



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

*Elaine Bobick*  
*Director*  
*Western Region*

11 Stanwix Street, Suite 260  
Pittsburgh, PA 15222

(412) 565-2339  
Fax: (412) 565-7808

**REPORT ON THE NEAR FATALITY OF**



**Date of Birth: January 12, 2010**  
**Date of Near Fatality Incident: June 23, 2010**

**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 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:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Subject child	01-12-2010
[REDACTED]	Father	[REDACTED]-1988
[REDACTED]	Mother	[REDACTED]-1990
[REDACTED]	MGGF	Unknown
[REDACTED]	MGGM	Unknown

**Notification of Child (Near) Fatality:**

The date of incident and report to Allegheny County Children Youth and Family (ACCYF) was 06-23-2010. A mandated reporting source, [REDACTED], reported that the father had hit and shook the 5-month old male child resulting in bruising to the head, arms and torso and [REDACTED] with [REDACTED] to the [REDACTED]

**Summary of DPW Child (Near) Fatality Review Activities:**

The Department of Public Welfare's Office of Children, Youth and Families (Department) obtained and reviewed the intake and closed past case record pertaining to the [REDACTED] family that was provided by Allegheny County CYF. The current case file included: demographic information; safety/risk assessment; family service plan; child permanency plan and review; safety plan; child dependency adjudication order; and [REDACTED] of [REDACTED] Assessment/medical evaluation history and treatment information. Interviews of

Allegheny County CYF intake and family services staff were conducted 11-18-2010, 11-22-2010 and 11-24-2010 included caseworker, supervisory and administrative staffs. The Department also participated in the County Internal Fatality Review Team meeting on 08-19-2010 where CYF, Children's Hospital Pittsburgh and Law enforcement activities were presented.

### **Summary of Services to Family:**

The mother had one supervised visit with [REDACTED] after the incident and by Court Order, the father was denied contact. The mother refused CYS services. In an earlier interview with the [REDACTED] physician, the parents expressed their decision to give up their parental rights to [REDACTED] and consistent with that, they later did sign consents to adoption. The agency's efforts were toward establishing the permanency goal of adoption.

### **Children and Youth Involvement prior to Incident:**

The birth parents are ages 22 and 19 years old, unmarried, unemployed and had been together as a couple for approximately three years. Both were estranged from other extended family. On the date of the incident, they were residing with the maternal great grandparents. There were reports of friction and domestic violence between the father and the maternal great-grandparents (MGGP) as well as physical maltreatment allegations of [REDACTED] and the mother by the father. The father was arrested in 2009 for simple assault, and the charges were dropped. Additionally, there had been a report of an allegation of abuse towards his adoptive parents committed by the father. The child's parents described themselves as medically healthy however the father reported [REDACTED] as a child by his biological parents and mental health problems. Prior to the date of the incident, the subject child was essentially healthy as well, having no significant medical problems. There was no known history of hospitalization, surgeries or ER visits. The child was seen by his PCP for regular visits and considered to be developmentally on target or advanced. He is the only child for both the mother and the father.

- The [REDACTED] was adopted in 1995. It was an Allegheny County CYF subsidized adoption. [Record was closed 10-22-2001.] The file reveals a history of physical maltreatment in the birth family of the [REDACTED] and his siblings that had precipitated CYF foster care placement and the TPR actions. The biological family case was closed 03-30-1994.
- On 5-28-2010, ACCYFS Intake received a [REDACTED] report alleging that the father beats [REDACTED] and the mother; that father smacked the baby in the face at the MGGP's home and after a fight in MGGP's home the birth parents and baby went to a homeless shelter in Braddock. It was reported that when father gets very angry, he beats and yells at the baby

and is especially angered when the baby cries and he is [REDACTED] toward the mother, the MGGP's and [REDACTED]. Prior assault charges had been filed; MGGP had pressed assault charges against the father from the incident resulting in the grandfather's hospitalization. There had been incidents involving the father beating/kicking the mother when she was pregnant, as well as incident(s) involving the father's assaultive behavior toward his adoptive parents.

