pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 04/15/2001
Date of Incident: 06/15/2017
Date of Report to ChildLine: 06/15/2017
CWIS Referral ID: [redacted]

FAMILY NOT 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:
November 2, 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))

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 07/13/2017 and 08/21/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	04/15/2001
	Mother	[redacted]/1979
	Sibling	[redacted]/1997
	Sibling	[redacted]/2002
	Sibling	[redacted]/2004
	Father	[redacted]/1978

* 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 (WERO) attended both the preliminary and the full Act 33 local review meeting. Additionally, WERO obtained and reviewed all records pertaining to the family.

Children and Youth Involvement prior to Incident:

Allegheny County Office of Children, Youth and Families had one prior report on the family from 2014 regarding a truancy referral on the older sibling. The referral was closed without offering services.

Circumstances of Child Near Fatality and Related Case Activity:

In the early hours of 06/15/2017, the victim child was transported via ambulance to the local hospital's emergency room as a level one trauma. He had been stabbed

twice, once in the neck and chest on the evening of 06/14/2017. The victim child sustained a collapsed lung and a liver laceration. The child's treating physician certified him to be in critical condition. The child was given a temporary chest tube and was admitted to the intensive care unit to monitor lung and liver function. The victim child did not require surgery and was discharged from the hospital on 06/20/2017. The only follow up treatment noted was the removal of stitches. The victim child reported he told his sibling to clean her bedroom and she responded by stating "no". An argument followed and the 14 year old sibling stabbed the victim child with a kitchen knife. Upon discharge from the hospital, the child went to live with his father. The sibling, who had been staying with the father since the incident, returned to her mother's care.

A second minor sibling resided in the same home where the incident occurred. The ACOCYF caseworker assessed the second sibling's safety, and there were no concerns. The second sibling remained living with his mother.

The victim child's sibling was initially charged with two counts of felony aggravated assault then on 07/06/2017 her charges were pled down to one misdemeanor count of simple assault. The child's sibling is currently on probation, and is required to follow all recommended [redacted] treatment, comply with medication management, abide by a 9:00 PM curfew, and participate in a [redacted]. In addition, the [redacted] between the victim child and his sibling, meaning all contact is supervised and may occur during therapeutic sessions. Additionally, the siblings are not able to reside in the same residence.

The victim child is also being supervised by Allegheny County Juvenile Probation after [redacted]. The victim child has been [redacted] as conditions of probation. The perpetrator of the stabbing is also [redacted]. Their assigned [redacted]

ACOCYF did not accept the family for services, as the family was engaged with [redacted] health supports and the juvenile justice system. In addition, ACOCYF assessed the family as having identified natural supports that would assist in ensuring the safety and well-being of the children.

The following update in regard to services provided to the family was taken directly from the county report. The juvenile probation officer referred the sibling for a [redacted]. She was recommended for and has begun service [redacted] At the time of review, the provider was working primarily with the sibling and the mother, with plans to engage additional family members, including the victim child and the father, once rapport had been

established. In regard to the victim child, he continues to receive [redacted] are being met. He was previously diagnosed with a [redacted], but was not engaged in treatment prior to the near-fatal event. He will continue to receive [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;
    - CYF responded immediately to the local hospital to ensure the victim's safety and to begin the CPS investigations.
    - Following the near-fatality, the CPS investigative staff contacted Juvenile Probation as well as the CYF Crossover Youth Manager to ensure timely collaboration between the child protection and juvenile justice systems.
    - The CPS investigative staff conducted home assessments at both parents' homes. CYF interviewed all household members regarding the near-fatality and obtained psychosocial information from each person.
    - The CPS investigative staff completed the initial safety assessment within the state-regulated timeframe

  Deficiencies in compliance with statutes, regulations and services to children and families;
    - Intergenerational family violence, including active violence between parents and violence between family members, were evident through this review, and services extended through the systems that work with the family may be less than adequate to address this family violence that affects all family members and that places them at risk. Father is now caring for his son but is not actively participating in services to address his pattern of violence. The [redacted] health system is now focused on provision of services only to mother and the perpetrator through [redacted], which may not adequately address the needs of the family.
    - The [redacted] acknowledged not having full knowledge and understanding of the case facts; namely, that the perpetrator stabbed the victim, resulting in the near- fatal event. The [redacted] also shared that the family was guarded and less than forthcoming about the details of the event. The facts presented at the review informed the therapist with an increased level of detail to provide more effective treatment with the family.
    - According to presenters, [redacted] In this

case, the juvenile probation officers shared that they were unaware of Father's [redacted], and both victim and perpetrator were placed, at separate times, with Father, without probation's knowledge of Father's pending charges. Also, the victim's stability in his living arrangement with Father would be in jeopardy if Father were convicted and incarcerated for his current criminal charges. CYF informed the team that the youth would reside with the paternal grandmother if Father were to be incarcerated.

- The Review Team discussed the lack of gender-responsive community intensive supervision programming for female offenders. The perpetrator who was [redacted] (in addition to other conditions). However, the juvenile probation system was unable to offer her community intensive supervision because there were no such services for female offenders.
- CYF investigative staff and the DHS staff who prepared the Act 33 review were unable to obtain the physical health records for the victim's hospitalization for the near-fatal event, despite CYF's having a legally executed release of information that was sent to the provider. Sharing of medical records are required by the Pa Child Protective Services Law and are critical collateral documentation in any CPS investigation.

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse</u>;

  - The Review Team received an update on CYF's strategies to enhance staff training and competency development and to increase availability of case consultation services related to intimate partner violence.
  - Allegheny County DHS Office of Children, Youth and Families, in collaboration with Futures Without Violence and Women's Center and Shelter, is implementing an IPV training curriculum to 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 strategies are led by [redacted] and include community partners from the IPV system (including [redacted]).
  - Thirty-five CYF practice leaders, including Clinical Managers, Peer Coaches, Best Practice Specialists, Supervisors, Father Engagement Specialists, attended three days of training with Futures without Violence and focused on IPV practice challenges within the child welfare context.

- Women's Center and Shelter plans to add three full-time CYF consultants for ongoing skill-building and consultation to support to CYF staff and families experiencing IPV.

- 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 DHS Office of [redacted] Health convene a team meeting with all systems partners engaged with the family: to review the facts of the case; to re-assess the availability and adequacy of the level of treatment services for the family; to ensure that all team members have been identified and are formed into an effective team that shares a common understanding and long-term view of the family (sharing information, planning, providing effective services, and conducting ongoing monitoring and adjustment of services).
  - On behalf of DHS and the Office of Children, Youth and Families, the DHS Integration Support lead, in concert with legal counsel, has developed and instituted a record-sharing protocol with local hospitals to ensure compliance with the provisions of the PA Child Protective Services Law (PA Act Mp1 176 of 2014 §6340.1 Exchange of Information).
  - The Review Team recommended that Juvenile Probation assess the need for the development of gender-responsive community intensive supervision services (CISP) that meet the unique needs of female juvenile offenders. In Allegheny County, male juvenile offenders benefit from involvement with CISP which provides a full range of programming. Every aspect of CISP is designed to change negative behaviors through electronic monitoring, parent support groups and various other competency building and [redacted] groups, including [redacted] focus.

Department Review of County Internal Report:

The Department received and reviewed a DRAFT copy of the report and the Department is in agreement with the report.

Department of Human Services Findings:

- County Strengths: The County conducted a timely and thorough investigation and made all necessary collateral contacts, including family members and law enforcement.
- County Weaknesses: No weaknesses noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

The Department agrees with the County that more programs should be designed to meet the needs of a female juvenile offender.