pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/20/2013
Date of Incident: From 07/07/2013 to 07/17/2013
Date of Oral Report: 07/25/2013

FAMILY WAS NOT KNOWN TO:

Allegheny County Children, Youth and Families

REPORT FINALIZED ON:

04/01/2014

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 has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Victim child	01/20/2013
	Sibling	[redacted]2010
	Mother	[redacted]1975
	Father	[redacted]1975
	Paternal Grandmother	[redacted]1957
	Paternal Grandfather	[redacted]1954

Notification of Child (Near) Fatality:

On July 24, 2013, Allegheny County Office of Children, Youth, and Families (CYF) and the Western Region Office of Children, Youth and Families learned of the child's condition via [redacted]. According to the report, the child had been admitted to [redacted] from July 7, 2013 and was deemed to be in serious and critical condition with serious and highly unusual infections [redacted] The child was in septic shock as a result of the infections. The lack of a medical explanation for the child's condition coupled with the mother's repeated claims of illness led to the medical staff becoming suspicious of the mother's behaviors.

Because of these concerns the hospital began monitoring the mother's actions with her son effective July 17th. The mother was observed via electronic monitoring doing things that made the child appear to be severely ill, such as making soiled diapers and smearing feces so that it looked like the child was going to the bathroom more often than he actually was. She was also seen tampering with the child's [redacted]. Because the mother's actions led to the child being subjected to multiple tests, [redacted], procedures, [redacted], and other unnecessary risks and treatments, the child was deemed to be a possible victim of child abuse. It was believed that the mother may have [redacted]

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region was provided with the case notes, safety assessments, risk assessments, and other pertinent documents from the case record. (The complete record is electronic and accessible at the Department's request.) This information was reviewed for this report. In addition, the Department participated in Allegheny County's child near fatality team meeting that took place on September 19, 2013.

Children and Youth Involvement prior to Incident:

Prior to this report, the family was not known to the agency.

Circumstances of Child (Near) Fatality and Related Case Activity:

In the early evening of July 24, 2013 Allegheny County OCYF received a report of suspected child abuse on the subject child, with the mother named as the alleged perpetrator. Based on the history of the child's medical condition and subsequent treatments, the reporting source, [redacted] believed the child to be a victim of medical child abuse, i.e., [redacted]. The reporting source stated that the child had gone through numerous medical interventions for issues that only the mother appeared to be witnessing. In addition to the medical treatments, the child became critically ill and nearly died. The treating physician believed that the mother put feces into the child's [redacted], which caused the child's infections.

After receiving the report, the CYF worker contacted the [redacted] Police to advise them of the child abuse report then went to [redacted] to observe the child. With the child at that time were the father and the paternal grandmother. The worker took a photograph of the child and then spoke privately with the father.

According to the father, he, his wife, and two sons reside with his parents. The father reported having a daughter to a past relationship. Although he has joint custody of the daughter, she resides with her mother. The father is gainfully employed and has been in a relationship with the child's mother for approximately five years, although they have never married. He denied any domestic violence and did not express any concerns for the mother as a parent. He described her as a "stay at home" mom who "had a rough time at the hospital when [redacted] was born." He reported no formal [redacted] for the mother, but said she was "frustrated" with the child's length of stay at [redacted] The father was able to identify a Primary Care Physician (PCP) for the children, as well as some minor medical concerns for the sibling (i.e., [redacted]

As far as the subject child's medical history, the father reported that the child was born healthy at [redacted]. The child has had [redacted] and was also brought to [redacted] to have [redacted] because he had [redacted] The father also said that at one point, the child

was having difficulty with bowel movements and was admitted to [redacted] but released "a couple days later." The father said that the child was currently in the hospital because he was brought to [redacted] with a fever.

