



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: November 30, 2009
Date of Incident: July 4, 2012
Date of Near Fatality: July 27, 2012

Date of Oral Report: July 24, 2012

FAMILY NOT KNOWN TO:

Allegheny County Children, Youth and Families

REPORT FINALIZED ON: June 17, 2013

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:

[REDACTED]

Relationship:

Victim Child
Biological Mother
Biological Father

Date of Birth:

11/30/2009
[REDACTED] 1988
[REDACTED] 1985

Notification of Child Near Fatality:

Allegheny County Children, Youth and Families (CYF) was first made aware of this incident on July 24, 2012, when they were informed that the victim child was involved in a house fire that occurred while the mother was intoxicated and cooking in the home. As a result, the child received burns to her buttocks, lower legs, face, and right arm. She had also inhaled smoke and was [REDACTED] at the hospital. Early in the morning on July 24th, CYF received the report as a General Protective Services (GPS) report, however, it was later registered as a Child Protective Services (CPS) investigation by ChildLine due to the mother cooking food while intoxicated and setting the house on fire.

After being admitted to the hospital, the child's condition worsened. She was originally being treated at [REDACTED] but needed to be transferred to the [REDACTED]. The child had to be [REDACTED] and was in the [REDACTED]. As a result, the report was registered as a near-fatality on July 27, 2012.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed the complete case record related to CYF's activity with this family. In addition to the record review, Regional Office staff participated in the near-fatality multidisciplinary meeting (MDT) held on October 25, 2012.

Summary of Services to Family:

Prior to this report, this family was not known to the agency. The child was a patient of [REDACTED]. She had a two year well-child visit scheduled in January 2012, but the mother did not take her to the appointment and was unable to be contacted to reschedule due to inoperable phone numbers. The child's last physical exam prior to the fire was an 18 month well-child exam in June, 2011. Two vaccinations were recommended at that visit.

The child was also recently referred to the [REDACTED], but found to be ineligible due to the referral being made too late. As a result, she was to be referred to [REDACTED]

Children and Youth Involvement prior to Incident:

Although the mother and father were not known to the agency as parents, CYF did have a history with the father as a child. The father and two siblings were removed from their parents' home after police responded to a report that the parents were holding someone hostage in their basement and demanding payment for drugs. The police found the home to be unsafe for the children. The father and his siblings were eventually returned home.

Both the father and mother have prior involvement with the criminal justice system in Allegheny County.

o [REDACTED]

According to CYF's social history, the father also had charges of receiving stolen property in 2007. He also has charges of possession of a controlled substance, possession with intent to distribute, and criminal mischief from 2007, as well as robbery and conspiracy charges from 2001.

- o The mother was arrested, charged, and convicted of a DUI in June 2011, for which she received a sentence of six months ARD.

Circumstances of Child (Near) Fatality and Related Case Activity:

On July 24, 2012 at 6:20 AM, Allegheny County CYF received a report from [REDACTED] regarding the child being the victim of a house fire. According to the hospital, the mother reported that she "was drinking (alcohol) and decided to make some french fries and fell asleep. The grease from the fries caught the home on fire."

As a result, the child suffered second and third degree burns on [REDACTED]. The child's burns were located on her [REDACTED]. The child also suffered an [REDACTED] injury and was [REDACTED]. When the reporting source contacted the agency, the child [REDACTED]; however, [REDACTED] who referred the case to Allegheny CYF did not specify the child was in serious or critical condition.

At the time of the report, Pittsburgh Police detectives were on scene and gathered information about the incident and took a blood sample from the mother.

At approximately 9:00 AM on July 24, 2012, the assigned CYF caseworker spoke with a hospital [REDACTED] to obtain more information regarding the child and circumstances surrounding the incident. According to the [REDACTED] suspicious of maltreatment.

The assigned caseworker went to the hospital in the morning of July 24, 2012 and met with the mother, her brother, and the child's godmother. According to the mother on the evening of July 23rd, she left the child in her father's care, who resides in the home with her and the child. The mother went to the South Side (neighborhood of Pittsburgh) and reported having two shots of tequila, after which she returned at approximately 1:50 to 2:00 AM. When the mother returned home, the father left. The mother reported that she had been awake since 4:00 AM in the morning of July 23rd, (22 hours).

The mother stated that at approximately 2:00 or 2:15 AM on July 24th, she began making french fries in a pot of grease on the stove. At this time the child was sleeping in her parents' room because they have an air conditioner and the child's room does not. After putting the fries on the stove, the mother went into the living room and fell asleep watching TV.

