pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 07/28/2013
Date of Incident: 09/15/2013
Date of Oral Report: 09/15/2013

FAMILY NOT KNOWN TO:

Allegheny County Children, Youth and Families

REPORT FINALIZED ON: 7/09/2015

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 not convened a review team in accordance with Act 33 of 2008 related to this report because the investigation was unfounded, as the child's condition was caused by a medical condition. Allegheny County Children, Youth and Families contacted the Western Region, Office of Children, Youth and Families to state that they would unfound the case within 30 days and would not be required to hold a meeting; however, the agency did not submit the finalized CY-48 report ChildLine within the first 30 days.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Subject Child	07/28/2013
[redacted]	Sister	[redacted]2011
[redacted]	Brother	[redacted]2010
[redacted]	Mother	[redacted]1988
[redacted]	Father	[redacted]1987
* [redacted]	Maternal Aunt/Caregiver	[redacted]1985
* [redacted]	Paternal Grandmother/Caregiver	[redacted]1956

* Denotes non-household members

Notification of Child Near Fatality:

On September 15, 2013, a near fatality report was registered [redacted]. According to the report (CY-47), [redacted] received the report at 3:56 PM and transmitted it to Allegheny County CYF one minute later. According to the reporting source, the child presented [redacted] in cardiac arrest. The child was determined to be in critical condition and the medical staff were unsure if she was going to survive. Initially, the physician that certified this case as a near fatality was unable to rule-out suspected child abuse, which resulted in the certification.

According to the parents, the child woke up screaming on September 15, 2013 and suddenly became "unresponsive and not acting like herself." The parents contacted 911 at that time. The child arrived at [redacted] between 9:30 and 10:00 AM on September 15th. When the child was weighed in [redacted], she weighed five pounds, which five ounces below her birth weight. Because of the inability to rule-out child abuse, this report was registered as a child protective services report (CPS), with the alleged perpetrator listed as "unknown caretaker" at this point in time.

Summary of DPW Child Near Fatality Review Activities:
Allegheny County CYF was very prompt in providing the Department with the file and a comprehensive summary of their involvement with the family from start to finish. The Department reviewed the agency's file for this near fatality. The agency determined the report to be "unfounded" within 33 days of initiation of the report. Allegheny County CYF had contacted the Department within the first two weeks of their investigation to state that the case would be unfounded within the first 30 days due to the child experiencing a medical related issue. The County did not hold an Act 33 meeting as a result. However, the unfounded CY-48 was not submitted within the first 30 days of the County's investigation; hence, a meeting should have been held.

Children and Youth Involvement prior to Incident:
These parents had no history with Allegheny County CYF as parents. The mother had prior involvement for truancy issues as a child. The father had never been in contact with the agency prior to this report.

Circumstances of Child Near Fatality and Related Case Activity:
Upon receiving the report on September 15, 2013, Allegheny County CYF began their involvement with the family by dispatching two caseworkers to Children's Hospital of Pittsburgh to make contact with the child and family at the hospital.

Once at the hospital, the workers met with the [redacted] informed the workers that the child was not current on her immunizations and was presently one half of a pound under her birth weight, nor had she had a well check with her pediatrician. One of the attending physicians also met with the caseworkers and told them that the child was dehydrated, however, they were still assessing whether the child's condition was due to a medical condition.

The workers saw the child and met with the parents in the [redacted]
The father claimed that the child was "normal and fine" until the morning of the incident. The father stated the child had no issues eating and was being breast fed up until the day before, when mother switched to formula because she was having difficulty producing milk. Both parents denied any medical issues with the child. The mother reported that she was asleep with the child on the couch at the maternal aunt's residence, which is near the parents' home. The family had been staying with the aunt because she was helping care for the children while the father was at work.

The workers spoke to the [redacted] staff, who gave a list of tests done on the child to that point. The full results would not be available for 48 – 72 hours. The parents were appropriate and cooperative, but the [redacted] staff was a little concerned because they didn't believe the parents didn't seem to grasp the severity of the child's condition.

The workers made arrangements with the parents to go assess the safety of the other two children, who were staying with the maternal aunt while the parents were at the hospital.

The two caseworkers then completed a contact with the two other children in this family at the home of the maternal aunt. Both children were seen at this time. The workers asked the aunt to describe what happened with the child. The aunt stated that the family had spent the last several days at her home. The two older children were asleep in her son's room because her son wasn't

home. The father slept on the loveseat and the mother and child slept on the couch. The aunt said on the morning of September 15th, the mother woke her up and told her the child was acting "odd" and her "eyes weren't looking right." Other than that, the aunt had no idea what happened because she was asleep. An ambulance was called and the aunt said that by the time it arrived to take the child to the hospital, the child was "limp" in the car seat. The aunt expressed no concerns with the parents' ability to parent, nor did she report any substance abuse or [redacted] issues with them. The aunt was willing to care for the children as long as necessary while the parents were at the hospital.
After ensuring safety, this caseworker contacted the [redacted] Police Department's major crimes section due to the severity of the child's condition and uncertainty of the cause of her condition. The detective would discuss the report with his supervisor and proceed as directed.

