pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/19/2016
Date of Incident: 08/08/2017
Date of Report to ChildLine: 08/09/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:

2/2/2018

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 Office of Children, Youth and Families (ACOCYF) convened a review team in accordance with the Child Protective Services Law related to this report on 09/06/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1978
	Father	[redacted]1982
	Victim Child	08/19/2016
	Brother	[redacted]2003
	Brother	[redacted]2001
	Maternal Grandmother	[redacted]1954
	Sister	[redacted]1999
	Maternal Great-grandmother	[redacted]1927

*Not a household member

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) attended the Act 33 meeting on 09/06/2017 and a subsequent County Near Fatality Review Team meeting on 10/16/2017. WRO reviewed documents provided by ACOCYF pertaining to the family's previous agency history, and the current Child Protective Services (CPS) investigation that relates to this near fatality. WRO was notified of the report on 08/09/2017.

Children and Youth Involvement prior to Incident:

The family has an extensive history with ACOCYF. There were 15 previous referrals dating back to 2010 for parental substance abuse issues, child substance abuse issues, parent/child conflict, truancy, and inadequate physical care. The family has been open for services six times, to include multiple placements for each child.

The most recent case opening was September 2014. The 16-year-old sibling was residing with the paternal grandfather. The youth was experiencing assaultive behavior [redacted]. The youth left paternal grandfather's home, and went to live with his mother. The mother was struggling with her own mental health issues.

At the time of the victim child's near fatal incident, the family was open for services with ACOCYF. The victim child [redacted] placed with the maternal grandmother due to the mother's substance abuse, lack of housing, and mental health issues. The victim child's parents were [redacted] at the time of the report.

Circumstances of Child Near Fatality and Related Case Activity:

On 08/09/2017, ACOCYF received a CPS report regarding the near fatal incident of an 11-month-old male infant. It was suspected the child ingested cocaine while in the care of his maternal grandmother. On 08/09/2017, ACOCYF obtained an emergency custody order placing the child and the 14-year-old sibling with the maternal great-grandmother due to the CPS investigation where it was suspected the victim child ingested cocaine while in the maternal grandmother's care. The victim child was taken to a local hospital's Emergency Department by ambulance, and then transported to the Children's Hospital of Pittsburgh (CHP). The victim child was admitted [redacted] on 08/09/2017. On 08/10/2017, the victim child [redacted] the hospital. The children [redacted] with the maternal great-grandmother.

On 08/16/2017, ACOCYF interviewed the maternal grandmother regarding the incident, and the events leading up to the child ingesting cocaine. The maternal grandmother reported the victim child, the child's mother, the 14-year-old sibling, along with her had made a trip to Ohio that weekend to visit the maternal grandfather. The family has a residence in Ohio, and a residence in Pennsylvania. The victim child's mother returned home to Pennsylvania before the rest of the family on 08/01/2017. The rest of the family returned home to Pennsylvania later in the evening on 08/06/2017, around 9:30 PM. When they returned, they found their home in disarray, which was not how they had left the home prior to their visit to Ohio.

The maternal grandmother reported that on 08/07/2017, she and the victim child were home all day. The child's mother was not home on 08/07/2017 from 9:30 AM to 12:30 AM the following day.

On 08/08/2017, the maternal grandmother took the victim child to his father's home while she attended [redacted] appointment. She also took the victim child's mother to an appointment [redacted], and then to a local hospital because she [redacted]. After that the victim child, the mother and the maternal grandmother returned home. The mother reportedly showered after returning home, she left the home with the father around 8:00 PM. The victim child went to bed between 9:30 PM-10:00 PM. The maternal

grandmother went to bed around 11:00 PM. The victim child's mother came home between 12:00 AM – 12:30 AM, but did not come directly upstairs to her bedroom.

The maternal grandmother reported that on 08/09/2017, the victim child was in the living room watching cartoons while she was in the kitchen. The victim child is able to crawl around the front hall, the living room and the dining room. Baby gates block the victim child from going upstairs, and both doors to the kitchen. The maternal grandmother can see the child in the living room, and the front hall if she leans over the baby gate. The victim child usually watches cartoons, or hangs at one of the baby gates. The maternal grandmother stated that she was in and out of the kitchen, and that she did not go upstairs. The maternal grandmother stated that she was sitting at the kitchen table reading or sorting through mail when the victim child came into her view at the baby gate that separates the kitchen and dining room. She could see the victim child had something in his mouth that looked "black and soft". She thought it was a "fuzzy". She described it as black, pea sized, and not real hard. The victim child's eyes then closed, and he began breathing heavy, it sounded as if he was snoring. Then his body became limp, and he began to make sounds as if hiccupping. The maternal grandmother videoed the victim child's behavior, and sent the video to the ACOCYF supervisor before contacting emergency services (911). The child was transported to the local hospital before being air-lifted to Children's Hospital of Pittsburgh.

The victim child was admitted [redacted] The child's urine screen came back positive for cocaine. [redacted] The victim child [redacted] the next day [redacted].

The ACOCYF caseworker asked the maternal grandmother about the object she took out of the child's mouth. The maternal grandmother attempted to retrieve it from the garbage she threw it in, but was unable to find it. She stated the object was soft from being in the child's mouth, so she "squished" it before throwing it away.

