pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 08/22/2017
Date of Incident: 12/27/2017
Date of Report to ChildLine: 02/13/2018
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 Families

REPORT FINALIZED ON:

07/10/2018

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 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 02/22/2018. An additional review team meeting was convened on 04/16/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	08/22/2017
	Sibling	[redacted]/2011
	Sibling	[redacted]/2016
	Mother	[redacted]/1987
	Father	[redacted]/1984
	Maternal Aunt	[redacted]/1985

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 and case documentation provided by Allegheny County.

Children and Youth Involvement prior to Incident:

On 02/28/2016, the Agency received a referral with allegations of parental [redacted] by the father and domestic violence between the mother and father. It was reported there was argument between the parents due to the father allegedly [redacted] in the home with the two children present. It was reported the mother flipped over a table and the father pushed her a few times while she was 4 months pregnant. The Agency obtained releases of information for the father's [redacted] and the pediatrician. Information was requested for both collaterals, however no confirmation information was received after being requested. This report was closed at Intake with low risk and no safety threats.

On 09/09/2016, the Agency received a referral identifying the mother, as a household member and the maternal aunt as the focus case. In regards to the aunt, there were six prior reports with two case openings in 2010 and 2016.

Circumstances of Child Near Fatality and Related Case Activity:

On 12/27/2017 the child was taken by the mother to the [redacted] emergency room due to fever, vomiting and fussiness. The mother reported attempting to feed the victim child and he was fussy and felt warm. After examination by the emergency room doctor additional assessments/test were requested as there were some concerns for the victim child "shaking" and appearing to have seizures. Upon evaluation it was found the child had bilateral subdural hematomas in the frontal region and high density subdural hematoma posteriorly; bilateral, extensive, multilayered retinal hemorrhages per dilated fundus exam. The victim child was admitted to the pediatric intensive care unit. After finding out about the hematomas, the mother was documented as saying to hospital staff "I think my husband did it". On 12/27/2017, Allegheny County Office of Children, Youth and Families (ACOCYF) received a child protective services (CPS) referral, alleging Causing Bodily Injury to Child Through Recent Act/Failure to Act-Causing, with an unknown alleged perpetrator.

The mother explained she was working the night shift 12/25/2017 through 12/26/2017 leaving the father as the primary caregiver for all three children. After leaving work she stopped for coffee and dropped off a co-worker arriving home around 9am. She gave the victim child a bottle and he immediately vomited. After awaking from sleep around 2pm that day, the victim child was fed by his father and reportedly vomited again. The mother then contacted the pediatrician with concern for the victim child having a high temperature and diarrhea and subsequently took the victim child to [redacted] emergency room.

The father denied knowledge of the seriousness of the victim child's injuries. The father explained while the mother was at work the victim seemed fussy, he rocked him to sleep and went outside to smoke. While outside the victim child's siblings told the father the victim child was awake, he returned into the home and laid down with the victim child until the mother returned home. On 12/26/2017, the father was notified around 3pm by the mother the victim child was taken to the emergency room. The father went to the emergency room and stayed with the mother and victim child until 1:30am when the mother told him to go home. On 12/27/2017 when the father received a text message from the mother telling him to leave the home, he complied.

ACOCYF interviewed the maternal aunt and her children during the investigation. The father was overheard swearing at the victim child and screaming "you act like people don't gotta get up in the morning" in response to the victim child crying. Around 4am on 12/26/2017 the father was heard swearing and screaming, telling the child to shut up.

An [redacted]; the victim child remained at [redacted] and his siblings were placed in kinship care on 12/27/2017. ACOCYF

recommended medical evaluations of both siblings. The one-year old sibling was found to have suspicious injuries and six-year old sibling was found to not have any injuries. The one-year sibling was found to have [redacted] On 01/23/2018 a ChildLine report was made certifying the victim child as a Near Fatality. It was determined after the victim child was evaluated by the [redacted] the victim child was found to have [redacted] suggesting the victim child was a victim of abuse on more than one occasion.