A Safety Assessment Worksheet (SAW) was completed by the responding caseworker on September 15, 2013. Through the process, three potential threats were identified: [redacted] These potential threats were mitigated by enhanced protective capacities of the father. (This will be discussed later in the "Recommendations" section of this document.) As a result, all three children were deemed "safe" in their current living environment.

On September 16, 2013, the worker assigned to complete the investigation met with the hospital [redacted] to get an update on the child's condition. Further testing showed that the child was born with a [redacted] This was described as a [redacted] According to the information provided by the county, most persons that have this condition never know that they have it and never need treatment for it. Testing was still ongoing, including a [redacted] and skeletal survey. The medical staff was monitoring her weight gain and she was [redacted] because the staff was concerned about [redacted]. The staff had yet to have a cause for the child's condition. The hospital staff have observed the parents with their child and expressed no concerns for their behaviors, nor did they appear to have any delays in functioning.

Also on September 16th, the worker met with the parents once again to review the night and day leading up to the child's hospitalization. Beginning with the father, he said that the family was staying with the maternal aunt in her residence. On the night of September 14th, he had held the child the evening before and had no concerns at that time. That evening, he went to an event with his brother and returned to the home around 1:30 or 2:00 AM. When he got home, father remembers everyone was asleep except the child's mother. He claims that the child was asleep on the couch beside her mother. The other two children were asleep in their cousin's room and the maternal aunt was presumably asleep in her room. The father said that he gave the children a kiss goodnight and slept on the floor of the living room.

According to the father, he was awoken by the mother at approximately 9:00 AM, with her telling him she thought something was wrong with the child. He held the child and said that she would not stop crying, which was not normal. While she was crying, he noticed the child's tongue was "pale." The father called 911 and then rode in the ambulance with her to the hospital. The father said that he rode with the child instead of the mother because she is "more emotional" and she would come later. When they got to the hospital, the staff had to give the child

[redacted] and told him that there was a possibility the child may not survive. The staff suggested that he get her mother to the hospital in case that happened. The father said he was trying to "hold it together" and the gravity of the situation didn't set in initially. He told the worker he never thought there was a chance that he would go home without his daughter.

The mother's account is very similar. She believed all three children to be fine in the evening of the 14th. The father went out with his brother and returned to the aunt's home between 1:30 and 2:00 AM, with the mother still being awake. Her sister was asleep in her room and the other two children were asleep in their cousin's room. The child was asleep on the couch next to her. She and the father went to sleep shortly after he returned home. The mother said she slept sitting upright on the couch and the father either slept on the loveseat or the floor.

Around 8:30 AM in the morning of September 15th, the mother said she was awaken to the child "screaming" and that the child's eyes "didn't look right." The mother said that the child wouldn't take her pacifier, nor would she grasp the mother's finger. At this point, she woke up the father and gave the child to him. The child would not stop crying so he called 911 while the mother changed the child's diaper. The mother said the child laid motionless while she changed her diaper. When the ambulance came, father rode with the child because "he is less emotional." Mother said that the father called her and told her she needed to come to the hospital, but didn't tell her why. Upon getting to the hospital, she learned that the child was [redacted]. The mother stated that she noticed the child felt cold on Friday, September 13, 2013, but held the child for 25 minutes to help regulate her body temperature. The mother said that [redacted] Hospital advised her to do this from her birth and this always seemed to improve the child's temperature.

On September 17, 2013 the assigned worker re-interviewed the maternal aunt at her home regarding the evening and morning leading up to the child's hospitalization. The aunt's account corroborates both parents' accounts. She was also asked about concerns for the parents' ability to parent their children, but she had no concerns. The aunt's home was also assessed for safety concerns, as the children were temporarily staying there.

On September 20, 2013 [redacted] staff from Children's Hospital of Pittsburgh contacted the assigned worker to provide an update on the child's status. According to [redacted], the child will make a full recovery and was not expected to have any lasting [redacted] She was described as in stable condition. The tests completed on the child showed that [redacted] was found in her nasal cavity, which is what they believed was the cause of the child's cardiac arrest. Although in an adult it is typically the cause of the common cold, the doctor said that it can "over take" small children. When young children get sick and have difficulty breathing, the heart slows as the children work harder and harder to breathe. Eventually, the heart could stop, which is what happened in this child's case. The doctor did note, however, that the child was so malnourished that her body didn't have enough energy to keep up the pace necessary to breathe and keep her heart rate up. Although the child was malnourished, the doctor believes the parents were not educated properly to their child's needs and were not abusing the child by not feeding her properly. Before the child would [redacted], she still needed to breathe on her own and show that she was able to gain weight properly.

