pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/02/2017
Date of Incident: 05/23/2017
Date of Report to ChildLine: 05/23/2017
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 Children, Youth, and Families

REPORT FINALIZED ON:
11/07/2017

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street, Room 260 | 412-565-5728 | 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 Office of Children, Youth, and Families (ACOCYF) convened a review team in accordance with the Child Protective Services Law related to this report. ACOCYF held their preliminary Act 33 meeting on 06/15/2017. Allegheny County's full review team meeting was convened on 07/17/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	04/02/2017
[redacted]	[redacted]	1999
[redacted]	[redacted]	1999
[redacted]	[redacted]	1976
[redacted]	[redacted]	2001
[redacted]	[redacted]	2008
[redacted]	[redacted]	1978
[redacted]	[redacted]	1976
[redacted]	[redacted]	2010

*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 (WRO) obtained and reviewed all current records pertaining to the family. WRO staff reviewed various reports, assessments, and case documentation provided by Allegheny County. WRO participated in the preliminary Act 33 meeting held on 06/15/2017 and Allegheny County's full review team meeting held on 07/17/2017.

Children and Youth Involvement prior to Incident:

The [redacted] and the [redacted] were referred to the agency [redacted] with various reports.

On 05/22/2011, a report was received alleging [redacted] were living in the home of [redacted]. The report alleged [redacted] was intoxicated, [redacted] had a panic attack, and that the children were running through the neighborhood unsupervised. The report [redacted].

On 03/29/2015, a referral was received stating [redacted] got into an altercation. [redacted] struck the [redacted] in the chest. [redacted] was requesting to be [redacted]. The report was [redacted] stating the [redacted]

On 09/23/2015, the agency received an allegation concerning the caregivers of [redacted] who was 5 years old at the time. The report alleged [redacted] was using substances, hallucinating, and caring for [redacted]. In addition [redacted] of the victim child was living in the home of [redacted] while using substances. The report was [redacted] after one visit to the home.

On 04/14/2016, the agency received a [redacted] referral alleging [redacted] was possibly coerced into having intercourse with a 31-year-old female. The report was [redacted]

On 04/22/2016, [redacted] reported that [redacted] was homeless after the [redacted] made [redacted] leave their home. This occurred [redacted] and [redacted] got into an altercation. [redacted] did not approve of the relationship between [redacted] and [redacted]. The report [redacted].

On 05/19/2016, the agency received [redacted] alleging [redacted] was without supervision in the home. The agency performed [redacted] and [redacted] the allegations. The family was [redacted] as [redacted] was [redacted]

On 10/24/2016, a report was filed alleging [redacted] was having reciprocal oral sex with a fourteen-year-old female while visiting with the fourteen-year-old's grandmother. It was unclear in the report if the fourteen-year-old was in a child care role. The relationship of the grandmother to [redacted] was also unclear. The report was [redacted].

On 01/02/2017, the WRO received a [redacted] alleging [redacted] was struck in the cheek with a clipboard at [redacted]. The report [redacted].

On 04/10/2017, the agency received [redacted] for [redacted]. These concerns were [redacted]. The agency addressed safe sleeping with [redacted]

[redacted], but [redacted] and victim child's cases were [redacted] on [redacted], as [redacted] did not wish to continue services.

Circumstances of Child Near Fatality and Related Case Activity:

On 05/23/2017, Allegheny County Office of Children, Youth, and Families (ACOCYF) received [redacted] report regarding the near fatality of a seven-week- old male infant for allegations [redacted]. [redacted] and victim child were visiting with [redacted] at the home of [redacted]. [redacted] allegedly dropped the infant while standing. Upon returning to the home of [redacted], emergency personnel were contacted and the child was taken to a pediatric hospital. Law enforcement was notified of the report and began the investigation along with ACOCYF.

[redacted] alleges [redacted] was standing up from the couch with the infant wrapped in a blanket. The child rolled out of the blanket and fell onto the coffee table then the floor. [redacted] stated [redacted] was outside, but [redacted] was present.

[redacted] reported [redacted] was outside and was unaware of where [redacted] was. [redacted] entered the living room after hearing [redacted] scream.

When interviewed, [redacted] denied being in the living room stating [redacted] was in [redacted] bedroom and entered the living room after the baby started crying.