When the mother woke up, her neighbor was helping her out of the home. Her neighbor called the fire department when they observed flames coming through their floor. The mother also stated that she woke up when the fire department arrived, contradicting her previous statement. The mother also told the caseworker that she and the neighbor "tried to kick the door to the apartment in" and when they couldn't do so, they "went to the back of the house and the neighbor ripped the air conditioning unit out of the window" to enter. They were unable to do so due to the smoke in the room. The mother believed that the child was found in the hallway. The child was transported via ambulance; however, mother was not permitted to ride along. She arrived at the hospital at approximately 4:00 AM.

The father was not at the hospital when the caseworker was present, as he was at the residence "looking at everything." The caseworker took photos of the child, who was described as [REDACTED].

At 10:51 AM, ChildLine contacted CYF to inform them that [REDACTED] filed a report and this incident was registered as a Child Protective Services (CPS) report.

A CYF caseworker went to the family home at approximately 11:45 AM to photograph the damage to the home. Approximately one hour later, CYF contacted the Pittsburgh Police to inquire whether or not an initial police report was available. The worker was informed that the mother's blood test was just sent out that morning, however, a detective had been assigned to the investigation as well as an arson investigator.

In the afternoon of July 24th, the caseworker spoke with the father via telephone to obtain his account of the night before. According to the father's recollection, he was at the home with the child and the mother left home around 10:30 PM to go to the maternal grandfather's home, which is located in [REDACTED] "to hang out". The father stated that the mother returned home around 1:30 AM and seemed "fine," although he knew she had been drinking because she told him so. The father did not believe the mother was drunk and she told him she was going to sleep. The father claimed that he went to a friend's home around 1:45 to 2:00 AM (both parents deny that any fight or argument took place at that time.)

The father reported that the mother called him at 3:17 AM to inform him of the fire and that the child had been taken to the hospital via ambulance. He claimed that he immediately returned to the home, but was unable to get close to the house because the street was blocked off. He was informed by the police that the child was taken to [REDACTED] and the father drove to the hospital to be with his family. Upon arrival, he stated he found the mother upset and crying, but not injured. The mother told the father that she was taken to the hospital by the police.

Also on July 24th, the assigned worker completed a Safety Assessment, in which the worker identified two active threats (#9: Not performing duties/responsibilities to assure child safety; #10: Caregiver's lack of parenting knowledge skills/motivation presents an immediate threat of serious harm to a child.) Only the mother's protective capacities to mitigate these threats were assessed on this assessment tool. They were found to be diminished. As a result, the child was deemed "Unsafe," which by definition specifies that the child cannot remain safely in the current living arrangement or with the caregiver and that the agency must petition the court for custody. This also requires that a safety plan be implemented (which was completed, but dated July 31, 2012.)

On July 25th, the caseworker contacted the investigating detective to gather more information. The detective reported that mother admitted to drinking and said she only had "two shots of tequila" on the South Side. The detective said that mother initially said she "passed out" instead of saying she fell asleep. The detective stated that according to the police report, when they first met with the mother at the hospital (just after the fire), she was "visibly intoxicated" and "had a strong smell of alcohol, was staggering, slurring her words, and had bloodshot eyes." The detective also said that another officer said that the mother initially agreed to have her blood drawn, but then went

outside and got into a car in an attempt to leave the hospital. The officer followed the car in which the mother was riding and described the driver as "continually dodging" the officer. The mother was later retrieved by the officer and returned to [REDACTED], where (after some reluctance) she eventually consented to have her blood drawn. This was done and sent out for testing, which would take approximately 30 days.

Later in the morning of July 25th, CYF learned that the child was still in critical condition and would be transferred to the [REDACTED] due to the extent of her injuries. The [REDACTED] better suited to care for her [REDACTED] injuries, as the child's [REDACTED] injury was more severe than originally thought.

The caseworker contacted the father to discuss using Family Group Decision Making (FGDM) to assist the family in meeting the child and family's complex needs due to the fire. In the afternoon of July 25th, the FGDM advocate met with the family at the hospital and they agreed to FGDM. The parents told the FGDM advocate that the child's chance of survival was listed as 50/50 and she was going to be hospitalized in [REDACTED] for approximately 30 days.

