pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/04/2015
Date of Incident: 03/14/2016
Date of Report to ChildLine: 03/14/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT:

Allegheny County Office of Children Youth and Families

REPORT FINALIZED ON:
08/14/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Allegheny County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 04/12/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/04/2015
[redacted]*	Mother	[redacted]1992
	Father	[redacted]1986
	Mother Paramour	[redacted]1987
	Sibling	[redacted]2013

* 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 Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. WERO staff participated in the Act 33 meetings that occurred on 04/12/2016 and 05/09/2016 in which the County caseworker, medical professionals from the local hospitals, the Assistant District Attorney of Allegheny County and law enforcement were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:

There were two prior referrals on the family, both occurring in February 2016.

A referral on 02/15/2016 was received as a General Protective Service (GPS) report alleging the child's mother was refusing to keep an appointment for the victim child at Children's Hospital of Pittsburgh's [redacted] The appointment had been in response to the mother's concern the victim child had a [redacted] after

she was seen on 02/08/2016 at a local community hospital for reportedly having blood in her stool. The victim child was seen for a follow up appointment and noted to have multiple bruises, which prompted the 02/15/2016 referral. Allegheny County Office of Children, Youth and Families (ACOCYF) completed a "field screen", at which time the mother reported having an appointment with [redacted] The victim child subsequently kept the appointment and no other risk/safety concerns were noted. ACOCYF screened out the report without receiving the test results.

Another GPS referral was received on 02/17/2016 expressing concerns about bruising to the victim child's cheek, scabbing to the back of her head and red marks on her neck. Additional concerns were noted for the victim child potentially being left unattended. The referral was accepted as a formal referral and was screened in for a comprehensive assessment. The caseworker met with the mother and children in the home on 02/18/2016. The caseworker noted the victim child had "long lasting marks" and "numerous marks on her body where mother was holding her", but did not go into any further detail. There was no documented assessment of the sibling completed. It also appears that the neglect concerns were not addressed at that time. There were no photographs of the victim child's bruising or bruises and the caseworker closed the assessment on 02/29/2016 as a screen out without completing a full assessment.

It was also reported by the County that at no time were any medical professionals contacted to confirm the medical information, and no release of information signatures requested from the mother by the county.

Circumstances of Child Near Fatality and Related Case Activity:

On 03/14/2016, ACOCYF received a report of a Near Fatality concerning the victim child. It was reported that she was brought to Children's Hospital of Pittsburgh (CHP) after having "an event" at home which caused the family to call the paramedics to transport the victim child to CHP. [redacted] A skeletal survey [redacted] She was admitted [redacted] for management of these injuries.

Additional testing showed that the victim child had suffered a [redacted] Her injuries were noted to be life-threatening. [redacted] were at various stages of healing, and [redacted] was considered to be approximately four to five days old. At the time of the victim child's arrival to the hospital, her mother could provide no history or reasonable explanation for her extensive and life-threatening injuries, other than, "she bruises easily."

ACOCYF immediately responded to the hospital and determined that no alleged perpetrator could be immediately identified. The victim child's safety could not be assured [redacted] The victim child's sister was immediately removed from parental care and placed into foster care. The injured child was placed with a separate resource family [redacted]

Upon receipt of the report, the ACOCYF intake casework staff interviewed the mother. At this time she indicated that the children had been staying at the home of her paramour's parents while she and her paramour moved their belongings between apartments. Present in the home on the day in question were reportedly her paramour and several relatives. The victim child was reported to be alone in a pack-n-play in an upstairs room. The mother reportedly checked on the victim child at approximately 2:00 PM on the day in question and indicated that she was "fine". The mother then reportedly went shopping, leaving a 16-year-old relative to supervise the victim child, as the remaining adults were reported to be outside working on a car. The mother reported that she called her paramour to check on the victim child and that he called back immediately, stating that she was "all white" and he thought "something was wrong." A relative contacted 911 and an ambulance transported the victim child to the hospital. Although the mother had reported the victim child to appear "fine" upon leaving the home, during her interview mother noted that the child had been "acting weird" since she reportedly had fallen in early February 2016.