All present parties denied the victim child had any visible injuries or was in any distress. There were additional reports of violence between [redacted] and [redacted]. It was initially reported that [redacted] and [redacted] were arguing in the emergency room and [redacted] remarked that [redacted] was the reason [redacted] dropped the child. This occurred after it was reported that [redacted] shoved [redacted]. [redacted] continued to deny [redacted] was present when the victim child was dropped; however, [redacted] did allege [redacted] pushed [redacted] in the emergency room. [redacted] stated [redacted] was attempting to grab [redacted] by the hip to make [redacted] sit down while in the emergency room. Both admitted to a history of intimate partner violence.

On 05/25/2017, the treating physician determined the child had multiple subarachnoid hemorrhages, which were caused by multiple impacts greater than the reported fall from [redacted] arm to the coffee table. ACOCYF received [redacted] on 05/25/2017 and the victim child was subsequently [redacted], as a [redacted] was not found. On 06/21/2017, during a follow up appointment,

healing rib fractures were discovered. It was concluded that these rib fractures likely occurred prior to the near fatal event.

On 06/30/2017, ACOCYF concluded the investigation and [redacted] against [redacted] for [redacted] The finding noted the inconsistencies between the report and the victim child's injuries. Law enforcement has not been able to file charges as [redacted] maintains that [redacted] was not in a caretaker role at the time. [redacted] contends [redacted] does not provide care to the child.

On 07/05/2017, the child was ordered into [redacted]. [redacted] receives liberal visitation. [redacted] is currently incarcerated due to numerous felony charges stemming from two separate events. [redacted] moved into the home of [redacted], but left after [redacted] was allegedly assaulted by [redacted]. [redacted] is now staying with a friend. The family is [redacted] and [redacted] is ordered to participate in [redacted].

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:

During the earlier [redacted] regarding the [redacted], the CYF Mon Valley caseworker documented two discussions related to safe sleep with [redacted] and ensured that the infant had appropriate baby supplies (diapers and formula). This caseworker also conducted a collateral contact with [redacted] active [redacted] service coordinator to obtain information related to [redacted] parenting abilities.

Upon receipt of the [redacted], the CYF intake caseworker contacted law enforcement to ensure adherence to the joint investigative protocol. The intake caseworker then responded to the regional pediatric hospital to ensure the safety of the infant and to conduct interviews with [redacted]

CYF obtained an [redacted] from [redacted] after the safety of the infant could not be assured in the care of [redacted]. The caseworker sought the assistance of the CYF [redacted], co-located in each regional office, to support identification and assessment of family, to locate an appropriate [redacted]. When an appropriate [redacted] could not be located, CYF [redacted].

During the [redacted], the CYF caseworker completed collateral contacts with medical professionals, including the infant's pediatrician.

The intake and assigned Family Services casework staff conducted a formal Transfer Conference to ensure a thorough transfer of knowledge and case understanding.

When [redacted] was arrested on adult criminal charges, the newly assigned casework supervisor contacted [redacted] probation officer to obtain information regarding [redacted] criminal justice involvement and to partner with this system. Following a physical altercation between [redacted], this supervisor also contacted law enforcement to obtain police reports for assessment and planning purposes.

<u>Deficiencies in compliance with statutes, regulations and services to children and families:</u>

The following challenges were noted by the local review team. Not all of these are identified as deficiencies.

Case review identified practice challenges related to the April 2017 [redacted] for [redacted] for allegations of [redacted]

The injured infant was not formally identified as a CYF client prior to the near-fatal event, despite his residing in the [redacted] home with [redacted] CYF practice requires that casework staff formally assess all household members during an investigation. While CYF conducted a limited assessment of the infant and [redacted], risk factors ([redacted]) were not identified. [redacted] was not assessed, risks associated with [redacted] recent [redacted] involvement, [redacted] pattern of violence toward [redacted] and others, and [redacted] intermittently treated [redacted] were also not identified.

CYF [redacted] with [redacted] and the infant at [redacted], as CYF assessed the infant as safe in [redacted], and [redacted] did not want [redacted] involvement.

[redacted] presented with significant risk factors that impacted the safety and well-being of the infant while in the care of [redacted]. CYF's assessment and subsequent planning did not reflect those risk factors that included:

[redacted] lack of acknowledgement or acceptance of responsibility for the violence inflicted on [redacted] newborn son. [redacted] demonstrate a lack of protective capacities in ensuring the safety and well-being of [redacted] infant.

