pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/09/2016
Date of Incident: 09/26/2016
Date of Report to ChildLine: 09/28/2016
CWIS Referral ID: [redacted]

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

Allegheny County Office of Children, Youth and Family Services

REPORT FINALIZED ON: 02/25/2017
Completed by State Reviewer

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 Children, Youth and Families(CYF) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/24/16 and held the County Review Team meeting on 01/22/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim/Child	04/09/2016
[redacted]	Mother	[redacted]/1982
[redacted]	Father	[redacted]/1972
[redacted]	Sibling-half	[redacted]/2010
* [redacted]	Father of Nezryn	[redacted]/1976
* [redacted]	Female Babysitter	[redacted]
* [redacted]	Male Babysitter/Alleged Perp	[redacted]/1977

* 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 Fatality Review Activities:

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed all current and past records pertaining to the family. The victim child's medical records were obtained and reviewed. Allegheny County Children, Youth, and Families (ACCYF) did have an Act 33 meeting on 10/24/2017, which is within the regulatory time frame. WRO was notified of the near fatality on 09/28/2016. ACCYF documented all of their investigation activities and supplied the WRO with all necessary documentation.

Children and Youth Involvement prior to Incident:

The family has been referred to ACCYF on five previous occasions. All five referrals were related to allegations of intimate partner and family violence. None of the referrals were accepted for services by the agency.

ACCYF received two General Protective Service (GPS) referrals in 2013; alleging that the half-sibling was unsafe while in her father's care due to a history of violence by the father towards the mother. In both referrals, the half-sibling was assessed as being safe in the care of her father. The mother and the half- sibling's father were engaged in an ongoing custody dispute during 2013, which was resolved with a joint custody order issued by the court.

ACCYF received two GPS referrals in 2015, both associated with reported violence towards the mother by the victim child's father. In the September 2015 referral, ACCYF had difficulty locating the family, as the mother and the older half-sibling were residing at a domestic violence shelter. The mother was also pregnant with the victim child at that time. The half-sibling was assessed as safe in her father's care at his home. The mother acknowledged ongoing intimate partner violence with the father of the victim child and reported that she had left him out of fear for her and her children's lives.

The most recent GPS referral on 09/07/2016 was made several weeks prior to the near-fatal event. Allegations were associated with the father of the older half-sibling. The report stated that the half-sibling's father grabbed her by the arm, with unknown pain, injury or impairment. ACCYF attempted to contact the mother and spoke with the school nurse who reported she had not seen the half-sibling. ACCYF screened this referral out.

The alleged perpetrator had no involvement with human services or criminal justice systems. He was not a household member or family member but was the intimate partner of mother's work friend, both of whom served as babysitters for the injured infant.

Circumstances of Child Fatality and Related Case Activity:

ACCYF received a GPS report on 09/26/2016 regarding injuries to a 5-month-old female infant. It was reported that the infant had inflicted brain injuries and bruising to the chest. The attending physician expressed concern that ChildLine did not initially designate the report as a child protective services (CPS) report as it was evident that the injuries sustained were inflicted by a caregiver. ACCYF then contacted ChildLine to request the report be correctly designated as a CPS report and certified as a near fatality, as the infant was evaluated to be in serious condition on 09/28/2016.

The victim child was admitted to the pediatric intensive care unit (PICU) at [redacted] She was diagnosed with an acute subdural hemorrhage, with concerns for subacute hemorrhages, bruising to her chest and

retinal hemorrhages in both eyes. These injuries are a result of significant trauma. The victim child was released from the hospital on 10/03/2016 to a non-relative foster home.

The victim child is the younger child of two children who reside with their biological mother. The older half-sibling also resides with her biological father, as the mother and the father of this child share custody. The victim child has no contact with her biological father due to an active Protection from Abuse (PFA) court order that prohibits contact. The father resides within Allegheny County but has not responded to ACCYF's efforts to locate and engage him. The victim child was in the care of the mother's former work friend and this woman's partner at the time of the incident. The partner of mother's work friend was later named as the alleged perpetrator on the CPS report.

At the time of the incident, the two adult babysitters had been caring for the victim child for approximately two-and-a-half months while the mother waited for subsidized day care for the victim child. The mother had dropped the victim child off with the babysitters on the morning of the incident and then went to work. Approximately two hours later, the mother received a telephone call, stating that the victim child had shown seizure-like activity while in the babysitters' home and was being transported via ambulance to CHP.

The caseworker contacted law enforcement prior to responding to the hospital. Law enforcement shared that they had conducted recorded interviews with both babysitters. Per law enforcement, the male babysitter stated that he observed and had photographed previous injuries to the infant, but that he had not told the mother about these reported older injuries. The male babysitter alleged to the police that the mother had told him that she had given the infant cough syrup with codeine, but this was not substantiated. Law enforcement reported the mother and both babysitters had agreed to complete polygraphs.