- ACCYF was unsuccessful with face-to-face attempted contact per the 05-28-2010 call designated "high risk" field screen and the agency policy requiring 0-2 hour response time to assess safety. The caseworker went to the site address of a homeless shelter that was provided in the report; the child and his family were not found. Per the record, it was reported that there was no evidence of a homeless shelter in the vicinity. The County Caseworker then called back to the Lexington Intake Office, Allegheny County CYF, on-call for further guidance, and was given the phone number of the reporting source and the grandparents' phone number. The caseworker made consecutive calls to both numbers but received no response from the voicemail left for the RS, and the grandparents' number remained disconnected.
- On 06-15-2010, the referral from 05-28-2010 was screened out by CYS Intake due to "insufficient information to locate family." The agency never assured the child's safety.

#### **Circumstances Of Child's Near Fatality and Related Case Activity:**

On the morning of 06-23-2010, [REDACTED] mother brought him downstairs and put him in the swing as she had a job interview and left the home about 8:30 am. Before leaving she awakened the child's father. The child's father reported that soon after the mother left, [REDACTED] became fussy and was crying. The father was angered that the child was crying and hit him with his hand in the face. [REDACTED] was crying vigorously and hysterically and would not stop crying. The father then picked the child up, trying to comfort him, and shook him as he continued crying. It was described that [REDACTED] never stopped breathing. His father reported that the child only drank an ounce of the formula from the bottle and then he threw up. At this point, the father called the child's mother telling her that [REDACTED] would not stop crying and that she needed to come home. Upon the mother's arrival back to the home, [REDACTED] was in his crib asleep. The mother saw bruises on [REDACTED] face and the father told her that the child had hit his head on the metal bar of the playpen. The mother picked [REDACTED] up who seemed to be breathing normally but "maybe a little more shallow than normal". The child's color was good but his head seemed a little limp and the child was not very awake. The parents and the maternal great-grand mother (MGGM) decided to drive [REDACTED] to Forbes Regional Hospital and realized the heavy traffic would

delay their attempts so they returned to the home and called 911. The child was transported to [REDACTED] via ambulance and was admitted to the [REDACTED] and certified by doctors to be in serious condition. The subject child had multiple bruising to his face, back and his chest; [REDACTED]. At the time of the initial report the child was expected to survive.

- On 06-23-2010, the date of incident, 5 month old [REDACTED] was transported to [REDACTED] Emergency Room, admitted to [REDACTED] and certified to be in serious condition. Child had sustained multiple injuries while in the care of his father, [REDACTED]. Bruises were noted on child's face, shoulders and upper chest/back. CT scan revealed [REDACTED] and [REDACTED] indicative of shaken baby syndrome. Physician's opinion that injuries caused "severe pain and that child will likely live but too early to tell."
- Both parents were interviewed on 06-23-2010 and on 06-24-2010 by the doctor, detective, and social worker at CAC & ACCYF. The father [REDACTED] made statements to CYF and law enforcement officials that he inflicted the injuries to his child. The father was arrested at [REDACTED] and charged with Aggravated Assault and Endangering the Welfare of a Child. The mother was also interviewed and gave [REDACTED] medical history, a chronology of the incident and expressed that she and the child's father were no longer willing to care for their son and requested their child's placement in foster care with a relative. The mother refused services.
- The Shelter order dated 06-25-2010, states that the child remain at [REDACTED] with permission to place with relative upon discharge; the birth mother was permitted supervised visits. The birth mother did not follow through with visits nor maintain contact with ACCYF. Mother had not called or visited since the child's hospital admission, except to call [REDACTED] on 07-03-2010 to check on [REDACTED] after his [REDACTED] and CYS were initially unable to contact mother after the incident to authorize additional [REDACTED], however the mother gave a verbal consent on 07-07-2010 via telephone to [REDACTED] for the [REDACTED]. Mother has visited once with her child after the incident and refused services from the agency.
- The child needed [REDACTED]. The judge approved the procedure. On 07-02-2010 and 07-03-2010, the child had [REDACTED]. On 07-07-2010 [REDACTED] tests identified that child needed a [REDACTED] which would prevent a buildup of fluid. The birth mother gave consent. The [REDACTED] performed on 07-09-2010 went well.