Also in the afternoon of July 25th, the assigned caseworker spoke with the arson investigator, who was the one to respond on-scene the night of the fire. He reported that when he arrived, the child had been in full cardiac arrest and was being loaded into the ambulance. He spoke with the mother on-scene, whom he described as having a "strong smell of alcohol and appeared visibly intoxicated, staggering." She told the investigator that the last thing she remembered was putting oil on the stove for fries and she "passed out." He confirmed that the fire started on the right, rear burner of the stove and the pot was clearly on fire, as it had melted. The caseworker asked if it was plausible that the mother could be uninjured even though the child's injuries were so severe. The investigator believes it is possible, as the air conditioning unit in the bedroom may have pulled more smoke into that room and less where the mother was located. The mother told him she was unable to get past the kitchen to get out of the home, so she broke a window to leave the home and then she and a neighbor attempted to kick the door in to re-enter and get the child. The neighbor confirmed the mother's story by stating they witnessed the mother breaking the window and they helped her out of the home.

After the child was transferred to [REDACTED], the agency maintained contact with the staff to remain updated on the child's condition.

On July 27th, the agency completed a Risk Assessment and found the overall severity of the incident to be high due to the child's age and the extent of her injuries. Overall risk was rated moderate, although the mother was cooking while under the influence, fell asleep/passed out and caused a fire that severely injured the child. The father lives in the home and had been cooperative with CYF and their recommendations. Based on the investigation, the family's case was accepted for service.

On July 27th the assigned caseworker also contacted [REDACTED] to get an update on the child's condition. According to the hospital [REDACTED], they were taking her treatment "24 hours at a time." When she is discharged, she will need to have follow-up care at [REDACTED] which will provide transportation for the family to [REDACTED]. The treating physician at [REDACTED] advised the caseworker that the child was in critical condition and [REDACTED]. Upon hearing that this doctor determined that the child was in critical condition, [REDACTED] Allegheny Co. CYF contacted ChildLine to have the report registered as a near fatality. As such, ChildLine registered the investigation as a near fatality and the Department was advised of its existence.

Over the next few days, the child had more medical procedures completed that were helping to stabilize and improve her condition, such as a [REDACTED]. The hospital staff expressed that the parents seemed to grasp the severity of the child's condition and they had lots of support from family members, as many had visited the child at [REDACTED].

On July 31st, the caseworker contacted the mother and asked her to recount the events on the night of the fire once again. The mother's story was mostly consistent with her first report, except she now reported that she did not drink while on the South Side, but had the two shots of tequila at her residence upon returning home.

The agency also completed a Safety Plan on July 31st that states the agency will reassess safety at the time the child would be ready for discharge and that the parents would benefit from FGDM and other recommended services. A copy of this safety plan was contained in the record. It was not signed by either parent. In addition, it listed the father as a "Responsible Person," however his protective capacities had not been assessed and documented on the Safety Assessment worksheet.

Over the next week, the caseworker maintained contact with the hospital to be apprised of the child's condition. The child continued to show improvement. On August 8th the case was transferred from intake to an ongoing worker. On that date the ongoing worker learned that the child was now in stable condition. The agency stayed in contact with the hospital regarding the child and was able to provide information to the detective investigating the arson.

On August 22nd, the county had a phone conversation with the arson investigator. The content of the call was that the child was [REDACTED] and had [REDACTED] on August 20th. Her chances of survival were now listed as "good." The detective advised the county that the mother would be charged for the fire, with some of the charges being felonies.

The ongoing caseworker also contacted [REDACTED] for an update and learned that the child was doing well and [REDACTED] for the child went well. The parents were trained on [REDACTED], as well as CPR. For the child to be discharged, an agreement was made that someone "[REDACTED] certified" must be with the child at all times, because if there were an issue and someone wasn't present, the

consequences "will be significant and severe." The hospital staff felt the parents understood the need for training and follow through. The parents as well as a maternal aunt with whom the parents would be residing received training needed to maintain the child's [REDACTED]. The child was still on a [REDACTED] and wasn't going to be discharged until the [REDACTED] was removed, which they believed would be sometime between August 29th - 31st.

In a conversation with the mother on August 29th, the mother informed the caseworker that the child would be discharged on the 31st and they would be residing with her maternal aunt in [REDACTED]. The caseworker obtained the address and phone number so that a home assessment could be completed.

On August 30th, the caseworker completed a home visit to the aunt's home and found it to be safe and appropriate.

On August 31st, CYF staff contacted the hospital social worker to learn the specific recommendations for the child's care and become more educated on what was necessary for the child upon discharge. The agency requested the discharge instructions be faxed to them, to which the hospital agreed. The child was to return for a follow-up appointment in three months.

