pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 09/13/2012
Date of Incident: 01/21/2013
Date of Oral Report: 01/22/2013

FAMILY NOT KNOWN TO:

Allegheny County
Children, Youth and Family Services

REPORT FINALIZED ON: 12/06/2013

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. 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 Children, Youth and Families (CYF) has not convened a review team in accordance with Act 33 of 2008 related to this report. The county did not conduct a review of this incident, as the medical professionals determined the injuries to be accidental in nature and the agency submitted an unfounded status determination within 30 days of the report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Subject Child	09/13/2012
	Biological Father	[redacted]1994
	Biological Mother	1994
	Paternal Grandmother	1973
	Paternal Great Grandmother	1951
	Paternal Great Uncle	1970

Notification of Child (Near) Fatality:
The injury to the subject child occurred on January 21, 2013. The incident was reported to ChildLine and then Allegheny CYF on January 22, 2013. According to the report to the agency, a mandated reporter contacted ChildLine to report that the father, who was listed as the alleged perpetrator, was co-sleeping with the child. The child was found to be unresponsive and [redacted] The child was hospitalized as a result of the [redacted] and lack of oxygen to the brain.

Summary of DPW Child (Near) Fatality Review Activities:
The Western Region Office of Children, Youth and Families received the complete record for this investigation, as well as the ongoing services file. The file also contained extensive medical records related to the child's medical treatment. This documentation was reviewed for this report. Allegheny County CYF did not conduct an internal review, as medical evidence showed the injury was accidental and the agency submitted an "Unfounded" determination within 30 days.

Children and Youth Involvement prior to Incident:
Allegheny County CYF had no prior history with this family.

Circumstances of Child (Near) Fatality and Related Case Activity:
On January 22, 2013, Allegheny County CYF was informed of the existence of this incident by ChildLine. As such, a caseworker was dispatched and made contact with the child at [redacted] and with the parents at their residence.

[redacted] staff advised the caseworker that the child arrived at the hospital via ambulance at approximately 4:00 PM [redacted] At that time, it was believed that the father rolled over on the child. At that time, the child did have brain activity. The father stayed with the child the entire night and the mother went to the hospital the next day. The hospital staff reported that both parents appeared to be sad about what happened.

The CYF worker made contact with the parents at their residence. The worker asked the father to recount the incidents that led to his child being hospitalized. According to the father, he had placed the child in bed with him and the father fell into a deep sleep (as per father, this was due to "insomnia"). When the father woke up at 4:00 PM, the child was "very limp" so he ran to get the grandmother. The grandmother allegedly performed CPR on the child while the father contacted 911. The mother reported that she left the home approximately 3:00 PM, but checked on the father and child prior to leaving. As per mother, she saw the child moving at that time.

The worker requested to see the sleeping arrangements for the family. The father and mother sleep on the third floor of the house. Their room included a bassinette, however, the mother stated the child rarely sleeps in it and usually sleeps with the father.

On January 23, 2013, the caseworker contacted the [redacted] and spoke with one of the physicians assigned to the child's case. According to the physician, the child began to receive CPR at 4:53 PM and did not have vitals until 5:31 PM. [redacted] He was admitted to the [redacted] in critical condition. [redacted] No bruising was noted, however, the child was to have a full skeletal survey when more stable. The physician said that the father reported that he had fed the child a bottle while lying in the bottom bunk and they both fell asleep. The father believes he was asleep about two to three hours before finding his son limp from being rolled on. The treating physicians did not suspect abuse, but believed this injury to be a result of an unsafe sleeping situation.

Also on January 23, 2013, Allegheny County CYF submitted a report of suspected child abuse (CY-104) to the Pittsburgh Police for investigation.

The mother and father were interviewed again at the hospital and provided more detail regarding the incident, but nothing that conflicted with what had already been stated. In addition, the caseworker conducted interviews with other household members, including the paternal grandmother and paternal great-grandmother. Both corroborated the father's timeline and activities.

The caseworker completed a safety assessment worksheet on this day and determined the child to be safe with a comprehensive plan [redacted]

[redacted] Since the child was hospitalized, the plan asked the parents not to remove the child against medical recommendations.

The caseworker continued to remain in contact with the medical professionals to get up-to-date information regarding the child's medical condition. As of January 28th, [redacted] The child had [redacted] and an [redacted], which showed injuries consistent with a [redacted] scans. The child had yet to have a skeletal survey, as he was still [redacted]

On January 29th, the caseworker was informed by the mother that she and the father were no longer together as a result of an argument. The mother told the caseworker that the doctors told her that the child [redacted] and may require [redacted] for life.

A risk assessment was completed, with overall risk to the child rated moderate. The justification for this rating related to the parents' deficits in parenting skills (as evidenced by co-sleeping with the young child causing the injury) and the uncertainty that they will be able to meet his complex medical needs when discharged. As a result, the agency accepted the family for ongoing services on January 30th. Referrals for services were made so the parents' needs can be properly assessed.

On January 31st, the mother provided an address of her own apartment and informed the caseworker that she was confident she would be able to care for the child, as she had family support in the forms of her father and brother. The worker went to the mother's new residence and ensured it was a safe environment for the child's eventual return to his mother's care.

As of February 4th, the child was [redacted] and [redacted] was "doing well," however, he had [redacted] and was being given [redacted] to reduce his [redacted] The child was still [redacted] but it appeared as though he would be discharged to either [redacted] by week's end.

On February 7th, the agency completed their child abuse investigation and determined the incident to be unfounded, as it was accidental in nature. A later follow-up with the Pittsburgh Police revealed no charges were ever filed, as the medical record showed the incident was accidental.