At the [redacted] all three children were [redacted] The case remains open for services with the mother and her children. ACOCYF attempted to assist the maternal aunt with alternate housing, however the aunt was unwilling to consider subsided housing and the aunt's case was closed on 03/15/2018.

ACOCYF indicated the father and mother on 02/13/2018 for causing bodily injury through a recent act of causing a hemorrhage and intracranial injury. On 01/31/2018 law enforcement arrested and charged the father with Aggravated Assault and Endangering the Welfare of Children. The father attended a pre-trial conference on 05/04/2018. The father's criminal case will continue to a non-jury trial scheduled for 07/24/2018.

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;
    - CPS immediately responded to the regional pediatric hospital to assess the infant's safety and to begin their investigation.
    - CPS collaborated with medical professionals to obtain information related to the infant's injuries and prognosis.
    - CPS contacted law enforcement to ensure adherence to the Joint Investigative Protocol.
    - CPS obtained [redacted] for the three children.
- Deficiencies in compliance with statutes, regulations and services to children and families;
    - In the 2016 CYF referral, documentation does not support that verification from collateral contacts was obtained prior to investigation closure.

- 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 develop written guidance on the referral process to access [redacted] assessments for incarcerated parents. Of note, CYF is in the process of addressing this issue with its contracted substance use provider and the local jail.

- 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 recommended that OB/GYN and other health care providers routinely assess women who are parenting and/or are pregnant for intimate partner and family violence.
    - The Review Team recommended that CYF carefully consider when to seek psychological evaluations for children and parents, suggesting that this practice may not benefit either the family or the decision-makers (courts, CYF). The Review Team further recommended that, in the event that a court orders the completion of an evaluation, CYF should request that the court specify questions to be addressed.
    - The Review Team recommended additional training and/or written reminders through the AAP for pediatricians on measure of head circumference as an indicator of possible abusive head trauma. In this case, the pediatrician evaluated the infant one week prior to the near fatal event, and the infant's head circumference indicated a significant increase in growth.

Department Review of County Internal Report:

The Western Region Office received the Allegheny County Office of Children Youth and Families draft report on 05/21/2018. DHS finds the county's internal report to be an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting.

Department of Human Services Findings:

- County Strengths:

    - The county Agency responded in a timely manner.
    - The Emergency Department doctor ordered additional testing due feeling uneasy regarding the victim child's condition.
    - The Agency insisted on medical assessment of the siblings, resulting in finding injuries on a sibling.

- County Weaknesses:

    - The Child Protective Services report initially was made on 12/27/2017 however the incident was not certified as a near fatality until 01/23/2018. The victim child remained in the Pediatric Intensive Care Unit from his initial admittance until early January, 2018 as he continued to seize and had to be intubated. It was reported in the near fatality referral the hospital was not ready at the time of the initial report to determine the victim child was a near fatality, and waited to consult with the [redacted] and have additional testing. At the time of admittance it was known the victim child did have bilateral subdural hematomas and that the statements provided did not account for the victim child's condition.

    - The victim child was seen by his Primary Care Physician (PCP) one week prior to being taken to the Emergency Department. Based on records review there was an increase in the victim child's head circumference between the two month and four month visit to the PCP and another increase at the time the victim child was seen at the hospital. It's believed the PCP had not reviewed prior head growth charts before each visit with the victim child.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.
There were no citations for regulatory violations.

Department of Human Services Recommendations:

The Department supports the county review recommendations. The Department notes that due to the delay in certification of the near fatality by almost 30 days, it would be the recommendation of the Department to have education/training for all physicians in a hospital setting with emphasis on educating/training for Emergency Department physicians.

Due to the concern regarding the victim child's increasing head circumference going unnoticed, it would be a recommendation of the Department that all Pediatricians review growth charts at each visit comparing the child's growth from one visit to the next.

Additionally, it would be recommended during Obstetrics appointments there should be open discussion and information provided regarding domestic violence at each visit.