When asked about the whereabouts of the mother, the father said that he had received a phone call from her telling him she was given two options by the police, which were go to a "shelter" or get arrested. The mother chose to go to a shelter in [redacted] PA. When speaking with the mother, the father said she told him that the hospital "blew out of proportion" what happened. The mother said the child had a waterproof cover on his bed and the child "threw up and moved around some." The mother said she took soiled linens out of the bin to show the medical staff because she didn't believe the child was being treated properly. The child also developed an infection in his [redacted] which the doctor said was "very uncommon." When a second infection happened a couple weeks later, the hospital didn't really discuss it because the father believed they were concerned about a potential lawsuit.

The father also added that approximately two weeks prior, the child had a fever and he and the mother were talking to the doctors about it, but they felt the doctors weren't taking them seriously and suggesting that the child just had a cold. The child's condition worsened while at [redacted] and he was transferred to the [redacted] The father reported that while in the [redacted] the doctors found "multiple infections" in the child, including [redacted] The doctors completed more testing and also found that he had a [redacted] The child was moved back into a regular room after one week in the [redacted]. The father stated that the child "had diarrhea and was throwing up while in the hospital."

While at the hospital, the worker interviewed the paternal grandmother, who provided her own background information. She had no concerns for the parents related to how they care for their children. [redacted] (the child's sibling) was present at the hospital and the worker photographed him as well.

Based on the information gathered during this contact, the caseworker that responded to [redacted] completed a preliminary Safety Assessment on the subject child and his sibling. [redacted] The father appeared to be appropriate and had ample support from his parents.

On July 25, 2013, the CYF worker assigned to complete the investigation visited the child at [redacted] The child's father was also present during this contact. The worker also spoke with the hospital social worker, who provided extensive detail regarding the child's medical history.

According to the social worker, the child had been admitted a total of 57 days. He was initially brought to [redacted] on May 13, 2013 and remained inpatient until May 28, 2013. The next day, the child was brought back to the hospital via private vehicle, but not admitted. The child came back to [redacted] on May 30, 2013 due to [redacted] for which he was admitted and remained through this contact. During this entire hospitalization, the mother remained at the child's bedside and was initially thought to be appropriate in her interactions.

After speaking with the social worker, the investigating worker spoke with one of the physicians from [redacted] The doctor stated that although the child's condition upon admission wasn't serious (the child had a fever), he suffered an "unusual infection" caused by bacteria and mold. This resulted in him being transferred to the [redacted] The doctor became concerned that someone was "interfering with" the child's treatment, so the hospital transferred the child to another room that had video recording equipment.

Once the child was in a room with recording capability, the mother was witnessed tampering with the child's [redacted], as well as pouring water in the child's diaper and then reporting the child had diarrhea. The mother also exposed her child to fecal matter, which is believed to have caused his infection. While in the [redacted] the doctor stated that the child's [redacted] which caused the child to be placed on life support. The child nearly died from the first infection he suffered, but he was currently in stable condition and likely to [redacted] the middle of the next week.

The investigating worker spoke to the father about the allegations. He has been in communication with the mother via cell phone. He was aware of [redacted] concerns, as they had discussed them with him. He stated the child's mother told him that the hospital told her that she could either go to a shelter in [redacted] to reside or be placed in jail. The father believed the shelter the mother referred to was a women's shelter. He denied domestic violence with the mother and there were no orders of Protection from Abuse (PFA). The worker asked the father to sign a safety plan that the mother would have no contact with the children, nor would she have any medical responsibilities during the investigation. The father agreed to do so. He initially didn't believe the mother was capable of harming her child, but appeared to change his mind after hearing the evidence against her.

Later on July 25th, the investigating worker went to the paternal grandparents' residence, with whom the mother, father, and children had been residing. The home was found to be safe and appropriate.

On July 26, 2013, the investigating worker visited the mother at the [redacted] Shelter. Due to the criminal investigation, the worker only obtained background information on the mother. There was no discussion of the allegations. She was asked to sign the safety plan that was put in place on July 25th, which she did. She agreed to follow the plan and cooperate with CYF during the investigation.