Pattern of intimate partner violence between [redacted] ([redacted] granted at the time of this review) as well as intergenerational intimate partner violence with [redacted]

[redacted] demonstrated pattern of violent criminal behavior; notably, [redacted] now faces adult criminal charges that may result in [redacted] incarceration.

[redacted] [redacted] serious and persistent behavioral health challenges. While [redacted] has been engaged in mental health services, [redacted] is not currently active in services for mental health and [redacted]

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 that CYF staff adhere to practice standards by completing the Risk Matrix on all household members and a Safety Assessment, documented on a Contact Summary, to ensure that all household members are thoroughly assessed for safety and risk.

The Review Team recommended that CYF policy leads review the *Investigative Practice Standards* (January 2017) and clarify the following investigative assessment procedure: *If there are children that are not on your report but living in the home, or there are children of the parents/caregivers not listed on the report, this information must be reported to your supervisor and a report should be made to Call Screening in order to have a new report generated.*

The Review Team recommended that frontline staff receive continued education on maltreatment risk factors for infants related to their physiologic vulnerability and developmentally normal crying during the first few months of life. The Review Team noted that serious traumatic brain injury in young children is largely result of abuse and results in significant morbidity and mortality.[1]

The Review Team reviewed CYF's strategies to enhance staff training and competency development and to increase availability of case consultation services related to intimate partner violence.

Training:

[1] Per the Centers for Disease Control and Prevention, child abuse is the third leading cause of abusive head injuries, after falls and motor vehicle accidents. The peak incidence and rapid decrease with age are thought to be related to prolonged, inconsolable and unpredictable episodes of crying that is developmentally normal for infants. Crying can trigger shaking behaviors from parents and caregivers. Fatality rates are estimated to exceed 20 percent, with significant disabilities for two-thirds of surviving infants.

Allegheny County DHS Office of Children, Youth, and Families, in collaboration with [redacted], is implementing an [redacted] Intimate Partner Violence) training curriculum that will be delivered to casework staff and support specialists.

All new CYF hires will be trained in the curriculum within their first year of hire

Capacity Building:

Capacity building strategies are led by [redacted] and include community partners from the [redacted] system (including [redacted] Thirty-five CYF practice leaders, including Clinical Managers, Peer Coaches, Best Practice Specialists, Supervisors, and Father Engagement Specialists, attended three days of training with [redacted] and focused on [redacted] practice challenges within the child welfare context.

[redacted] plans to add three full-time CYF consultants for ongoing skill building and consultation to support to CYF staff and families experiencing [redacted].

The Review Team recommended that CYF staff and system partners carefully consider clients' safety and potential risks when planning conferencing and teaming meetings with families who are experiencing [redacted].

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:

Pennsylvania Department of Human Services Office of Children, Youth and Families, Western Region will communicate Act 33 designation errors with the Pennsylvania Act 33 Lead Team and ChildLine administration.

Department Review of County Internal Report:

ACOCYF submitted a draft report to the WRO. The report provided important information regarding the victim child's incident and possible cause of his critical state. WRO agrees with agency's recommendations.

Department of Human Services Findings:

County Strengths:

ACOCYF maintained significant collaboration between law enforcement and the regional hospital during the entire investigation. This began immediately upon receiving the allegation.

The county review team emphasized practice standards where frontline staff are required to complete assessments on all household members, even those not listed in a report. This emphasis allows for a global assessment of the family and may trigger service needs not readily identified in initial reports.

County Weaknesses:

The [redacted] had numerous [redacted] referrals during the last two years. These referrals included allegations of homelessness, [redacted]intimate partner violence. The allegations regarding homelessness and intimate partner violence were [redacted] without a visit according to the reports. This conflict later contributed to the near fatal event according to the allegations. A field screening of one of these allegations may have identified earlier intervention for the families.

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

No areas of non-compliance identified.

Department of Human Services Recommendations:

The Department of Human Services recommends agencies consider the number and frequency of reports on a given family in their determination to [redacted] a report.

It is also recommended that allegations of intimate partner violence between [redacted] be assessed and referred for appropriate services. Given the nature of domestic violence, where victims often feel compelled to remain despite escalating abuse, early intervention is critical.