The caseworker then went to CHP to ensure the safety of the victim child. The caseworker interviewed the mother while at the hospital. The mother reported that she had received a telephone call at work from the female babysitter, stating that the victim child was "unresponsive, went stiff, went limp, and had a seizure." The mother reported that she had seen broken blood vessels in the infant's eye approximately two weeks prior to the near-fatal event. The mother reported that when she had asked the female babysitter about broken blood vessels in the infant's eye, the babysitter told the mother that the victim child had poked herself in the eye. The mother was unaware of the bruise to the infant's chest. The mother denied injuring the victim child and stated that she would be willing to submit to a polygraph test for law enforcement. She also stated that she had taken the victim child to an urgent care facility on 09/16/2016 to evaluate the victim child's fever and nasal congestion with cough. The victim child was diagnosed with a respiratory infection, with recommended follow up with the pediatrician. Urgent care assessed the victim child's eyes as normal, with no discharge.

The mother stated that she had known the female babysitter through their mutual previous employment. The mother commented that she reached out to this woman approximately two and a half months ago, as she was returning to work and needed temporary child care for the victim child while she waited to receive subsidized child care. Mother also detailed her own history of childhood and adult trauma, including intimate partner violence with both of the children's fathers and her own experiences with maltreatment as a child. She stated that the half-sibling resides between both parents' homes through a shared custody arrangement. Mother noted that she has a limited support system; both of her parents are deceased, and she has no contact with her older brother.

The caseworker then responded to the home of the older sibling's father to ensure the safety of the half-sibling. The caseworker spoke with the father, who stated that the babysitters were used for his daughter on occasional Saturdays when the mother had to work and she was in the mother's care. He stated that he did not have much information about them. The half-sibling's father reported that, although he had observed the mother's temper when they were together, he had never seen her express anger towards either of the children and had difficulty believing that she would have caused harm to the victim child.

The caseworker interviewed the half-sibling who reported that her mother would yell at her if rules were broken but denied that her mother would display anger toward the victim child. The half-sibling reported that the mother would soothe the victim child by giving her a bottle or changing her diaper. The half-sibling did not disclose witnessing anyone causing harm to the victim child. The half-sibling did however, report a history of intimate partner violence between the mother and an unidentified male, describing this person as punching the mother in the stomach and frequent physical fights.

The caseworker interviewed the male babysitter first. He reported that he and his partner had been caring for the victim child since the beginning of summer. He described the victim child as an, "easy baby to take care of" and stated that he primarily cared for her as his partner had physical health conditions that limited her ability to care for the infant. He reported that he had noted broken blood vessels and bruising to the infant's legs on previous occasions, had photographed the injuries, and had spoken to the mother about the injuries. The male babysitter had previously noted to law enforcement that he had not spoken to the mother about the older injuries that he had allegedly observed. He stated that the mother explained that the bouncer seat was the cause of leg bruising. He then stated that he had researched causes for broken blood vessels online and noted that some causes included crying or bowel movements. He reported that sometimes the victim child would cry so hard, she would lose her breath. He reported that on the morning of the incident, the victim child was dropped off in her car seat and appeared fine. He denied observing any bruising or broken blood vessels. He stated that the victim child played normally, and after taking a walk she slept and awoke crying a hard cry. He stated that he picked her up and attempted to feed her, but she refused her bottle. He stated that he began walking the victim child up and down the hallway, bouncing her and singing to her. He stated that the victim child

became stiff. He took her back into the living room and informed his partner that something was wrong with the victim child. By that time the victim child was reportedly not making any noise, but began crying when Emergency Medical Services (EMS) arrived at the home and transported the infant via ambulance to CHP.

The caseworker interviewed the female babysitter, who was the mother's former work friend. She reported that the victim child acted normal on the day of incident. She stated that she and her partner took the victim child for a walk and then placed the victim child in her pack 'n play upon return. The victim child awoke from her nap, crying, which was unusual, as she did not cry often. She stated that she picked the victim child up and handed her to her partner, who walked her up and down the hall, bouncing her. She stated that she heard the victim child stop crying, and, when her partner brought the victim child into the room, she observed that she appeared stiff, with her arm straight up and backwards. She denied observing any broken blood vessels or bruising to the victim child.

The half-sibling had a forensic interview on 10/13/2016. The sibling disclosed that she believed the female babysitter had injured her infant sister, stating that, while she had never observed this babysitter cause harm, there was an occasion when the victim child was left to cry in her pack 'n play.

ACCYF accepted the family for services on 10/03/2016 and obtained an Emergency Custody Authorization (ECA) to [redacted] in a non-relative resource home. The half-sibling remained in her parents' care as there was a joint custody order and no assessed risks for that child in either parent's home. The victim child was [redacted] on 10/24/2016 and returned to the care of her mother on 11/08/2016 (after mother was ruled out as a possible perpetrator of abuse), with crisis in-home services. The female babysitter died in November 2016. On 11/07/2016 the agency filed the Child Protective Service Investigation Report with a status of "Indicated" to ChildLine on the male babysitter. Law enforcement arrested the male babysitter and charged him with causing the injuries to the victim child.