The agency worker referred the family for Family Group Decision Making (FGDM) on September 23, 2013 due to the parents' apparent deficits in parenting despite their best intentions. On September 30, 2013 the assigned worker and a worker from the county's Family Group Decision Making staff went to the hospital to meet with the family. The child was no longer in the [redacted]. Prior to that meeting, the staff met with the [redacted] expressed concerns with the mother's ability to follow the child's required feeding schedule (every 3 hours) on a regular basis. At times, mother refused to wake up to feed her daughter.

On October 2, 2013, the caseworker conducted another visit with the parents at Children's Hospital of Pittsburgh. [redacted] still had concerns with the mother's ability to meet the child's feeding schedule, so the hospital stated they would only [redacted] the child if a third party was in the home with the parents while they cared for her. The case note states "CW and CHPSW comprised a safety plan…" (This will be addressed in a later section.) The safety plan was discussed with the father, who identified the paternal grandmother and maternal aunt as persons that could assist them in caring for the child. The hospital's plan was [redacted] the child on October 4th provided the safety plan was in effect.

The child was [redacted] the parents' care on October 4th, with the parents temporarily living with the maternal aunt as they had been doing prior to the child's hospitalization. The agency continued to maintain frequent contact with the child and family. On October 8, 2013 the caseworker transported the child and family to a follow-up medical appointment. At that time, the doctor said the child had "excellent weight gain" thus far. The child was scheduled for another appointment two weeks later, was to have a 4 month well-child visit, and be followed at the [redacted] until she was one year old.

On October 15, 2013 the assigned worker spoke with the [redacted] Police, who had closed their case because the physician advised them that the child's condition was not as a result of suspected child abuse. The worker accepted the case for services on October 17, 2013 and completed their child abuse investigation on October 18th, with an unfounded status.

Current Case Status:

The family was cooperative throughout the agency's involvement, working well with the services implemented in the home. The child continued to gain weight and be monitored by the [redacted] By mid-December 2013, the child's weight was up to over 11 pounds. As a result, the family's case was closed on January 2, 2014. None of the professionals involved with the family had any concerns for the children.

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

Allegheny County Children, Youth and Families did not hold an Act 33 meeting due to the anticipation that the report would be "unfounded" within the first 30 days of the investigation; however, the CY-48 was not submitted to ChildLine until 33 days after the investigation commenced.

Department Review of County Internal Report:

Allegheny County CYF did not write a County Internal Report given that an Act 33 meeting was not held.

Department of Public Welfare Findings:

- County Strengths:
  Allegheny County CYF is consistent in responding quickly to reports such as this and assessing the safety of all children in the household. In addition, the responding workers contacted the [redacted] Police to involve them in the investigation. The workers maintained very good contact with the medical staff throughout the investigation, which helped them make a determination within the required timeframe. The assigned worker made referrals to agencies that would help meet the parents' unique needs, as well as transported them to appointments to ensure compliance with recommendations. The workers' case notes were clear as to what happened with the family during the contacts.

  The safety assessment process was used to safety plan, as well as close the case when it was deemed safe to do so. The agency was able to close the family's case after a short time of providing ongoing services because they linked the family with services such as FGDM and other services to help educate the parents to address their shortcomings.

- County Weaknesses:
  The only weakness that was identified while reviewing this report is related to the Safety Assessment and Management Process. In the worksheet dated September 15, 2013, there were three potential threats identified. Only the protective capacities for the father were assessed [redacted], all of which were described as "enhanced." The mother's protective capacities weren't assessed even though she is a household member and primary caregiver. Her protective capacities, although unlikely to have done so, may have negatively impacted the safety decision for these children.

  In addition, the case note dated October 2, 2013 states that the caseworker and hospital social worker "comprised" the safety plan for the family, rather than discussing their concerns with the parents and having them involved in its development.

- Statutory and Regulatory Areas of Non-Compliance:
  The County did not hold an Act 33 meeting due to determining that the CPS report would be unfounded within the first 30 days of the investigation. Due to a technical error the report was not "unfounded" until 33 days from when the investigation commenced. The Department addressed this issue through technical assistance with the County.

Department of Public Welfare Recommendations:

Allegheny County CYF should continue to respond quickly to all reports of suspected child abuse and reports where the safety of children cannot be determined. In addition, collaborating an investigation from the beginning can not only help ensure the safety of the children in the home, but also maintains the integrity of investigations by reducing the possibility of conflicting information. Allegheny County CYF has demonstrated that they do this on a consistent basis and should continue to do so.