pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY:

[redacted]

BORN: 11/22/2009
DATE OF NEAR FATALITY: 11/09/2013
DATE OF ORAL REPORT: 11/09/2013

FAMILY KNOWN TO:

Allegheny County Office of Children, Youth, and Families

REPORT FINALIZED ON:

06/22/2015

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, DHS 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]	Child	11/22/2009
[redacted]	Mother	[redacted]1972
[redacted]	Father	[redacted]1973
* [redacted]	Half-Sister	[redacted]1991
[redacted]	Brother	[redacted]1994
[redacted]	Sister	[redacted]1996
[redacted]	Sister	[redacted]1997
[redacted]	Brother	[redacted]1999
[redacted]	Brother	[redacted]2001
[redacted]	Brother	[redacted]2005
[redacted]	Sister	[redacted]2008
[redacted]	Sister	[redacted]2012

*indicates this individual does not reside in the child's family home.

Notification of Child Near Fatality:

On 11/9/13, Allegheny County Office of Children, Youth and Families (ACOCYF) received a General Protective Services referral [redacted]. An anonymous reporting source reported that there were 10-12 children living in the house. Two ambulances were at the house and took one of the kids to the hospital. There may have been more than one child who went to the hospital. The reporting source stated that the ten year old carries a pellet gun and shoots people with it. The reporting source went on to say that the children were left in the care of irresponsible teenagers. The parents leave the children a lot and do not supervise the children. The children are not aware of safety. The father works under the table and the mother is a stay at home parent. [redacted] The mother is heard yelling at the children that "I am going to beat your asses". Some of the children have [redacted]

[redacted] In the past, the reporting Source has seen one of the children with yard scissor sheers around his neck. At the time of the call, some children were in the home, the caller did not know if an adult was in the home.

On 11/10/13, the agency received a [redacted] report that an 8-year-old child had shot his 4-year-old brother in the face with a pellet gun. The pellet shot had nicked the child's brain and eye. The child's injuries included [redacted] The child was expected to survive [redacted]. He was currently in Children's Hospital of Pittsburgh in serious condition as a result of his injuries. He was awake and alert. The pellet gun was under an older sibling's bed who is believed to be over eighteen years old. It was not known if the pellet gun belonged to [redacted]. The reporting source was concerned about the imminent danger of all the children in the home. It was not known if the parents were at home at the time of the incident and who was supposed to be caring for the child. It was not known if the parents knew that a B-B gun was in the house. The reporting source was concerned that 8-year-old had access to a loaded B-B gun. The reporting source was not suspicious of non-accidental trauma, but was suspicious of lack of supervision. The report was registered for lack of supervision resulting in physical injuries with an unknown alleged perpetrator. The report met the criteria of a near fatality. It was unknown if Police were notified of the incident. The parents have eight minor children ages one, three, five, eight, twelve, fourteen, sixteen, and seventeen living in the home. The family has an extensive history with ACOCYF.

Summary of DHS Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. The regional office also participated in the County Near-Fatality Review Team meeting on January 16, 2014. The Region had continued contact with ACOCYF on this case.

Children and Youth Involvement prior to Incident:

The family has been known to ACOCYF since 1994. In the 1990's the agency received four referrals on the family that were screened out. The first referral in 1994 was concerning family disputes. The second referral in 1995 was on the half-sister who was three years at the time. The father who was identified as being the mother's paramour was accused of being rough with the little girl and there was concern that she may have been sexually abused by a neighbor. The next referral was in 1997, this report was on the same child who was six at the time; she was playing chicken with cars. The oldest son who was nineteen months was observed playing in the street at midnight. Another referral was received in 1998; the half-sister who was seven was reportedly not attending school. There were two toddlers in the home at the time plus a ten month old who was reportedly dirty and had soiled diapers. The family reportedly asked neighbors for food.

The next referral on the family concerned the oldest son. He was six years at the time. The initial report on 7/11/02 was a general protective service report even though he had told his father that a babysitter had sex with him. It was reported that the babysitter was

[redacted]. The father was reportedly off the wagon. Two days later the report became a child protective service report alleging sexual abuse. The report was indicated on two babysitters. [redacted] The case was accepted for services and transferred to Ongoing Services. The oldest son did have a [redacted] evaluation in September of 2002 at a local hospital after this incident. [redacted] After this incident, he [redacted]. The mother began receiving services [redacted] in November of 2002. The father began [redacted] in December of 2002.

