



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR DEATH OF**



**BORN: December 4, 2008**  
**NEAR FATALITY: February 13, 2009**

**FAMILY KNOWN TO:**

**The family was not known to Children and Youth Services.  
The family was referred to the Alliance for Infants and Children after the  
twins' birth due to premature birth and low birth weight.**

**REPORT DATE: 01/21/10**  
**REPORT FINALIZED: 02/03/10**

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 by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, January 4, 2009. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.<sup>1</sup>

**1. Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Child	12/04/2008
[REDACTED]	Mother	[REDACTED] 1980
[REDACTED]	Father	[REDACTED] 1979
[REDACTED]	Sibling	[REDACTED] 2003
[REDACTED]	Sibling	[REDACTED] 2008

**Notification of Fatality / Near Fatality:**

The child was brought to the hospital on the evening of February 13, 2009 by ambulance, accompanied by both parents. Child presented with limpness. Child had an abnormal head [REDACTED] showing [REDACTED]. Parents did not have an explanation for the injuries. Child was in serious condition and expected to live. Parents are the only caretakers for the child.

**2. Documents Reviewed and Individuals Interviewed:**

For this review the Western Region Office of Children, Youth and Families reviewed the Children's Hospital of Pittsburgh medical records regarding this child, and the investigative case file, which included case notes and interviews.

Western Region Office of Children, Youth and Families interviewed Allegheny County Children, Youth and Families caseworkers who worked with the family during this investigation.

**Case Chronology:**

Prior to the near fatality incident on February 13, 2009, the family and children were not known to Allegheny County Children, Youth and Families.

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<sup>1</sup> 23 Pa. C.S. 6343 (c) (1)-(2).

**Previous CY involvement:**

Prior to the near fatality incident on February 13, 2009, the family and children were not known to Allegheny County Children, Youth and Families.

**Circumstances of Child's Fatality or Near Fatality:**

Two- month old [REDACTED] and his [REDACTED] sister, [REDACTED], were in the care of their father on the day of the near fatality while mother and the five- year old sister, [REDACTED], were out on an errand. After positioning the twins on the floor for 'tummy time", father reported that [REDACTED] was crying "very, very, very hard", per AC CYF case note. Father attempted to give the baby a pacifier, which he refused, and then changed the baby's diaper on the couch. [REDACTED] suddenly turned white, went limp and became unresponsive, according to father. Upon mother and the five- year old sister's return, mother observed [REDACTED] condition, and she placed [REDACTED] in a bathtub with cold water to attempt to arouse him (because he did not like bathing.) 911 was summoned, and [REDACTED] arrived at CHP Emergency Room with an [REDACTED] and in critical condition, according to treating physicians. [REDACTED] was diagnosed with [REDACTED]. Parents had no explanation for the injuries but denied causing the injuries. CHP stated that [REDACTED] injuries were consistent with the clinical picture of inflicted trauma and with shaking a baby.

Allegheny County CYF [REDACTED], based on medical evidence of [REDACTED] and their [REDACTED], Father [REDACTED], and, upon review of father's request to [REDACTED] the report, the Department of Public Welfare upheld CYF's determination of [REDACTED]. Father has the right to request a hearing before the Secretary of the Department of Public Welfare or designee through the Bureau of Hearings and Appeals.

Order of [REDACTED] events--

- Child was transported to the Children's Hospital of Pittsburgh Emergency Room on February 13, 2009. [REDACTED] presented with limpness and his [REDACTED] to the head area. Parents did not have any explanation for the injuries, although the father was the caregiver at the time of the injuries.
  - The parents did not admit to the [REDACTED] of the child; in fact, the parents strongly denied any wrongdoing.
  - Interviews were conducted with the parents and medical personnel.
  - Medical evidence, specifically the [REDACTED], validated the [REDACTED] occurred, [REDACTED]
  - Allegheny County CYF [REDACTED] on the father.

**Current / most recent status of case:**

- The [REDACTED] on the father.
- The case was accepted for services, and remains open for monitoring and services.
- The victim child and his siblings reside with the mother and father in their home.
- The family receives in-home services from Alliance for Infants and Toddlers.

**Services to children and families:**

The family receives in-home services and monitoring from the Alliance for Infants and Toddlers, as well as the Allegheny County Children and Youth Services casework staff.

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:****Strengths –**

The county did not identify strengths.

**Deficiencies-**

The county did not identify deficiencies.

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

- 1) CYF to reassess safety and risk factors and aftercare planning associated with closure of the CYF case prior to a decision for case closure;
- 2) Training of court and CYF personnel on use of psychological and/or psychiatric evaluations in determining whether a parent will abuse a child [i.e., because there is no extant, empirically tested profile for abusive caretakers, there is no capability to predict future abusive behavior based upon a given profile; however, evaluations may offer other predictive possibilities, such as a tendency for violent behavior]
- 3) Review of referral process between municipality police and requests for assistance from Allegheny County police departments to ensure immediate referral and response for investigatory purposes; and,
- 4) Training of medical personnel, Medical Examiner's Office staff, court personnel, and child welfare personnel on Abusive Head Trauma research (Dr. Mary Carrasco, A Child's Place at Mercy)

**Western Region Findings:**

County Strengths-

The county agency has a good working relationship with area hospitals to support forensic interviewing and the Child Protective Services investigation. The county agency ensured the family received appropriate in-home services quickly after the referral.

Deficiencies-

There were no deficiencies noted by the Western Region Office of Children, Youth and Families in this case.

Statutory and Regulatory Compliance issues:

- A safety assessment was completed on February 13, 2009 which warranted the development of a safety plan. All children were evaluated by Children's Hospital of Pittsburgh [REDACTED]. [REDACTED] denied maltreatment, reported feeling safe at home, and had no medical findings of maltreatment. [REDACTED] received a [REDACTED] in March 2009, and there were no medical findings of maltreatment.
- [REDACTED] was [REDACTED] from CHP on 2/17/2009 where he returned home in the care of his mother, with 24- hour supervision by family members. Maternal grandparents reside on the same street as the family, maternal great grandparents reside approximately two minutes by car from the family, and maternal aunt resides across the street from the family, are aware of the issues and agree to support mother in ensuring the safety of the children.
- The [REDACTED] was completed within 60 days, in compliance with the [REDACTED].
- All risk assessments were completed as required.
- The family was accepted for service in the appropriate timeframes, and the Family Service Plan was developed within 60 days of the accept for services date.

