doctors report of there being no signs of maltreatment, the detective consulted with the district attorney and concluded that it would be difficult to prosecute the case due to lack of evidence of maltreatment. The detective stated that their office would not be pursuing the case unless the report changed from "near fatality" to a "fatality". On June 12, 2014, the parents were provided the option [redacted] On June 18, 2014 despite mother's wavering decision to maintain the child [redacted], the parents concluded that they would prefer to maintain the child's life in this manner. The plan was to transition the child [redacted]. Due to the parents' ongoing [redacted], their young ages and the lack of consistent and reliable family support it was determined that the child would do better in a resource home. Once he was stable and [redacted] foster home had been identified, he would be transitioned to a resource home.

Current Case Status:

[redacted] The child was transitioned to the resource home on September 17, 2014 [redacted]

Child is having some milestone accomplishments such as pulling up on things. He is also rolling over, putting his thumb is in his mouth, tracking and responding to the color red.

On March 8, 2015, the child entered Children's Hospital of Pittsburgh via ambulance for breathing complications. His condition was reportedly very critical. On September 9, 2014 the mother signed an order of Do Not Resuscitate; however she has since revoked the order and has requested that all possible measures be taken.

Per the case documentation, the mother has been showing some interest in the child's condition however her attention span is very limited and she has recently made some inappropriate decisions in regard the child's care. The mother has been attending some training to improve her medical care but has reportedly not been consistent with following directions and signing off on material. The family continues to be involved with Allegheny County Children Youth and Family Services. Mother is now attending training to learn proper care of the subject child. The subject child's sibling is residing with his father and is reportedly doing well. Father will maintain custody of the child, however mother is permitted to have liberal supervised visitation. At this time, there have been no identified needs concerning the sibling's father.

The father has been incarcerated since late October 2014 for Robbery. He maintains contact with the resource parents via cards and letter and has requested that they allow him to parent when he is released.

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

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report to ChildLine. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report

- Strengths: The Act 33 review identified several strengths with regard to the love that parents have for their child. Parents also have reportedly remained positive about the child's physical health condition. They have maintained contact with the child. Parents are receptive to learning about child's condition and ask questions. Parents also indicate a desire to be a family.

- Deficiencies: The Act 33 review identified several deficiencies in regard to the history of current intimate partner violence between the parents. [redacted] Additionally, there are also housing and employment challenges for both parents.

- Recommendations for Change at the Local Level:

  - The Act 33 review identified that caseworker supervisors should be making sure that caseworkers are assessing for safe sleep at each home visit and with every family involvement. For example, assessing if the child has a bassinet, crib or bed that is age appropriate and provides a proper sleeping environment for the child.
  - They also examined the handling of the previous case and acknowledged that there were some missed steps. The family was never referred to Conference and Teaming giving the parent's young ages, history of intimate partner violence and limited identified family supports. The team felt that if this measure was taken it may have limited the level of risk for the child.
  - The agency determined that the completion process for safety assessments and the way they are being completed across the broad should be evaluated to ensure more consistency.
  - A discussion was held in regard to doctors being more certain of the patient's condition due to doctors providing different perspectives.

- Recommendations for Change at the State Level: The Act 33 review did not identify any recommendation at the state level.

Department Review of County Internal Report:

The Department received the County Internal Report via email on June 24, 2014. The Department agrees with the recommendations given by the review team. The County Internal Report was sent to the Department in a draft format. The Department has not received a finalized version of the report. The Department acknowledged the receipt of the report on June 24, 2014 via email.

Department of Human Services Findings:

- County Strengths: The county agency responded immediately to ensure safety of the child while in the hospital and of the child's sibling who was still in the home. There was ongoing contact made by the caseworker to all involved parties on a daily basis. The agency continues to closely monitor the case and is aware of all changes that have occurred. The child's safety has been assured through the agency [redacted] and locating a resource family that is qualified to care for the child.

- County Weaknesses: The counties initial involvement in April 2014 lacked a thorough assessment. Identification of high risk factors may have prevented the present incident if proper assessment measures were followed. There were previous reports of drug use, intimate partner violence and immaturity of both parents, however there was no attempt to contact or identify resources for the parents before case closure.

- Statutory and Regulatory Areas of Non-Compliance:
  There were no statutory or regulatory areas on non-compliance.

Department of Human Services Recommendations:

There are no additional recommendations outside of what have already been identified within the Internal County report.