Law enforcement officers conducted interviews with the mother and her paramour. During the interviews, the mother denied knowledge of the victim child's injuries. The mother referenced a suspected [redacted] as the likely cause of injuries. This was later disputed. The mother also reported that she "blacks out" and often wakes up in the victim child's room, leading her to believe that she "had to have done this." The mother has stated that she "feels responsible" for the injuries. However, she had neither confessed to causing nor taken responsibility for the child's near-fatal condition. The mother's paramour was also to be interviewed; however, he exercised his right to obtain legal counsel and remained silent. The father of the victim child and her sibling has not been involved in their care, nor had ACOCYF engaged with him prior to the near-fatal event. He has since voiced a desire to be involved in his children's lives, but to date there does not seem to be much involvement.

The county conducted background checks on several family members in order to find a relative placement. [redacted] the victim child was placed in a private foster home where all of her medical needs were being addressed. Her sibling resided in a separate private foster home. The siblings were placed in different homes due to the heightened need for the victim child's care. [redacted]

The county submitted an investigation summary on 5/12/2016, Pending Criminal Court for causing serious physical neglect and causing bodily injury as the criminal investigation remains ongoing. Both the mother and her paramour were charged with Endangering the Welfare of a Child in connection to the injuries. The investigation continues to as whether additional charges will be added, and what those charges may consist of.

Currently the victim child and her sister are living with their maternal grandmother and are doing well. The victim child is attending all medical appointments, and the grandmother is in the process of becoming certified as a foster parent. The victim child receives [redacted] and is improving developmentally and physically. The mother, who is currently in the local jail, awaiting her criminal proceedings, is again involved with [redacted] services, and her paramour is also awaiting further criminal proceedings.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  ACOCYF responded to this near fatality report immediately and ensured the safety and well-being of the victim child and her older sibling. ACOCYF ensured that the older child was medically evaluated, and she was found to have no injuries.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  ACOCYF designated the referral dated 02/15/2016 as a Field Screen, and the assessment focused on confirmation of mother's willingness to seek further medical evaluation for her child. Once ACOCYF confirmed that mother kept the medical appointment for the child, the Field Screen was concluded, and ACOCYF closed the referral. ACOCYF did not obtain the actual medical findings from this evaluation, to be incorporated into their safety and risk assessment of the child.

  In the two previous GPS referrals received in February 2016, allegations included information related to possible physical maltreatment; specifically, bruising to the child's body. Neither assessment included photographing the child, as required by the state regulations related to photograph requirements in investigations of reports of suspected child abuse § 3490.55 (f), When investigating a report of suspected child abuse in which a child has sustained visible injury, the county agency shall, whenever possible and appropriate, take, cause to be taken or obtain color photographs of the injury; and, Act 126 of 2006- amended. Agency practice also requires that photographs be taken when there is evidence of any injury or mark on a child regardless of the investigation or assessment designation.

Of note: the ACOCYF worker who was assigned the second referral stated that he had observed marks on the child's body and had taken photographs with his agency-issued cell phone. However, those photographs were not uploaded into the ACOCYF system and made part of the formal record.

The referral dated 02/18/2016 was designated as a General Protective Services (GPS) report and, as such, was screened-in for a full GPS assessment by ACOCYF. However, the assigned caseworker and supervisor erroneously understood that the referral was accepted as a Field Screen rather than as a full assessment and, therefore, failed to conduct a comprehensive assessment that included completion of collateral contacts and adequate assessment of safety threats and risk factors.

Community medical staff had evaluated the child one month before her near-fatal event, when the child was described as covered in bruises. Although the child's mother raised concern regarding a possible medical explanation of a [redacted] and had agreed to have the child undergo additional testing within days, medical staff did not submit a report of suspected child abuse.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  This information is included in the paragraph below under Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  The Review Team requested an update on this specific case and on the recommended practice and system improvements noted in the review.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  1. In the case reviewed, the two prior referrals were assigned to a ACOCYF regional office that is currently piloting what is referred to as the "one caseworker model" of practice. In this model, caseworkers who were previously assigned Family Services duties are now also conducting GPS investigations while maintaining case management responsibilities for families- from investigation to case closure. The Review Team discussed the need for additional training related to investigative practices for GPS referrals in the ACOCYF regional offices, as well as application of standardized investigative practices across the agency.

