COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF

BORN: September 27, 2010
Date of Near Death Incident: April 7, 2011

The family was known to Allegheny County Children and Youth Services.
The family was known to other public/private social service agencies.

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 No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Circumstances of Child's Near Fatality:
According to [redacted], the mother reported on April 5, 2011, the child started having [redacted] and was "acting strange", but was still eating. The mother brought child to the emergency room on April 7, 2011. The hospital found that the child had old and new brain bleeds. The child was taken [redacted] immediately. The child was certified to be in serious/critical condition.

Summary of Review

1. Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Child	09/27/2010
	Mother	[redacted]1985
	Father	[redacted]1991
	Sister	[redacted]2005
	Sister	[redacted]2009
	Maternal Uncle (MU)	[redacted]1983
	Girlfriend to MU	[redacted]1979
	Mother's Boyfriend	[redacted]1992
	Father of [redacted]	[redacted]1986
	Father of [redacted]	[redacted]1986
	Maternal Aunt	

2. Documents Reviewed and Individuals Interviewed:

The Office of Children, Youth, and Families (OCYF) Regional Program Representative reviewed the case file provided by Allegheny County Children, Youth, and Families (CYF) for the intake investigation on this family, as well as the prior history. The file included the investigation summary, demographic information, risk/safety assessment and safety plan, and progress notes. Interviews were conducted with Allegheny County CYF staff, including the intake caseworker and the current intake supervisor. Also reviewed were the medical and forensic records provided by the [redacted].

Additionally, the OCYF Regional Program Representative attended the Allegheny County Near Fatality Review team meeting.

Case Chronology

On April 8, 2011, Allegheny County CYF received a referral from [redacted] due to a report made by [redacted]. The hospital reports that the mother witnessed the child having [redacted] on Tuesday, April 5, 2011, which were 20 minutes long with an hour in between. She reported that the child was "acting strange," but was still eating. On April 6, 2011, the mother arrived at the hospital with the child, where he was evaluated. It was determined that the child was suffering from old and new brain bleeds that required surgery.

According to the [redacted] investigation documentation, the mother reported the child was acting "fine" on the morning of April 4, 2011. On Tuesday, April 5, 2011, the child awoke at 7:00am and shortly after, the mother noticed the child's arm had started twitching, which then turned into his entire body [redacted]. The mother stated that she believed the child had a sore neck, so she "rubbed him down" with lotion and massaged it into his body. She stated that this lasted for 10-20 minutes, and the child eventually calmed down and fell asleep.

The mother reported that the child slept most of the day on Tuesday, April 5, 2011, however he was more fussy and crying more than usual, especially when she tried to pick him up.

On Wednesday, April 6, 2011, the child was again exhibiting the same unusual symptoms when he woke up. The mother reported that she contacted the pediatrician around 12:00pm. She stated that she spoke with a nurse who instructed the mother to take the child to [redacted]. On this date, the mother transported the child to [redacted] via public transportation.

The mother stated that she did not take the child to the hospital earlier because "it did not seem like anything was really wrong." Additionally, the child did not have a history of [redacted], and this had not occurred in the past. When offering information to the caseworker, the mother did report that on April 3, 2011, the child's 18 month old sibling returned to the home from her father's, and at some point on April 4, 2011 had stepped on the child's back, hit the child with a broomstick and threw a sippy cup at him. It was the belief of the mother that these actions caused the injuries to the child.

During an interview with the mother's boyfriend, which occurred separately and immediately after the mother's interview, it was reported that he returned to the home early in the morning of April 5, 2011. He reported that he does not live with

the mother, but goes back and forth between the mother's home in Wilkinsburg and his home in the Lincoln neighborhood of Pittsburgh. The mother's boyfriend reported that he noticed the child was crying more than usual when he was at the home on April 5, 2011. Additionally, he corroborated the mother's account that the child woke up what he reported as a "twitch" his arm, and had "woken up stiff." He also reported that the child cried when he was picked up, and that additionally corroborated the fact that the 18 month old sibling threw items at the child, including a sippy cup and a broomstick that hit him in the head.

While these interviews were occurring, doctors from [redacted] completed an [redacted] on the child, and new and old blood was found in [redacted]. The treating physician explained at this point that this is an indicator of [redacted], not of spontaneous bleeds in the brain. It was also noted, however, that there was not enough information to make a definitive answer as to whether or not the injuries were inflicted. The child was scheduled for an [redacted] that night, and was scheduled to be in the [redacted] for a few days.

At that point, Allegheny County CYF and the mother developed a safety plan for the 18 month old sibling. The mother had identified the father as a caregiver, as they have shared custody of the child. The County and mother were not able to reach the father, so an alternative caregiver was provided by the mother; a neighbor, [redacted] The neighbor agreed to be the caregiver of the 18-month old child, until the father was able to be reached. While the neighbor was on her way to [redacted], the father of the 18 month old returned the call, and stated he would pick up the child from the neighbor the following day. The father did in fact pick up the 18 month old child the following day from the neighbor.

On April 12, 2011, the investigating County Caseworker contacted Dr. [redacted] from [redacted] to obtain information related to the condition of the child. Dr. [redacted] reported that a CT scan showed old and new blood on his brain. They wanted to complete x-rays, but the child was not stable enough to complete them. When stable, the child would receive a body scan. Dr. [redacted] reported that the brain bleeds could be due to being premature, but there is also evidence of [redacted] and reported [redacted], which would not be the result of being born premature. Dr. [redacted] "couldn't say for sure" that it was definitely [redacted], but that it is "most likely [redacted]. Additionally, Dr. [redacted] stated that a 20 minute [redacted] is possible, but this would be considered an emergency and the baby, per the mother's history, had multiple [redacted] over a period of 2 days and she did not view it as problematic.

