pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/07/2016
Date of Incident: 07/18/2016
Date of Report to ChildLine: 07/19/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Children, Youth and Families

REPORT FINALIZED ON:
01/02/2017

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))

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street, Room 260 | 412-565-3658 | 412-565-7808 | www.dhs.pa.gov

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 08/18/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	01/07/2016
[redacted]	Biological Mother	[redacted]/1981
* [redacted]	Biological Father	[redacted]/1988
[redacted]	Half-Sibling	[redacted]/2006
[redacted]	Ex-Paramour of Parent	[redacted]/1983
* [redacted]	Father of Kayla	[redacted]/1981
* [redacted]	Half-Sibling	[redacted]/2003

*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 Review Activities:

The Western Region Office of Children Youth and Family Services reviewed the case and casework activities to the current referral and previous referrals with the Allegheny County Act 33 Review team.

Children and Youth Involvement prior to Incident:

The family has been referred to Allegheny County Office of Children, Youth and Families (ACCYF) four previous times. Two referrals in 2013 were screened out. The first report was received on 10/29/2013 alleging the sibling was displaying sexualized behavior, which involved the child touching her own privates. There were no services referred as the child was being treated for a medical condition, which was causing the behavior. The second screen out from 09/05/2013 alleged the sibling had been left home alone. Documentation indicated the father arranged an appropriate caregiver.

A referral on 07/03/2014 addressed the sibling being found outside without supervision. Law enforcement returned the child to her home and discovered a marijuana grow-room in the father's residence. The father was arrested at that time and made arrangements for the child to reside with relatives. At that time, the mother was in an [redacted]. The case was accepted for services and noted as being closed on 09/25/2014 with no services being provided.

On 01/08/2016, a report was received stating the mother and victim child tested positive for tetrahydrocannabinol (THC) at the time of the victim child's birth. The mother reported she did not know the identity of the birth father. There was limited contact with the mother and the victim child after an initial home visit. During which the mother informed ACCYF she would be moving to Ohio. There was no follow up to confirm the mother's move and the mother's whereabouts were unknown; therefore, the county did not request an out-of-state assessment.

The county indicated miscommunication regarding the mother's move being permanent or temporary. And to the fact, at the time of the case being serviced by the agency, per the supervisor, it was "very busy at that time of year". The case was closed on 03/15/2016 without completion of a full assessment of the mother's ability to care for her newborn, or the mother's [redacted]. No services were provided.

Circumstances of Child Near Fatality and Related Case Activity:

ACCYF received a Child Protective Services (CPS) report on 07/19/2016 regarding a 6-month-old male victim child. According to the initial report, the victim child began displaying seizure-like activities on 07/18/2016 while at home with his mother, her paramour and the victim child's sibling. The mother contacted the paramedics and the victim child was then transported to Children's Hospital of Pittsburgh. Upon examination, the victim child was found to have injuries to his head and brain, which required immediate surgery. The victim child was diagnosed as having a large skull fracture and subdural hematomas from differing ages. The mother's explanations of the injuries were not consistent with the victim child's injuries and noted to be highly suspicious for abuse. The county caseworker responded to the referral immediately and upon interviewing the physician it was discovered the report should have been certified as a near fatality report. Subsequently, ChildLine certified the report on 07/20/2016.

ACCYF completed thorough assessments with all parties. The mother was interviewed at [redacted] and provided varying accounts of how the injuries were sustained. The mother stated she and her paramour had been the only caretakers for the victim child during the timeframe the injuries would have taken place. The mother provided a statement that on 07/13/2016 the victim child was left alone on the living room couch for approximately five minutes while mother went upstairs to brush her hair. When the mother returned to the living room, the victim child was on the floor. The victim child, according to mother, did not cry until she picked him up and did not appear to be behaving out of the ordinary, except for being a bit fussier than usual. On 07/16/2016, the mother said

the paramour was caring for the victim child while she napped for approximately one hour. When the mother came downstairs the paramour said the victim child had been "acting funny" (whining) and had thrown up after he ate. Mother and her paramour thought the victim child may have had a virus. On 07/18/2016, the mother stated the victim child had a seizure, which lead to her calling 911.

The mother provided other alleged incidents from two to three months prior where she had left the victim child alone on the couch and when she returned, found him on the floor. The mother also reported one incident of the victim child falling backwards while with his 9-year-old sibling. This information was provided in a vague account and the mother stated she and paramour heard the victim child cry when this occurred.