- Allegheny County CYF filed dependency petition on 07-02-2010.; dependency hearing was scheduled for 07-26-2010 and the child was adjudicated dependent. Permanency review was scheduled for 10-25-2010
- The child was discharged to kinship caregiver (maternal aunt) on 07-11-2010 with follow up medical appointments scheduled.
- The father was incarcerated and a preliminary hearing was scheduled 07-19-2010.
- The [REDACTED] status determination of [REDACTED] was made for [REDACTED] by the father. The [REDACTED] was completed; dated/filed 07-20-2010. The child's injuries were due to confirmed [REDACTED]. The child was no longer in serious or critical condition.
- Pediatric visit, Well Child Care, immunizations were completed on 07-19-2010 and the child had a follow-up with [REDACTED] in August 2010 and with [REDACTED] in September 2010. The Child was discharged from [REDACTED] to the maternal family on 07-11-2010. A referral to [REDACTED] through the Alliance for Infants and Children for [REDACTED] was made on 07-14-2010 and the evaluation was scheduled for 09-02-2010.

### **Current Case Status:**

The placement with the maternal aunt disrupted because the maternal aunt objected to ACCYF inquiries/allegation concerning drug or alcohol use and refused to submit to testing. The child was removed from the maternal aunt on 09-29-2010 and was placed with the paternal aunt where he currently remains. The parental rights of the birth parents have been terminated. The birth parents signed consents to adoption and the child's permanency goal is adoption. The adoption finalization is expected to occur in May, 2011. The paternal aunt is the prospective adoptive parent.

Medically, the child is doing well. He has continued to be followed by his PCP, CHP and receiving therapy through Alliance for Infants and Children. By Court Order, [REDACTED] has had no contact with the child since the incident and prior to the terminated parental rights, the birth mother visited once in the foster home which was supervised.

The father's criminal case was adjudicated and he is awaiting sentencing. In a non-jury trial, there was a guilty plea negotiated regarding the aggravated assault charge and the endangering the welfare of children charge was withdrawn.

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

Allegheny County convened a review team in accordance with Act 33 of 2008 related to this report and the meeting was held on 08-19-2010.

- Strengths: CYF responded immediately to the near fatality report of 6/23/2010, conducted a thorough investigation and instituted a safety plan for the child.
- Deficiencies: The Act 33 Review Team identified two regulatory compliance issues related to the assignment of the first referral of 5/28/2010 as a field screen, rather than as a [REDACTED] assessment; specifically 3490.103. [REDACTED] reports received by the county agency or other public agency from [REDACTED] and 3490.232. Receiving reports and assessing the need for services. Compliance issues are related to the assignment of the [REDACTED] referral from [REDACTED] to the field Screen tract, failure to visit the grandparents' home (last known address of the family), and failure to make additional attempts to identify the correct address of the homeless shelter to locate the family.
- Recommendations for Change at the Local Level: The Act 33 Review Team made several recommendations for change at the local level. They are as follows:
  - Immediate administrative review of the Field Screen Policy, decisions related to Call Screening's assignment of field screening, and supervisory decisions related to attempts to locate the family in order to conduct a safety assessment of the child.
  - Additional staff training on diligent searches for families whose whereabouts are not immediately known, including use of DHS databases and communication with other DHS program offices to obtain accurate addresses of service providers.
  - Greater access to information about normal crying behavior in infants and what to do when babies cry.
- Recommendations for Change at the State Level: The County did not include recommendations for changes.

### **Department Review of County Internal Report:**

The Department is in agreement with the findings of the report as it relates to the analysis of the [REDACTED] report made on 5-28-2010, which concluded the agency failed to assure the child's safety at that time, as the child was never seen. The child was subsequently injured less than a month from the initial referral. The

Department is also in agreement with the agency's finding regarding the 6-23-2010 near fatality [REDACTED] report.