The child was returned to the mother's care sometime between February 25th and February 28th. After a short period of time caring for her child, the mother informed the in-home worker on March 1st that she was considering placing her child for adoption. It was also discovered that she was no longer taking her [redacted] which she had been taking for [redacted] The mother requested the child be placed into foster care until she was able [redacted]

[redacted] and the child was placed into formal foster care, with the mother scheduled for supervised visits. Weekly contact with the child was being made either by provider agencies or the caseworker.

Over the next several weeks, the biological mother was inconsistent with keeping her supervised visits with her child. The mother reported that she would be moving to Albany, New York with her new boyfriend [redacted] that he could be adopted by the foster mother. As a result, CYF began the Family Finding process to locate potential family willing to adopt the child.

[redacted] Supervised visits with the father were discussed and agreed upon.

Although they had taken good care of the child, on May 29th the foster parents provided the foster care worker with their 30 day notice to relocate the child, as they felt he would be better suited in a home where there were less stimuli and more one-on-one time could be given to him. Although the maternal great-grandmother had expressed a desire to care for the child, she was already caring for three grandchildren, in addition to an adult son who is dependent on her for care. As a result, she was ruled out as a resource home. A new foster home was located and the foster mother that was ending her care assisted in the child's transition and training of the new foster parents.

Current Case Status:

As of the date of this report, the child continues to reside in this foster home, which is licensed by [redacted] The child attends [redacted] daycare and [redacted] He is medically stable and making progress, albeit slowly.

The mother continues to reside in New York with her paramour, but has maintained contact since moving and visits with her son at least monthly. [redacted]. Thus far, she has been compliant and showing progress. The agency plans on requesting to move the child to the mother's care through the Interstate Compact on the Placement of Children (ICPC). [redacted]

As for the biological father, [redacted] with which he has yet to follow through. It was also suggested by the agency that he obtain a [redacted] The agency scheduled [redacted] for the father however, he did not attend. He has recently [redacted] and as such, is not having contact with him or requesting visits. He is not being considered as a placement resource.

The child receives [redacted] to assist the foster parent in meeting the child's needs. [redacted] is still trying to engage the father and have him [redacted] so that he can be part of his son's life in whatever capacity he is willing and/or able.

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

The agency had obtained substantial information and documentation to determine that the incident, although tragic, was accidental in nature. The agency completed their investigation on February 7, 2013 by assigning it an "Unfounded" status determination. Since this was done within 30 days of the report, the county was not required to complete an internal review or report.

Department Review of County Internal Report:

As stated above, no internal report was done because the report was "Unfounded" within 30 days of the report.

Department of Public Welfare Findings:

- County Strengths:
  The county demonstrated multiple strengths with this case:
  - The agency ensured that the child, family, and foster parents received supportive services in a timely manner and that the services put in place were appropriate and beneficial for the child.
  - Although the case was not rated "high risk," the contact with the child was made weekly by either the agency worker or [redacted] service provider.
  - The agency maintained ongoing communication with the medical staff to get updates on the child's condition and information to assist them in making a status determination.
  - The [redacted] service providers were thorough with their case notes, which made understanding what was happening in the case easy.
  - The agency did a very good job matching foster homes for the child. Both homes that the child resided in had a foster parent that was currently or had been employed in the medical field dealing with needs this child has.
  - The agency is taking proper steps to find this child permanence, which included the use of Family Finding.

- County Weaknesses:
  While reviewing the case, some deficiencies were noted:
  - Although the case notes and other documentation was fairly detailed, it was difficult to determine the household composition, as there is conflicting information within the structured case notes and the other reports in the file (transfer summary, referral snapshot, etc.). There were adults and children mentioned in the case notes as living in the home, however, these persons weren't listed anywhere in the composition.
  - A case note entry documenting the exact date the child was returned to the mother's care was not located in the documentation provided. This is important, as the child's

return to the mother's care would have triggered a new Safety Assessment be completed.

- The provider entry dated March 8, 2013 at 4:00 PM has multiple dates of contact included, dating through March 12th.
- Although it is addressed at the end of the case notes, there is very little information regarding the father after the investigation was completed. While it is made clear that the mother obtained a PFA for herself and the child against the father, he still maintained rights to this child, who was in placement and could possibly return to his father at some point if deemed appropriate. Based on the lack of contacts documented, it appears as though the father wasn't engaged to the fullest extent.
- While Family Finding was utilized in this case, the documentation shows that it began in April 2013, even though the agency [redacted] the child in January 2013 and placed the child in formal foster care in early March of 2013.

- Statutory and Regulatory Areas of Non-Compliance:
  Although deficits were noted, there does not appear to be any areas of non-compliance. Recommendations to address the deficits will follow in the next section.

Department of Public Welfare Recommendations:

- Overall, the agency routinely has good communication with medical professionals in investigations and cases such as this. This is one practice that should continue.

- In addition, matching a foster child's need with the strengths of a specific resource home should also continue, as it is in the best interest of the child(ren).

- The household composition should be verified by caseworkers and specifically identified somewhere in the case record (not just in a narrative form). Should a worker identify an error in household members, the correct information should be included so that anyone involved in or reviewing the case is aware of who has access to the child(ren) in the home.

- Case notes should not contain multiple dates. The agency should ensure that anyone entering a case note / contact entry separates contacts by date.

- All county agencies, not just this specific county, should be mindful to include non-custodial parents in service planning and service provision when any child is in placement.

- Family Finding should be utilized as early as possible in a case so that potential family members as potential placement resources can be identified early on and included in planning.