Interviews were conducted with the mother's paramour and the victim child's 9-year-old sibling. The sibling provided information indicating that about one month before the incident, her mother told her and her mother's paramour that the victim child had fallen off the couch. The sibling did not witness this alleged incident. She did however corroborate the victim child sitting with her on the couch and falling to his side. There is no documentation or statement that the victim child hit his head. The sibling provided family history which included domestic violence and the mother presenting as stressed with caring for the victim child. She stated her mother would call the paramour to come home from work to care for the victim child and her mother would then leave the home. During a forensic interview, the sibling disclosed she heard her mother call the paramour to come home stating, "I need you to come home; I'm going to freak out, I'm going to end up hurting him". The sibling also stated the victim child had a "gigantic bump on his head from when he fell off the couch". This statement was regarding the story mother had told paramour prior to the incident.

The paramour indicated the mother had told him about the victim child falling off the couch three to four weeks prior. The paramour did notice an "egg" on the victim child's head but did not notice any behavioral changes. He corroborated the disclosure of the 9-year-old sibling regarding the victim child falling to his side while on the couch with his sibling. The paramour and mother were in the kitchen and heard a "thump", they heard the sibling yell and then heard the victim child crying. Neither the mother nor the paramour noticed any bumps or bruising.

The county caseworker received information on 07/20/2016 from Allegheny County Detectives that the mother had confessed to hurting the victim child on multiple occasions. The mother was adamant that neither her paramour nor her daughter heard or witnessed any of these incidents. Per her admission, the mother reported several incidents potentially relating to the injuries. She admitted to hitting the victim child on his head with a Similac bottle. On another occasion she stated she punched the victim child five to six times to the head. She also disclosed to the detective she had "body slammed him into his pack n' play". The mother admitted to the victim child rolling off the couch multiple times since he was three months old, while she was out of the room. The mother also disclosed to the caseworker on

07/25/2016 "I hurt him ([redacted])-I hit him on the head with a full (plastic) bottle pretty hard, hit him with my hand, and he did fall off the couch a while ago".

The county took custody of the victim child upon discharge from the hospital on 07/25/2016. The [redacted] At one of the continued hearings the victim child was placed in a kinship care foster home of a paternal aunt and uncle. A test to determine paternity took place and the outcome did verify the identity of the biological father. Supervised visitation has been taking place between the victim child and his biological father. The ChildLine Report was indicated on 08/26/2016 against the victim child's mother for 'Causing Bodily Injury to a Child through a Recent Act/Failure to Act'. The mother was arrested on 07/20/2016 and criminally charged with two counts of Aggravated Assault, one count of Endangering the Welfare of Children, three counts of Recklessly Endangering another Person, and one count each of Criminal Attempt-Aggravated Assault and Criminal Attempt-Criminal Homicide. The county has made referrals for drug and alcohol assessments for both the paramour and biological father.

The victim child remains placed with his paternal aunt and uncle. The family members supervise visits between the child and his sibling as well as the child and his biological father. The victim child continues to be involved with developmental health providers.

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:

ACCYF responded immediately to the CPS report and assured the safety of the infant and his nine-year-old half-sibling. ACCYF also assessed the thirteen-year-old half-sibling in her home with her father and assured her safety.

The assigned CPS investigator and law enforcement worked jointly to conduct their investigations. They also worked in partnership with the regional hospital's child advocacy center for completion of the forensic interview and investigative information.

ACCYF completed a diligent search to locate the putative father of our focus infant and initiated case planning with this person until genetic testing confirmed his paternity.

ACCYF explored extended family supports and established a visitation schedule to ensure that the infant remained connected with his half-siblings.

ACCYF accepted the family for services and is providing supports and continued assessments of the mother, the nine-year-old half sister and her father, as well as the infant and his paternal kin.

Deficiencies in compliance with statutes, regulations and services to children and families:

Allegheny County CYF's standards of investigative practice require comprehensive assessment of all safety threats and risk factors to ensure that children are safe in their living environments and that parents/caregivers have demonstrated protective capacities to ensure the safety of their children.

The nine-year-old sibling reportedly assisted mother in caring for the infant. She was documented to have witnessed mother's screaming and using profanity toward the infant and reportedly becoming so distressed that the nine-year-old would intervene, taking care of the infant until her father returned home from work. ACCYF has accepted this family for services in order to continually assess this child's [redacted], given her trauma and her father's decision not to pursue therapy for her at this time.

Further assessment and understanding of the infant's father, confirmed through genetic testing, will advance the safety, permanency and well-being outcomes for the infant. Father has a documented and self-reported history of [redacted] and criminal justice involvement, including substance use and sexual offenses as a juvenile.