The investigating County Caseworker and Supervisor contacted Dr. [redacted] again on April 20, 2011 to gather more information regarding the medical status of the child, and to obtain medical documentation related to the [redacted] investigation to assist them in making their determination. Dr. [redacted] reported she

was "95 percent sure" the child's injuries were non-accidental, however she could "not be 100 percent sure" as the child was premature, the mother was not able to give a time period for the injuries, and the delay in seeking medical treatment. Dr. [redacted] believed but could not definitively state that the injuries were the result of [redacted] Additionally, Dr. [redacted] stated that she could not make a determination of [redacted] on [redacted] alone, and that is was possible the child was an "unlucky bleeder", but that if she were asked her opinion, she would say the injuries are non-accidental.

The County received [redacted] on April 21, 2011, and the child was [redacted] assess the maternal uncle to see if placement with him was appropriate.

The assessment of the maternal uncle occurred quickly. The maternal uncle was determined to be appropriate for the child to be placed with him, however the maternal uncle had some concerns that he expressed to the County caseworker. He and his girlfriend were expecting a child of their own, and they were concerned over the amount of transporting the child to medical appointments and the amount of care that the child required.

On May 1, 2011, the maternal uncle called the County caseworker and reported that he and his girlfriend would care for the child. Prior to the child's [redacted] to his care, the maternal uncle and his girlfriend visited with the child two to three times a week, two hours per visit. On May, 17, 2011, the maternal uncle contacted the County agency, and stated that he did not believe he and his girlfriend would be able to care for the child, due to the complexities of his care, including the numerous medical appointments and the amount of care he needed. The maternal uncle reported the stressors of expecting his own child with his girlfriend, as well as the fact that he is the legal guardian of his sister's other child, [redacted]. These mitigating factors precluded him from [redacted]. The County agency immediately began exploring other relatives who would be willing and able to care for the child.

On June 1, 2011, the [redacted] investigation was determined to be [redacted] by Allegheny County Children, Youth and Families. The County was unable to determine who the [redacted] was. Additionally, medical documentation noted that the physician could not say with 100% certainty that the injuries were caused by [redacted] due to the child's medical history; specifically complications surrounding the premature birth of the child, along with the child's other health issues.

The mother expressed to the county that she could not care for the child due to the level of medical care and follow-up care that was needed. The County

agency was able to locate a maternal aunt who was willing to care for the child. On July 1, 2011, the child was transferred to the maternal aunt's home, where he remains to date.

The child has supervised weekly visits with the mother at the East Regional Office of Allegheny County CYF. He continues to receive [redacted] through the Alliance for Infants and Children. The mother's other child, [redacted], remains in the custody of her father. The father will not allow the mother to see [redacted] until custody is [redacted]. The child's sibling, [redacted], continues to reside with the maternal uncle in Westmoreland County. The child continues to receive medical treatment for pre-existing conditions related to his premature birth and the near fatality incident. No criminal charges have been filed by law enforcement.

Previous CY involvement

The family was previously referred to Allegheny County Children, Youth and Families in January 2006 due to concerns that the mother was not ensuring child [redacted] (at the time six months old) was immunized. The referral was accepted and investigated. The County determined that the child was safe and immunizations were then brought up to date.

The family was again referred in May 2008 by [redacted], which was screened out as an information & referral. The content of this referral is unknown.

In October 2009, Allegheny County received a referral at the birth of [redacted], stating that there were concerns about the mother's ability to care for the child. The referral was accepted and referrals were made to community supports.

The family was referred to the agency at the birth of the subject child of this report in September 2010, because the mother tested positive for marijuana. Services were provided to the mother at that time to assist her with the child returning from the hospital, as the child had many medical issues due to being born premature. The agency had planned on closing this investigation in November 2010, when they learned that the mother had been discharged from [redacted] due to missed appointments. It was learned that the mother was missing appointments because she was taking the child to his medical appointments. Once this was verified, and the agency was able to verify with medical providers that the child's extensive medical needs were being addressed, the agency closed the case in March 2011.

The final referral in April 2011 is related to this near fatality report.

Compliance with Statutes and Regulations

The review found a violation with respect to the reporting of [redacted] by the reporting source, as the report of [redacted] was not reported to ChildLine immediately, as is defined by §6313 (a) of the Child Protective Services Law.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

1) Review Mandated Reporter policy with area hospitals, related to the timeliness of the reports to ChildLine;

2) Provide continued services and supports to the mother, including supervised visitation;

3) Child to continue medical care, involvement with [redacted] and

4) Work to improve the engagement of father's in their children's lives;

Findings and Recommendations

After reviewing the case record and interviewing stakeholders, the Western Regional OCYF has concluded Allegheny County Children, Youth and Families followed appropriate protocol in regards to the investigation of the aforementioned referral.

The [redacted] investigation has been determined to be [redacted], as the agency was not able to determine who the caretaker of the child was at the time of the injuries. Additionally, medical documentation did not definitively attribute the child's injuries to [redacted]

The County agency continues to provide services, as well as supportive services to the family with respect to [redacted] for the child.

The Department is in agreement with the recommendations from the county, as it is imperative to provide the necessary supports to the mother and children to ensure the health and safety of all parties.

An opportunity for improvement should focus on providing technical assistance to local hospitals to ensure compliance with reporting procedures. While the child

was transported to the hospital on April 6, 2011, the referral was not made to ChildLine regarding the suspected abuse until April 8, 2011.