Later in the day on the 31st, the caseworker had a home visit with the child and family for the first time since being assigned the case. The child was doing well and the parents appeared to be properly caring for her medical issues, although at this point in time the needs were minimal. The caseworker advised the family that FGDM would be working with them and a referral to "Small Seeds" was made. The parents were agreeable to both services. Both parents also agreed to complete assessments for [REDACTED]. The worker asked the parents to refrain from any "mood altering chemical," to which they agreed. The mother informed the caseworker that she was scheduled to complete her ARD classes September 8th and 9th.

The caseworker and FGDM providers conducted a home visit with the entire family on September 5th and to arrange a conference, as well as the referral for [REDACTED].

On September 6th, the caseworker was informed by the detective that the mother was served with a warrant the prior evening and would be turning herself in that evening.

A visit with the entire family was held on September 10th, during which they scheduled the date of the FGDM conference, which was to be held on September 23rd.

According to the case record, the agency developed a Family Service Plan with the family on September 12, 2012. The plan included stipulations that: the parents would be screened for [REDACTED] and follow through with recommended treatment; would obtain adequate housing; and would ensure that child's medical needs would be met. This plan was agreed upon and signed by all parties.

In a subsequent visit on September 13th, the mother informed the providers that she completed her ARD as ordered and the child was to return to [REDACTED] the next day for a check-up. The mother also informed them that her [REDACTED] was scheduled for September 19th at 11:00 AM.

A home visit was completed on September 18th. The parents reported that they were told the child is healing well, however, they were provided with a [REDACTED] [REDACTED] for her hand.

The FGDM conference was held on September 23rd and was described as having gone well. Twenty two family members were in attendance in support of the family. The family's plan was accepted and the agency felt it would address the issues identified, which were housing, parental [REDACTED] and the child's well being.

The FGDM provider (Small Seeds) continued to have regular contact with the entire family after the family conference. During a phone call with Small Seeds staff on October 10th, the mother informed them that she was going to look at a new residence that Friday, however, the family would need assistance with furniture items should they get it. The agency agreed to offer assistance with obtaining necessary items.

The family continued to receive services from Small Seeds (FGDM) through December 21st to address possible [REDACTED] for mother, parenting, supervision, housing, basic supplies, and any possible medical needs of the child. CYF continued to maintain an active case with the family to help ensure the child's needs were being properly met by the parents.

Current Case Status:

At the present time, the mother is scheduled for a jury trial to begin on September 9, 2013 where she will be tried for Causing a Catastrophe, Endangering the Welfare of Children, three counts of Recklessly Endangering Another Person, Dangerous Burning, and Criminal Mischief.

The agency reported that an [REDACTED] [REDACTED], so it appears as though the family will be moving to a new residence. CYF remains open with the family.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. On August 31, 2012, Allegheny County convened a review team in accordance with Act 33 of 2008 related to this report. The following information was contained in their report:

- Strengths:
 1. Compliance with Statutes and Regulations
 - The Review Team identified no issues related to compliance with statutes or regulations.
 2. Services to Family
 - CYF was not active with the family at the time of this referral; therefore, no services were provided to the family.
- Deficiencies:
 1. The Review Team identified deficits in CYF's assessment of all adult caregivers as it relates to alcohol and other drug use, particularly the lack of assessment of the father's alleged substance abuse and impact on his care for the child.
 2. The Review Team noted that CYF had not finalized its assessment of the father as an appropriate caregiver for the child in the event that the mother is convicted of criminal charges and is sentenced to any period of incarceration.
 3. The Review Team also noted that the child required an [REDACTED] that had not yet been completed. The team recommended that CYF address this need immediately (which subsequently was arranged).
- Recommendations for Change at the Local Level:
 1. Reduction of the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.

The Review Team commented on the need for public awareness of the impact of alcohol consumption on one's ability to care for a child.

The Team recommended:

- Enhanced training and supervision of issues related to the assessment and understanding of alcohol and other drugs with all family members.

- Immediate access to substance abuse assessments and evaluations, as well as treatment recommendations and compliance, for continued assessment, case planning and measure of improved outcomes for children and families.
- CYF engage in advanced planning for alternative caregivers in the event that parents/caregivers are facing criminal charges and possible incarceration upon conviction.