The investigating worker completed a Safety Assessment based on the information obtained during his contacts. [redacted]

The mother contacted the worker on July 30th to advise him that she was no longer at the shelter, but was temporarily staying with her friend in the [redacted] area of Pittsburgh. While at the shelter, she had been evaluated for [redacted]. According to the mother, [redacted] was recommended and she was in the process of locating a provider. She agreed to provide a copy of her [redacted] and any recommendations.

On July 30, 2013 the [redacted] Police Detective investigating the incident contacted the worker to advise him that he would be reviewing [redacted] Police's report and watching the video surveillance footage of the mother. He was hoping to schedule an interview with her on August 5, 2013 at Police Headquarters. He welcomed the caseworker to participate.

The child [redacted] on July 31, 2013 to his father's care. The father and children continued to live with the paternal grandparents. The investigating worker made contact with all household members on July 31st [redacted] provided the father with specific recommendations for follow-up care for the child and home health care was also visiting him to ensure any potential feeding/nutrition needs were met. The child was [redacted] to ensure he would not vomit and that he received proper nutrition for growth. The father and household members were provided instruction on feeding the child.

Another Safety Assessment was completed on August 1, 2013 as a result of the child returning home to his father's care. [redacted]

On August 5, 2013, the investigating caseworker observed the [redacted] Police Detective's interview with the mother, who is the perpetrator in this incident. During the interview, the mother admitted to doing the following things to the child while he was at [redacted]

- moving the diaper pad to make it look as though the child threw up more than he did
- spreading the feces in the diaper out to look as though he had a larger bowel movement
- attempting to make the child's vomit look like bile
- tampering with the child's [redacted] (but denies spreading feces on them)
- exaggerating the child's medical condition (saying he threw up twice when it was only once)

The mother claimed she initially didn't realize then that her actions placed her child in serious danger, but understood they did after the investigation commenced. Although she denied any domestic violence from the children's father, she claimed she was doing these things because she felt pressure from him.

The worker continued to have weekly face-to-face contact with the father and children at the paternal grandparents' home. In a visit on August 16th, the father stated he was "not sure" about the allegations. He did agree that the allegations were very serious and was committed to keeping his children safe.

On August 21, 2013 the worker contacted the investigating detective's partner and was informed that the mother was arrested for Aggravated Assault (Felony 1), Recklessly Endangering Another Person (Misdemeanor 2), and Endangering the Welfare of a Child (Felony 3). The

Detective reported that typically a "No contact" order between the defendant and victim is put into place.

The worker continued to have weekly contact with the family and maintained communication with the child's medical providers. On September 11, 2013, the worker was informed by a treating physician that the child looked "very well" and could begin spoon and bottle feedings. Other follow-up visits were scheduled and the father was demonstrating a continued willingness and ability to ensure these appointments were met.

On September 19, 2013 the county convened their Act 33 Team meeting, which was well attended. During the meeting, several medical professionals spoke about the mother's probable [redacted] and their strong opinion that this was a case of "medical child abuse." As a result of their investigation, recommendations from the Act 33 Team members, and the police investigation, Allegheny Co. CYF submitted their abuse determination on September 20, 2013 as "Indicated" based on medical evidence and the CPS investigation.

Also on this date, a home visit with the father and family was completed. The father informed the caseworker that he ended his relationship with the mother and would continue to cooperate with the police and to keep his children safe by not allowing the mother to have contact with them.

A "Case Closure" Safety Assessment was done on September 20th. [redacted] Due to the father's expressed commitment, the agency determined that services were no longer necessary and closed the investigation / assessment.

Current Case Status:

Although the case was closed in September 2013, it has been re-referred for several reasons. After her arrest and brief incarceration in the Allegheny County Jail, the mother was released on her own recognizance in hopes she would appear for her trial. The mother failed to appear, so a bench warrant for her arrest was issued.

On January 23, 2014 Allegheny Co. CYF received a referral on the children while in the care of their father. While executing the warrant and receiving a tip about the mother's whereabouts, the [redacted] Police found the mother hiding in the paternal grandmother's home. The mother's presence violated the safety plan that was left in place at case closure. In addition, the home was reportedly in poor condition, with "clutter so severe it posed a fire hazard." The ceilings were also cracked and falling in, making it unsafe for the children.