### **Department of Public Welfare Findings:**

#### **County Strengths:**

Per the 06-23-2010 near fatality [REDACTED] report:

- The safety assessment and risk assessment based the goals for the FSP.
- The case acceptance and transfer was timely.
- ACCYF Field Screening Policy: Allegheny County's Field Screening Policy states that all calls involving children ages 6 and younger are designated "high risk". The Call Screen Supervisor assigns 0-2 hour response time to consist of a field screen to assess safety of each child in the family, and an observation of environmental factors of the child's residence to evaluate for immediate safety. The caseworker supervisors discuss information received with the Call Screening Supervisor within 24 hours of the assigned initial response. If the Call Screening Supervisor deems the preliminary evaluation warrants further assessment, that Supervisor assigns the case to a Caseworker to conduct a full [REDACTED] investigation and /or [REDACTED] assessment. The Caseworker submits a completed Field Screening form to the Supervisor for approval and delivery to Call Screening Supervisor within 72 hours of the assigned time.
- [REDACTED] investigation compliance
- Documented safety assessment and plan
- Completed Risk Assessment
- Collaboration with Law enforcement, {Penn Hills Police Dept.} and Children's Hospital
- Emergency caretaker /Kinship placement plan
- Case transfer and child permanency goal established

#### **County Weaknesses:**

Per the 05-28-2010 call:

- Beginning with the call on Friday, May 27, 2010 in the late afternoon proceeding the Memorial Day holiday, there began the apparent 17 day lapse that occurred before follow-up to the 05-28-2010 "field screen" initially assigned intake referral requiring a 0-2 hour response. This case was improperly screened out due to "insufficient information to locate family" from the very same 05-28-2010 failed face to face assessment attempt that by then CYF inaction had remained seriously dormant. The CYF Field Screening policy/procedures were not followed i.e. there was no documentation of a discussion between the CW Supervisor, and Call Screening Supervisor within the 24 hour of the assigned initial response.

Consequently from there the other procedural steps were totally missed as well. The initial 0-2 hr. response was made but to the contrary, did not provide information on which to base/warrant a need to further pursue the child's whereabouts for safety reasons. The attempts by the case worker to obtain more information from the intake worker failed. The county agency was non-compliant in regards to the screening time frame. The significance of the response time was either miscommunicated or missed or not communicated by the call screening or on-call for further action. The seriousness of that was not acknowledged at that point because even at the 17 day mark it was screened out without further inquiry or action. This is of great concern to the Department given the severity of the allegations regarding the father's [REDACTED] of this child.

The Department believes that there was a two tiered error: The agency's failure/non-compliance pursuant to the county-specific field screen policy and procedures, as well as being non-compliant with [REDACTED] requirements regarding the 05-28-2010 call to intake. Within 24 hours from the time of the call, the casework supervisor and call screening supervisor were to exchange information obtained during the preliminary evaluation, to determine if further action was warranted; however they did not do so. The required meeting may have prevented the subsequent incident.

**Statutory and Regulatory Areas of Non-Compliance:**

Allegheny County CYF will be issued a Licensing Inspection Summary regarding Regulatory Areas of Non Compliance per the 05-28-2010 CYF intake call:

- 3130.12(c)(1)- Responsibilities for Children and Youth Services
- 31.30. 31(2) (ii)(A)(B)- Responsibilities of the County Agency
- 3130.38 (b)-Other Required Services
- 3490.231(1) (2)(3)-Functions of the County Agency for General Protective Services
- 3490.232(f),(c),(g),(i),(d)(2)(3)—Receiving reports and assessing the need for services
- 3490.235 (e)—Services available through the county agency for children in need of general protective services

**Department of Public Welfare Recommendations:**

The agency needs to develop and document a closer tracking system and back up protocol for all "field screens" that essentially remain a [REDACTED] assignment. The preliminary outcomes, verbally, electronically and/or written must be timely communicated back to the Call Screening Supervisor; particularly all calls involving children ages 6 and younger designated "high risk".

In future cases, the agency needs to include as part of the case review, a discussion of previous referrals and the agency's actions/involvement with the family for the period of 16 months prior to the any subsequent incident. The allegations regarding the 05-28-2010 report included eye witness accounts of the father being [REDACTED] to the child and the mother, as well as other relatives. Given the fact that the child was only 5 months old, the case should not have been closed without the agency's assuring the safety of this infant as it was less than 30 days when the child sustained the near fatal injury. The only mention of this referral in the report submitted by the county is a time-line of events. There needs to be a discussion in the report of strengths and weaknesses regarding previous activity.

The agency must develop a system that allows the differing agencies under the DHS umbrella to communicate and share information to ensure children are safe, and families' needs are being met. This family was housed in a DHS supervised emergency shelter following the 05-28-2010 referral, yet the County child welfare agency did not know how to navigate their own DHS system to find out information about the child and family.