Review revealed significant investigative practice challenges during the January 2016 referral.

Collateral checks were not documented to have occurred with mother's [redacted] or the infant's pediatrician.

When mother reportedly left the state with the infant during the January 2016 referral, a diligent search was not conducted in order to locate the mother and her infant, resulting in no courtesy assessment from the out-of-state agency to assess and assure the safety of the infant while in mother's care.

The Review Team discussed the frequent delay in ACCYF's receipt of genetic testing results, delaying further assessment and planning. In this case, ACCYF and the Court received testing results over one month after testing had occurred and delaying ACCYF's assessment and planning with the family. ACCYF was hesitant in moving forward with permanency planning prior to confirmation of father's paternity.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

The Review Team recommended further integration between adult [redacted] and child welfare systems. Mother had previously resided in [redacted], but facilities are not equipped to take children. Mother left this housing while pregnant, citing that she was not allowed to have a child with her in this level of service. It is unknown if conversations occurred regarding planning for after the infant's delivery, including potential resources for mother's care of her infant. Transition planning by [redacted] with consumers with children and/or who are expecting babies should occur to ensure continuity of treatment and adequate supports for both mother and children, including a referral to home visitation services and to child protection, when warranted.

The Review Team discussed establishing a reporting mechanism for pediatricians to notify appropriate public agencies in events where children, especially newborns and infants, are repeatedly missing medical appointments and well-child visits. Those public agencies may include, but are not limited to, physical health managed care organizations who are responsible to track children, as well as home visitation services and, ultimately, child welfare agencies when children are deemed unsafe in families.

> In this case, mother had taken the infant to his well-baby visits on two occasions, and both visits occurred within the first two weeks of the infant's life. Mother scheduled but failed to attend other required and scheduled appointments.
>
> While mother reportedly had decided against immunizations for the infant and did not comply with appointments, the Review Team reinforced the importance for well-child visits as a means to discuss mother's postpartum needs, feeding and sleeping concerns for the infant, and any other areas regarding adjustments with a newborn.

The Review Team recommended that ACCYF issue a written process by which casework staff can receive paternity test results without excessive delay. The Team learned that, while there is an established process by which family members, courts and ACCYF are informed of testing results, ACCYF staff may make a request for earlier release, with certain safeguards in place. The ACCYF Manager for Safety, Permanency and Best Practice will address.

The Review Team supported county efforts to improve communication and data sharing between criminal justice and child welfare systems for individuals served by both systems.

DHS is in the process of adding adult probation and criminal court data for individuals served by both systems to provide ACCYF with historical and current information on individuals served by this system. Criminal justice data, including hearing dates, convictions, conditions of bail, and probation office contact information, will be accessible in KIDS to the ACCYF workforce by spring 2017.

The Review Team also discussed the benefit of appointing a point of contact within the court system for ACCYF to access individual-specific conditions of court proceedings, including bail conditions and no contact with children orders. A representative from the District Attorney's Office will address this need with adult court personnel and communicate findings to the Team.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

The agency's internal quality assurance team will continue to monitor practice improvements and provide feedback to leadership and casework staff.

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

The Review Team recommended continued enhanced collaboration between behavioral health and child protection as related to assessment, understanding and planning for mitigating risks to children in cases that involve both systems.

Department Review of County Internal Report:

Allegheny County CYF completed a preliminary Act 33 county review meeting on 08/18/2016 with the county's larger follow review on 10/31/2016. The county internal report received by the department was a draft with no date listed noting when the report was sent to the department. The report lacked dates of previous referrals and screen outs.

Department of Human Services Findings:

County Strengths:

The County responded immediately to the report and clarified with hospital staff to have the report certified as a near fatality. The county completed detailed

assessments with all family members. The county collaborated with law enforcement and medical professionals. The county had multiple agencies and representatives present for the Act 33 meeting.

County Weaknesses:

The County failed to complete a thorough assessment, diligent search or make follow up contact with collaterals during the previous January 2016 investigation. Additionally, the decision was made to close the case with no information to base the safety and well-being of the children.

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

No statutory or regulator areas of non-compliance.

Department of Human Services Recommendations:

The Department recognizes and concurs with the recommendations set forth by the County within their report. Allegheny County continues to greatly surpass other counties within the region in numbers of fatality and near fatality reports. As always, the county report is thorough and allows for an extensive list of thoughtful and appropriate recommendations. Along with this fact, the Department does recognize that many of the county reports provided by Allegheny County are submitted in their draft version. It would be recommended that the county review their finalization process regarding the Act 33 county reports and determine if a more timely submission of the final county report can be accomplished.