The male babysitter was arrested on 10/27/2016 and charged with two counts of a felony 1: aggravated assault with a victim less than 13 and a defendant 18 or older; one count of a misdemeanor 2: recklessly endangering another person; and one count of felony 3: endangering welfare of children-parent/guardian/other commits offense. At the preliminary hearing on 01/24/2017 all charges were waived for court.

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

- Strengths in compliance with statutes, regulations and services to children and families;
    - CYF responded immediately to the CPS report and assured the safety of the infant and the infant's sibling while in her father's care.

- CYF accepted the family for services and is providing continued assessment of and supports to mother and her two children.

- CYF assumed protective custody and filed a dependency petition for the infant immediately after the near-fatal event. The infant was initially placed in a non-relative resource home, but has since returned to her mother's care. The court adjudicated the infant dependent. CYF also filed a dependency petition for the older child but later withdrew that petition, as the older child is assessed as safe in the joint care of parents.

- The assigned CPS investigator and law enforcement worked jointly to conduct their investigations.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The review team noted child welfare involvement with the family prior to the near-fatal event. Review of previous referrals indicated the need for adherence to established standards of investigative practices, including collateral contacts, face-to-face interviews with all parties, and routine medical assessment when there are allegations of physical maltreatment and/or injuries.

  - In two previous referrals, the older child reportedly witnessed ongoing intimate partner violence between adults. In one instance, mother and child resided in a shelter to ensure their protection from violence. Record indicated that this child did not receive assessment or services to address trauma associated with her witness of violence. The Review Team discussed the need for assessment and understanding of and planning of intervention for trauma for children who witness violence.

  - While CPS had made multiple attempts to locate the infant's father, he had not been located at the time of review. The Review Team discussed the need for diligent search to be completed as a routine practice, in order to fully engage all parents, particularly fathers.

- 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 discussed ChildLine's designation of reports as General Protective Services, when the written details regarding events clearly establish a Child Protective Services report designation.
  - PA DHS Office of Children, Youth and Families, Western Region continues to communicate report designation errors with the state Act 33 Team and ChildLine administration.

- The Review Team discussed the difficulty in addressing recommendations to prevent or reduce future fatalities and near fatalities when the perpetrator is not a household member or family member and where the perpetrator has no known involvement in systems. In this case, the named perpetrator had no documented systems' involvement, and CYF was unable to conduct a psychosocial interview of the male babysitter, given active law enforcement involvement.

- The Review Team discussed the need for safe, immediate and affordable childcare. Mother had been placed on a wait list for subsidized childcare and reached out to a friend for temporary babysitting to ensure that her child was cared for while mother worked.

- The Review Team recommended further education of medical professionals, including urgent care and pediatric practices, to assess and report suspected child abuse when children present with specific injuries or medical conditions. In this case, mother presented the infant to an urgent care facility for assessment of cold symptoms. The urgent care facility assessed the infant with a respiratory infection and recommended follow up with the pediatrician. While the urgent care report indicated that the infant's eyes were evaluated as "normal", team members discussed the possibility that the infant's symptoms (vomiting, loose stool) could have been symptoms of inflicted injury.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - 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 discussed opportunities where behavioral health providers can expand their assessments of parents with behavioral health challenges to include discussions on parenting needs and stressors (e.g., childcare arrangements, family supports, strengthening of informal supports) to link parents with needed formal and informal supports.

Department Review of County Internal Report:

- The county submitted a very thorough and well written report to the Department that met and exceeded regulatory requirements.

Department of Human Services Findings:

- County Strengths:
  - ACCYF responded immediately to the CPS report and ensured the safety of the victim child and victim child's half sibling.
  - ACCYF worked well with law enforcement.
  - ACCYF worked well with the hospital and child advocacy center physicians.
  - ACCYF provided follow-up to the family and remains open with the family to ensure that the family is receiving all appropriate services.
  - ACCYF documented safety assessments on 10/05/2016, 10/25/2016 and 11/09/2016 to ensure safety of children.
  - Allegheny County CYF has a very good Near Fatality review team with all stakeholders involved.

- County Weaknesses:
  - It is unclear if the victim child had bruised/bloodshot eyes when she went to [redacted] on 11/09/2016, the Urgent Care notes do not indicate any injury to child's eyes. However, mother reported that she had observed broken blood vessels in the victim child's eyes two weeks prior to the incident. IF this is true, this should be noted on the Urgent Care documentation. There is no documentation that ACCYF followed up with this discrepancy.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None.

Department of Human Services Recommendations:

- In order to avoid similar instances in the future, procedures should be given to medical providers as to when a toddler enters a medical facility with similar symptoms (i.e. broken blood vessels, diarrhea, vomiting). The child should be further examined with more extensive testing that would test for subdural hematomas, etc. in a more thorough manner.
- Parents are still struggling with finding adequate child care for their children especially when they are waiting for CCIS approval. A registry of approved caregivers should be made available to parents when they are waiting for CCIS approval.