2. Monitor and Inspection of County Agencies

- The Review Team identified no issues related to monitoring and inspection of the county agency.
- Recommendations for Change at the State Level:

The Review Team had no recommendations for change at the state level.

Department Review of County Internal Report:

Allegheny County CYF provided a copy of their internal review that took place on August 31, 2012. The Department is in agreement with the findings contained within the report; however, some of the information contained in the "Recommendations for Changes at the State and Local Levels" section seemed to be placed there in error.

Although the section for "Strengths and Deficiencies" in CYF's report identified a strength, it did not identify any deficiencies. However, there were three deficiencies contained in the "Recommendations" section of the county's report. In completing this report the identified deficiencies have been under the correct heading.

The Department agrees with the Review Team's findings related to the identified deficiencies.

Department of Public Welfare Findings:

- County Strengths:
 - The caseworkers did a very good job communicating with the investigating officers and treating medical staff throughout the investigation and child's hospital stay. This greatly aided the agency in completing their investigation and planning for necessary services for when the child returned home.
 - The agency's process for organizing and facilitating an internal near fatality review meeting is effective and efficient. In addition, the attendance, handouts provided during the meetings, and follow-up information provided after the meeting is very good.

- The agency did a good job ensuring services were in place that could benefit the family, such as FGDM and referrals to other agencies to address the identified issues.

- County Weaknesses:
 - The Department is in agreement with the deficiencies identified by the internal review team and listed in the previous section. In addition, the following issues were identified by the Department:

1. The agency completed a safety assessment worksheet that identified two threats related to the mother in Section II. In Section III of the worksheet, only the mother's protective capacities were assessed, both of which were found by the worker to be "diminished." As a result, threats remained and the safety decision for the child was determined to be "Unsafe."

As a result of the safety determination, a safety plan was developed for the child on July 31, 2012. The safety actions for both identified threats were identical and stated the agency will, upon discharge; assess "whether child can return to her parents care or an ECA (Emergency Custody Agreement) may need to be obtained."

Either the agency erred in their safety determination for the child by considering her unsafe, rather than making her safe with a comprehensive safety plan, or the agency erred in not securing an ECA as required by the safety assessment protocol, when a child is determined to be unsafe.

In addition, the safety plan dated July 31st lists the father as one of the responsible persons to keep the child safe, however, his protective capacities had not been assessed or documented on the safety assessment worksheet. How did the agency determine he was responsible to ensure safety?

Lastly, neither parent signed the safety plan showing they agreed to follow the plan. Both parents were listed as responsible parties.

2. The child returned home to her parents' care on August 31, 2012. It does not appear that the agency completed either a new safety or risk assessment for the child upon doing so. Neither was included in the file provided by the county, although the case notes contain contacts with the family at least a month and a half after the child's return home.

- Statutory and Regulatory Areas of Non-Compliance:

As a result of the safety assessment completed on July 31, 2012, the agency determined the child to be unsafe. As per the Safety Assessment and Management Process (SAMP), the agency was required to petition the court for custody. There is no documentation showing this was ever initiated.

In addition, the SAMP requires a new assessment be completed if the agency learns new information or information that may affect the safety of a child or children. When the child was returned to the parents' care on August 31, 2012 the assigned worker should have completed a safety assessment to re-assess the parents' ability to care for and protect their child.

Department of Public Welfare Recommendations:

The Department recommends that the agency ensure better supervisory oversight related to the SAMP. If the supervisor was in agreement with the worker's safety determination, both failed to realize the process requires a petition for custody be filed. If the supervisor and/or caseworker did not believe custody was necessary due to the child's circumstances (i.e., hospital admission), the supervisor should have recognized the child could have been considered safe with a comprehensive plan." The supervisor should have then had a discussion with the caseworker regarding the safety decision and what must happen as a result.

When threats are identified on a safety assessment, any protective capacities that could mitigate the potential threat are to be assessed. Once assessed, they are to be described as "enhanced, diminished, or absent." It is common for a county agency to list only "diminished" or "absent" protective capacities; however, it is just as important to describe one that is enhanced, as that could be used as a foundation for child safety with that caregiver. In addition, if multiple persons are going to be considered responsible caregivers, those persons' protective capacities should be assessed and described as well. This will help justify the agency's decision to utilize them in any safety planning.

Lastly, when a safety plan is developed, the supervisor is responsible to ensure their caseworker is obtaining signatures that the responsible parties are in agreement with it or documenting why signatures are not obtained. If a responsible party is not in agreement, they cannot be counted on as a person to help keep the child safe.