Due to the condition of the home, the grandmother took the children to the paternal aunt's home, where they could remain while the home was being repaired. [redacted]

The mother was placed in the [redacted] Jail and was ordered that she was only permitted contact with the victim child through a CYF visitation plan. Since mother did not show for her hearing, monetary bail was denied this time. A non-jury trial is scheduled for March 26, 2014. The mother remains incarcerated at the [redacted] Jail.

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

The Western Regional Office OCYF received the county's internal review team's report on March 6, 2014.

- Strengths:
  The county's internal report did not address strengths.

- Deficiencies:
  The internal report did not address any deficiencies either.

- Recommendations for Change at the Local Level:
  Although the report did contain recommendations for change, they were not categorized as being for the local or state levels. They will be listed under the "State Level" section below.

- Recommendations for Change at the State Level:
  1. The team recommended enhanced professional training in the area of medical child abuse to better prevent, assess, understand and intervene with children who may be abused by their parents in the medical environment.

  2. The team also discussed the need for additional research in this area, including diagnosis, treatment, and prevention strategies, noting the work of Dr. Carole Jenny, MD, MBA, and FAAP on the subject.

  3. The team also recommended that hospitals develop policy and procedure regarding when a hospital notifies their own public safety officers versus local law enforcement in the event of medical child abuse. This could help ensure a timely and comprehensive investigation and response.

Department Review of County Internal Report:

Department of Public Welfare Findings:

- County Strengths:
  - As is typical with Allegheny Co. CYF, the Act 33 meetings are well organized, well attended, and informative.
  - Allegheny Co. CYF is very proactive in ensuring the Department has the necessary information related to the case and very prompt in responding to additional questions.
  - The caseworkers that completed the Safety Assessment Worksheets (SAW) dated July 29, 2013 August 1, 2013, and September 20, 2013 did a good job justifying potential threats. The justifications contained information specific to the investigation.

- The investigating worker was very prompt in getting releases of information from medical and [redacted] providers and also documented multiple attempts at obtaining information to support the determination and need for services.
- The agency collaborated very well with the [redacted] Police Department's detective investigating the abuse.
- The investigating worker was diligent in ensuring that the father was not only aware of the child's follow-up medical needs, but willing and able to meet them.
- The agency had weekly contact with the children once the child was returned to his father's care.

- <u>County Weaknesses:</u>
  Allegheny County CYF's internal report of its findings did not differentiate between recommendations for change at the local and state level.

The other area of weakness identified through this review is related to the inconsistent completion of Safety Assessment Worksheets (SAW). It should be noted that all of the safety assessments were approved by a supervisor. The specific issues are detailed below:

[redacted]

[redacted]

- Statutory and Regulatory Areas of Non-Compliance:
  There were no areas of non-compliance identified; however, improvements in the completion of Safety Assessment Worksheets could be made.

Department of Public Welfare Recommendations:

1. Allegheny County CYF should continue to coordinate and facilitate the Act 33 meetings with the same organization and planning as this one. They are very informative and helpful in not only reviewing strengths and weaknesses within the agency, but in the social service system as a whole.

2. CYF should continue to conduct joint investigations with law enforcement with the same collaboration as in this case. It appears as though the agency has a good working relationship with law enforcement agencies within Allegheny County. This should continue to be fostered.

3. Although Safety Assessment Worksheets were completed at the proper intervals and in a timely manner, they were done inconsistently and at times contradictory. Supervisors should be more vigilant in reading the assessments they are approving to ensure they accurately and adequately capture current safety status. The worksheet is clear in Section III as to what is to be documented and why.

   The agency may want to consider having small group Transfer of Learning (TOL) sessions related to safety assessments where workers bring a current case in need of a safety assessment and discuss each potential threat. These have proven helpful in other county agencies where workers are still struggling to understand the process and the importance of individualized responses in the justifications and completion of the rest of the worksheet. The Child Welfare Resource Center and the Regional Office could be utilized to help facilitate these groups.