The maternal grandmother denied any drug use or any knowledge of how the victim child had access to the drugs in her home. She reported the mother told her she was cleaning out old purses, and perhaps something had fallen out. The maternal grandmother speculated that the victim child's mother or father could have brought something into the house during the week that she and the children were in Ohio, or the mother brought something home when she came home the night before the incident. The maternal grandmother kicked the mother out of her home when the child's toxicology screening came back positive for cocaine and [redacted]. According to the maternal grandmother the mother has always admitted to using cocaine, but denies use of any other drug. She also reported, the child's father has a history of heroin and cocaine use.

The ongoing ACOCYF caseworker had a conversation with the child's mother on 08/16/2017. The child's mother reported she was willing to stay out of the maternal grandmother's home, so the maternal grandmother could have the child back in her

care. Visits between the child and the child's mother and father were also discussed. On 08/25/2017, the maternal grandmother's drug screen came back negative.

The mother, father, and the maternal grandmother were interviewed during the investigation. The mother stated that she was sleeping when the incident occurred, and the father was not in the home at the time of the incident. On 10/05/2017 ACOCYF submitted the Child Protective Services Investigation report as "Indicated" against the maternal grandmother.

[redacted]

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

Strengths:

- The CPS investigator and active casework staff remained in communication to ensure the appropriate interviews were completed and that the child's safety was assured.
- CYF ensured the children's safety [redacted] for the infant and the 14-year-old brother who was also residing in the home at the time of event.
- The active caseworker explored kinship supports and were successful in placing the victim child and his sibling with family.
- The active caseworker contacted Mother's adult probation officer following the near-fatality to obtain collateral information.
- At the time of the near-fatality, CYF was providing [redacted] to Mother. The agency had previously referred the infant's Father and Mother [redacted] Following the near-fatality, Mother was re-engaged with a service provider [redacted]
- Following the near-fatality event, the infant was referred for case management services. Maternal great-grandmother voiced that she did not want to become a certified foster parent.

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

- The Review Team identified that safety assessments were not completed in accordance with state regulations.
- Prior to the near-fatality, collateral contacts were not conducted.

[redacted]

Recommendations for Changes at the State and Local Levels:

- The Review Team discussed the need for uniformity across CPS investigations in decisions to add alleged perpetrators to a report when investigative information results in the identification of other possible alleged perpetrators in child abuse reports.
- Information shared during the investigation reflected that, while one household member self-reported substance use prior to the infant's ingestion, no other persons were added to the CPS report as alleged perpetrators. There was discussion among the team as to whether other persons should be added to the report as alleged perpetrators.
- The Review Team recommended that law enforcement continue its investigation to determine identification of alleged perpetrators who may be held legally responsible for causing the near death of the infant.
- The Review Team recommended casework staff consider lifelong permanency when determining placements. At the time of review, the infant was placed with a relative who is elderly and has significant physical health challenges.
- [redacted]The Review Team discussed conditions under which parents maintain medical and/or educational guardianship for their children. [redacted]
- When the court allows parents to reside in a kinship home that is designated as a resource home placement for a child, the kinship care agency will no longer provide supervision and supports to that kinship home, as the home cannot be certified. The Review Team recommended that DHS consider a mechanism by which a kinship care agency may continue to provide some level of support for and supervision of kinship caregivers who are unable to be certified.

- The Review Team discussed the need for CYF to request that the court reconsider orders with which CYF disagrees due to safety or risk factors. In this case, CYF was not in agreement with the court's decision to allow Mother to return to the maternal kin home. The Review Team recommended further discussion with CYF leadership and legal counsel on development of procedures for reconsideration requests.

[redacted]

- The Review Team discussed the availability and adequacy of psychoeducational supports for family members of persons with behavioral health challenges. In this case, maternal grandmother was ordered to seek psychoeducation on behavioral health disorders and took an online course that was accepted by the court. However, team members from the behavioral health system were unfamiliar with the specific online course and its adequacy for the purposes ordered by the court.
- The Review Team discussed the adequacy of [redacted] interventions within the juvenile justice system that support changes in the trajectories of delinquent youth's lives. In this case, the two older brothers are on paths that may be like those of their parents' (i.e., criminal justice involvement, [redacted] challenges).
- The agency's internal quality assurance team will continue to monitor practice improvements and provide feedback to leadership and casework staff.
- Collaboration of community agencies and services providers (external systems) to prevent child abuse and neglect.

Department Review of County Internal Report:

The Department received the County Internal Report within 90 days of the Act 33 meeting. The County's Internal Report shows a true depiction of what transpired during the meeting and the Department is in agreement with the recommendations that were presented within the meeting and in the report.

Department of Human Services Findings:

County Strengths:

- ACOCYF held the Act 33 meeting in a timely manner.
- ACOCYF held a subsequent near fatality meeting.
- ACOCYF responded to assessing and assuring the safety of the other children in a timely manner.

[redacted]

County Weaknesses:

- The victim child and his brothers were placed with the maternal great grandmother after the incident. The maternal grandmother is elderly and was not able to provide long term care for the child. It does not appear that the agency considered the challenges that a 90-year-old woman would have caring for a 1-year-old.

- Even though the maternal grandmother had to have a drug test after the incident neither the mother nor the father who had a history [redacted] and who were in and out of the home were required to have a drug test.

Areas of Non-Compliance/Statutory Violations:

None

Department of Human Services Recommendations:

The Department recommends further education for caretakers caring for children whose parents are unable to care for them due to parental substance abuse issues. This education would focus on the necessity of close monitoring of the children when interacting with their parents to insure no transfer of pills or substances accidentally occurs.