2. The Review Team discussed inconsistencies in ACOCYF's practices related to the Field Screen process. Investigative practices vary from office to office and from supervisory unit to supervisory unit. ACOCYF indicated that the finalization and training of investigative practice standards is aimed at remedying these inconsistencies. ACOCYF is instituting a new Client Engagement Unit to conduct field screen assessments, in addition to other duties, in order to better ensure child protection and establish consistency in practice.

3. In the case reviewed, the child was evaluated by community medical staff one month before her near-fatal event. At that time, information described the child as covered in bruises; medical staff did not submit a report of suspected child abuse. The Review Team recommended that, in such circumstances, all mandated reporters adhere to the state Child Protective Services Law and its provisions for mandated reporting of suspected child abuse, with the caveat that additional medical testing may need to be conducted to further diagnose other possible causes.

4. ChildLine classified the two previous referrals made in February 2016 as General Protective Services (GPS) reports rather than Child Protective Services (CPS) reports, in part, due to the reporter's description that they were reporting alleged neglect due to mother's refusal to take the child to her medical appointments, rather than allegations of physical maltreatment. The Review Team requested that the state regional office also review with ChildLine the designation of these reports for quality assurance and improvement purposes.

5. Additionally, the Review Team recommended education for mandated reporters regarding specific language to be documented in suspected child abuse referrals.
    - The ACOCYF Training Department is in the process of conducting refresher training related to GPS investigative practices in the offices piloting the "one caseworker model." In addition, ACOCYF is in the process of finalizing standards of practice for GPS investigations. Safety, Permanence and Best Practice specialists and training staff imbedded in each regional office are partnering to provide real-time technical supports in these areas of practice.

6. In this case, the injured child exhibited significant signs of [redacted] (e.g., fear of adult males; sleeplessness; wanting to constantly be held; inconsolable crying) related to maltreatment while in her resource home. Her resource family initially struggled with caring for her, given these behaviors and severe emotional distress. She was initially placed separately from her sister, resulting in additional severe stress.

   The Review Team discussed the importance of pre-placement planning for children who are hospitalized and/or who have special needs. Identification of a resource home prior to discharge would allow the resource parents to visit with the child in the hospital and to establish a relationship prior to placement. It also would offer the resource parent an opportunity to learn any skills required to continue the child's care in their home. Additionally, the Review Team discussed the hope that this type of thoughtful and advanced planning would reduce the chances for emergency placements, often resulting in multiple moves for vulnerable children, already experiencing extreme stress.

   The Review Team recommended that ACOCYF adopt a protocol in which resource parents are identified for children with special needs prior to their discharge and that these resource parents engage with children and ACOCYF to better prepare for transition to their homes.

Department Review of County Internal Report:

The County submitted their report in a timely manner within the required 90 day timeframe. The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
  The County conducted a complete and thorough assessment of the family; they immediately ensured safety of all of the children, [redacted] They also requested and received all documentation concerning records on this family.

- County Weaknesses:
  The county worker and supervisor did not adhere to their internal policies on the investigations prior to the event. As stated in the county deficiencies the worker did not follow agency policy in the completion of the assessment of the prior referrals and that the worker and supervisor mistakenly read the report and did not complete a full assessment which included collateral

contacts and adequate assessment of the safety threats and risk factors of the family.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  §3490.55 (f) The agency did not obtain photographs of the victim child's injuries. She was reported to have multiple bruises which were not photographically documented.

  §3130.21 (b) The agency did not adhere to their own policies when conducting a General Protective Services investigation.

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings in this review:

Upon receipt of any type of report whether it be a GPS or CPS report, the workers and supervisors must follow all regulatory requirements and all internal County policies pertaining to the investigation of the report, to include but not limited to completion of all assessments, completing all required collateral contacts, obtaining photographs, and any other additional requirements as it pertains to the investigation.

It is recommended all medical professionals adhere to the requirements established in the Pennsylvania Child Protective Services Law regarding mandated reporting. Continuation of education be provided to the medical community about the importance of reporting suspected child abuse to ChildLine or to the appropriate local Children and Youth Services agency.