pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

BORN: November 1, 2013
DATE OF INCIDENT: January 10, 2014
DATE OF ORAL REPORT: January 11, 2014

FAMILY WAS NOT KNOWN TO:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:

3/16/15

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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, DHS 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:	Relationship:	Date of Birth:
[redacted]	Victim Child	November 1, 2013
	Mother	[redacted] 1988
	Father	[redacted] 1987

Notification of Child (Near) Fatality:

The victim child was taken to the Children's Hospital of Pittsburgh [redacted] approximately around 10:30 p.m. on the evening of January 10, 2014 by his parents. The parents reported to the physicians that the victim child had been vomiting, and was lethargic and irritable. The attending physician notes that the victim child had a bruise on his right ear. [redacted] was conducted and showed that there [redacted] which is indicative of head trauma. Children's Hospital of Pittsburgh [redacted] could have been life threatening and the child was determined to be in critical condition as a result of suspected child abuse. The child was admitted to the hospital [redacted].

On January 11, 2014, Allegheny County Office of Children, Youth and Families (OCYF) received the Child Protective Services (CPS) report [redacted] reporting concerns for physical abuse. The report was also registered as a Near Fatality Report as well.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families obtained and reviewed all current records pertaining to this family. Follow up interviews were conducted with the caseworker and supervisor on this case to obtain additional information. Two Act 33 Child Near Fatality Reviews were held at Allegheny County OCYF on February 12, 2014 and on March 20, 2014. The February 12, 2014 meeting consists of a smaller team, so as to be in compliance with the Act 33 requirements. The March 20, 2014 meeting consisted of the entire Multi-Disciplinary Team.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had no prior history with Allegheny County Office of Children, Youth and Families and had no involvement with any other counties

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

During the day of January 10, 2014, the father reported that he was the only caretaker for the victim child during the afternoon while the mother was at work. The father claimed that he had attempted to feed his child, but he was not interested in eating and slept most of the afternoon. At one point, the father went to pick up the child from his crib and reported that the child's arms were hanging. The father immediately placed him back into this crib.

When the mother returned home from work, she attempted to feed the victim child. He began to vomit and the parents contacted their pediatrician who instructed the parents to give their son Pedialyte. Once the victim child ingested the Pedialyte, he began to vomit again. At that time, the pediatrician was contacted again and the physician requested that the parents take the child to Children's Hospital of Pittsburgh [redacted].

Once at the hospital, the attending physician noticed a bruise to the child's right ear. Upon further examination and [redacted] it was determined that the victim child had sustained [redacted].

On January 13, 2014, given that the parents were unable to explain how the victim child had sustained the injuries [redacted]

The child remained at Children's Hospital of Pittsburgh until January 15, 2014, when he [redacted] into a kinship foster home of the maternal cousin. However, due to his follow-up medical appointments the child was moved to

another kinship foster home on February 2, 2014. This home is more equipped to meet his continuing medical appointments and needs.

The father was arrested on January 24, 2014 by the [redacted] Police Department and was charged with aggravated assault, endangering the welfare of a child, and recklessly endangering of another person. He was determined to be the only caretaker when the injuries would have occurred. He remained in the [redacted] Prison until January 27, 2014 when he was able to secure a $50,000 bond. On April 30, 2014, a formal arraignment occurred, and the charges were held over for court. The father still remains free on bond and resides with the mother.

On February 7, 2014, Allegheny County OCYF submitted their CY-48 indicating the father of physical abuse based on medical evidence and the CPS investigation.

[redacted]
He is to remain in his present kinship care foster home. [redacted]

On June 4, 2014, the victim child was placed with his maternal grandmother. The maternal grandmother is the primary caregiver for the victim child; however, the mother has moved into the grandmother's residence and she has unsupervised contact with her child. The county's kinship care provider offers supervision and supports to the child and his 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. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report.

- Strengths:

- CYF responded immediately to this report, conducted a thorough investigation and ensured the safety of the child.

- After the near fatality event, the child was placed with a kinship caregiver. The child received [redacted] and medical follow up services, and the kinship home received support from a kinship agency.

- Deficiencies:
- None noted
- Recommendations for Change at the Local Level:
- The Review Team recommends enhancement of CYF's Safety Management Protocol through support for the development of a Safety Academy to address casework understanding and application of safety and risk assessments as decision- support tools for service planning, including safe case closure decisions.
- The Review Team recommends enhancement of the communication protocol between CYF and physical health providers who serve children at risk and their families, including timely sharing of new information that informs CYF's decisions around safety and family planning.
- The Review Team recommends exploration of universal nurse home visitor services for new parents in need of supports.
- The Review Team recommends the distribution of the "When Your Baby is Crying" video for new parents.
- Recommendations for Change at the State Level:
- The Review Team requests updates on the recommendations

Department Review of County Internal Report:

The county holds their Act 33 meetings in a timely manner; however, their County Internal Reports are not received within the time frame established in the Act 33 bulletin. The Department did attend the Act 33 meeting and agreed verbally with the recommendations that were presented both meetings on February 12, 2014 and March 20, 2014.

Department of Public Welfare Findings:

- County Strengths:
- The County immediately responded to [redacted] report and the near fatality of the child. This included the In-Home Safety Assessment and Safety Plan as a result of the child's injuries and the services provided by the county to the parents.

- County Weaknesses:
- The county's safety assessments provided minimal facts and they should contain more detail as to what is actually transpiring with in a case.
- Statutory and Regulatory Areas of Non-Compliance:
- No statutory or regulatory citations.

Department of Public Welfare Recommendations:

Allegheny County Office of Children, Youth and Families holds two separate Act 33 meetings with each of their near fatality reports given the volume of these cases based on being a Class 2 County. As such the first meeting is comprised of a smaller team so that the 30 day requirement for the Act 33 can be met. Then within the next 60 days a larger multi-disciplinary meeting is held. With that stated the Regional Office does not receive a finalized Act 33 County Internal Meeting Report until months later. The Department receives a draft version. The Department is requesting that these reports be finalized within the requirements of the Act 33 bulletin.