While the case was active with the agency in Ongoing Services the agency received a report of suspected physical abuse on the oldest daughter on 4/10/03. The 7-year-old girl had gone to school on 4/8/03 and was observed to have a bruise to the right side of the head two inches above her ear which was raised one and half inches in size. The mother had sent a note to school saying that her daughter had fallen on 4/7/03. The next day the same child went to school with a left eye bruise and 3 linear bruises on her left hip. She said that her father had caused the injuries. The report was substantiated for physical abuse with the father being the perpetrator. The six children who were in the home at the time were removed from the home and placed in foster care.

Prior to the April incident, the oldest daughter had [redacted] This occurred in January of 2003 and in March of 2003 [redacted] A 22-month-old child also had a [redacted] in March of 2003 for [redacted] The children received their [redacted] In November of 2003, all of the children were returned to the parents. The oldest daughter was to continue to receive [redacted] through school. [redacted] A son, age 4 years, was to [redacted]. A 6-year-old daughter had started [redacted] in September of 2003 and those services continued when they returned home. They continued to receive [redacted] until June of 2004. [redacted] started for the 22-month-old in September of 2003 and those services continued when he returned home. The eldest son continued to [redacted] The parents were to [redacted] In 2005 the father received [redacted]

The case was closed [redacted] with the agency in July of 2006. Within weeks of the case closure the agency received a referral that the half-sister who was fifteen at the time and son who was five years old at the time were at a local park without adult supervision. The report was screened out. On 11/6/06 the [redacted] Police and Fire Departments responded to a fire at the home. The mother found the fire in an upstairs bedroom near one of her daughter's beds. It was the bed near the window. All of the family members

got out of the house without injury. The cause of the fire was not determined. A referral was not made to ACOCYF.

In March of 2007, the agency screened out a referral that they had received that the children were running around the street and were crossing the street without looking. In July of 2007, the agency received another referral that two of the girls who were eleven and [redacted] nine at the time were riding their bikes without adult supervision and the children were all over the place. The case was closed at Intake. By this time, an 8-year-old son had been [redacted] The eldest son [redacted]

The family was again referred to the agency on 6/24/08 with a report that the father was observed driving a sports car really fast with the 9-year-old [redacted] in the back seat without a seat belt. It was also reported that he mother was observed chasing the same child down the street and spanking him hard with her hand. This report was screened out by the agency. A month later on 7/29/08, the mother filed a report with [redacted] Police Department that she had seen a male neighbor looking into the bedroom window of her three oldest daughters with binoculars. Then on 10/12/08, the [redacted] Police Department received a report that the father had killed a kitten in front of 11-year-old daughter. On 10/14/08, the agency also received this report. According to the police report, the father told him that the kitten had a potato chip stuck in its teeth. He tried to remove the chip from the kitten's mouth and the kitten scratched him on his hand and he threw the kitten approximately ten feet into the kitchen from the living room. The kitten struck the corner of the nook in the middle of the kitchen with its head and started to bleed and died shortly thereafter. The father was charged with cruelty to animals and was found not guilty. The agency did make a home visit to the home and noted that there were no safety concerns. The case was not accepted for assessment. The agency received two referrals in December of 2008. The first one was on 12/5/08. This report stated that the oldest son, who was thirteen at the time, came to school tired, smelled bad and worn the same clothes every day. The reporting source stated that he was [redacted]. His little sister who [redacted] comes to school wearing two left shoes. This report was screened out because it did not meet the legal definition of child maltreatment or risk. A week later on 12/12/08, the agency received a report that the children were unattended every day. The parents are sometimes not home and are not attending to the children. The children pull on neighbor's gutters and slide down people's steps. The reporting source stated that the children shoveled snow onto his car and he has it on video tape. A home visit was made to the home and no safety concerns were noted. The case was not accepted for assessment. During 2008 the oldest boy continued [redacted] In June of 2008, the 9-year-old had an [redacted]

