



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

██████████

Date of Birth: 02/28/2014
Date of Death or Date of Incident: 02/17/2016
Date of Report to ChildLine: 02/18/2016
CWIS Referral ID: ██████████

**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:
08/11/2016

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 03/17/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	02/28/2014
[REDACTED]	Father	[REDACTED] 1986
[REDACTED]	Mother	[REDACTED] 1989

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) reviewed the entire case record pertaining to the victim child’s family. The WRO staff conducted phone interviews with the Intake Caseworker, and participated in both of the county’s Act 33 meetings. The first Act 33 meeting occurred on 03/17/2016 and the larger Act 33 meeting occurred on 04/25/2016. Due to the volume of near fatality cases received in the County they hold two separate Act 33 meetings to adhere to the regulatory guidelines. During the second meeting, medical professionals and law enforcement presented their information. The Intake and Ongoing caseworkers presented the current information. The WRO also reviewed all information in Child Welfare Information System.

Children and Youth Involvement prior to Incident:

Allegheny County Office of Children Youth and Families (ACOCYF) report no involvement with the victim child or the family prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:

The victim child was referred to ACOCYF on 02/18/2016 when it was reported that a 23-month-old child with multiple medical problems was brought to Children’s Hospital of Pittsburgh (CHP) due to abnormal behaviors, fast breathing, shakiness

picked up the father to go grocery shopping. They both returned home around 6:30 PM. At that time, the mother noticed the victim child's mouth was really dry and she was pale in color. [REDACTED]

[REDACTED] The parents fed the victim child dinner and noticed she had a mild tremor and seemed a little disoriented. The parents decided to take the child to CHP where she was admitted [REDACTED] She [REDACTED] on 02/20/2016 to the care of her parents. [REDACTED]

During the investigation, ACOCYF interviewed the mother, father, [REDACTED] All of the parties felt the parents were attentive and had appropriate interactions with the victim child. None of them reported the parents ever cancelled appointments. It was the opinion of the providers the victim child was well cared for by the parents. The parents were very cooperative and consistent with their statements. The ACOCYF caseworker completed home visits and completed an assessment of the home. They found the home to be appropriate. ACOCYF filed the Child Protective Services Investigation Report with a finding of "Indicated" on an unknown perpetrator on 04/14/2016. The parents are expected to appeal this decision. ACOCYF did accept the case for ongoing services. [REDACTED]

[REDACTED] Police Detectives are also investigating the incident. They have taken food samples to the lab and all results were negative. No charges are being filed. Law enforcement has closed their investigation with no charges pending. The father and [REDACTED] had polygraphs and both passed. Due to the mother being pregnant she could not have the polygraph. [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;
 - The Act 33 Review Team identified no statutory or regulatory compliance issues.
 - CYF responded immediately to this report and conducted a thorough investigation. Upon consultation with medical personnel and completion of a home assessment, the victim child was returned to her parents [REDACTED]
 - The Review Team noted that ChildLine initially failed to certify the child protective services report as a near-fatality, and therefore requiring a multidisciplinary review by the local and state Act 33 review teams. ACOCYF notified ChildLine the day after receipt of the CPS report to

inform them that the report met the criteria for certification as an Act 33 child near-fatality.

- Deficiencies in compliance with statutes, regulations and services to children and families;
 - None
- 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 the state child welfare representative serving on the local review team communicate the delay in certifying the CPS report as a near-fatality to state leadership. Furthermore, county staff was asked to identify previous cases that were not immediately certified, as required by Act 33 of 2008 legislation to better inform the state on potential corrective actions.
 - The Review Team discussed the benefits of stricter hiring practices related to review and screening of criminal background checks for offenses that are not legal barriers to employment when an agency is providing physical health care for children within a family setting. A private in-home nursing service provided nursing care for approximately 16 hours daily. The agency reportedly screened all employees prior to hire, as legally required. During the course of case review, it was learned that one of the staff members caring for the child during the time frame in question had recent substance abuse-related criminal charges and was engaged in the criminal justice system while working as a home care nurse. While the agency adhered to the legal requirements of hiring, the Review Team noted that further scrutiny of a prospective hiring candidate could be expected to strengthen the safety net for vulnerable consumers.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
 - The team has recommended updates on the Department's recommendations
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - Allegheny County CYF is in the process of expanding the available pool of resource families through a diligent recruitment grant and other resources, demonstrating continued commitment to place children in community family settings, including those children with highly specialized physical and other health needs.
 - The Review Team was advised that the Allegheny County Joint Investigative Protocol, developed among the Office of the District Attorney, law enforcement, medical providers and CYF, is under review and revision. The revised protocol will be shared with this team once finalized.

Department Review of County Internal Report:

Western Region reviewed the report and found its contents to be an accurate reflection of the case activity. The Region is in agreement with the recommendations that were illustrated in the County's Internal Report.

Department of Human Services Findings:

- County Strengths:
 - ACCYF immediately responded to the hospital to interview the parents and see the child.
 - ACCYF interviewed all of the service providers who were in the victim child's home the day of the incident.
 - ACCYF communicated with numerous collateral contacts to ensure the child was safe in the home.
 - ACCYF worked collaboratively with law enforcement during the investigation.

- County Weaknesses: and
 - On the Child Protection Investigation Report in the Basis for the investigation Outcome section the agency did not identify all the parties that they interviewed to make their determination.
 - ACCYF should have completed the home visit prior to the child's [REDACTED]

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
No citations

Department of Human Services Recommendations:

ACOCYF should ensure that the Child Protection Investigation Report accurately reflects all the work the caseworker completed during the investigation.