On 3/2/09, the agency received a referral on the thirteen-year-old in the home at the time. According to the referral he had nine illegal absences and ten unexcused absences. His hygiene was poor and he would wear the same clothes two to three times a week. The child is failing the eighth grade. He was sleeping in classes all day and had told the

reporting source that he had to take care of his baby sister. According to the reporting source he was [redacted]. The reporting source had contacted the mother about the situation, but there had not been improvement in the situation. An agency worker made a home visit to the home. The home was clean and properly furnished. There were working utilities in the home and at the time of the home visit there was ample food in the home. The caseworker saw that the child had a variety of clothing. The children were up to date with their wellness visits and dental visits. The mother reported that she washes clothes daily and that the children bathe daily. The father stated that their son was sick a lot that school year and that was why he was absent. Both parents knew of services that were available in the community. They agreed to work with the school. The child was [redacted] in 2009. The case was closed.

In 2010, the agency received nine referrals from January to August due to lack of supervision of the children. The family was in a dispute with [redacted] who would file a report whenever one of the children was outside without adult supervision. The majority of the reports were on the boy who was four at the time. He had learned how to get out of the house whenever his mother or one of the older children was not looking and he would run down the street. There were also allegations that the parents used marijuana and alcohol and yelled at the children. The parents used physical discipline and the older children would hit the younger children. The police were called to the home on numerous occasions. The agency made unannounced home visits to the family home shortly after receiving the reports. No risk or safety concerns were determined. The agency checked with the local Police Department and did not find any police reports. These reports were not accepted for assessment.

Then on 8/26/10, the agency received a report that one of the sons who was nine years old at the time had stuck hot wheel cars into the vaginas of his female cousins who were ages seven and four at the time. According to the report, the maternal aunt confronted the boy who started crying and said that his older brother who was 14 at the time was touching him inappropriately. He also said that older brother smoked marijuana and had given him marijuana. An agency caseworker made an unannounced home visit to the family home. Both boys denied the allegations. The other children and their step-sister were interviewed and denied the allegations. The mother was interviewed and acknowledged that she was watching the two girls in her home on 8/25/10. She was aware of the allegations. The mother stated that the girls were never left unsupervised with either boy. The mother went on to report that both boys were [redacted] The 14-year-old daughter is [redacted] and 11-year-old is [redacted]. The father said that the girl's mother had told him that the 14-year-old son was bothering her girls sexually. The father stated that he did not witness this behavior. The parents agreed that their son would stay with the maternal grandmother during the investigation. [redacted] had a forensic interview and did not make a disclosure of sexual abuse. The report was not substantiated and the case was closed at Intake. The maternal grandmother died in December of 2010.

In February and March of 2011, the agency again received multiple referrals which claimed that the children were unsupervised and out at night vandalizing neighborhood property. After each report, an agency worker went to the home and met with the parents and children who denied the allegations. The reports were not accepted for assessment.

Then on 5/1/11, the agency received a report of suspected child abuse on one of the children who was five years old at the time. He had run out into the middle of the street and was almost hit by a car. An unannounced home visit was made to the family home on that day. The mother stated that he had broken out the screen in the window and had gotten outside twice that day. The first time he got out his then 20-year-old half-sister caught him and brought him back inside the house. The second time he went to a family member's house and the relative brought him back. The mother was unaware that he had almost got hit by a car. According to the parents, he was very active and [redacted]. They were planning to [redacted] when he went to school. The caseworker spoke to the child who told her that he went out of the window. The other children in the home told the caseworker that their brother broke the screen and went out of the window. The caseworker observed that the home was cluttered and that family had four dogs and a rabbit that was in his cage. The home had working utilities and there was food in the house. The parents agreed to fix the window so the child could not get out of the house. The mother reported that she was feeling overwhelmed since the death of her own mother in December of 2010. The maternal grandmother had lived in the home and had helped the mother care for the children. The report was unsubstantiated.

Then on 5/11/11, the agency received a report from the local police department that the child who was two years old at the time was found in the middle of an intersection two blocks from his home. The child was barefoot and had cuts to the bottom of his feet. There was bruising and abrasions on his body. Paramedics were called and they took the child to a local hospital. A maternal great aunt went to the hospital to be with the child. A caseworker made an unannounced home visit to the family home that evening. The mother was upset and crying that the child had got out of the house. She said that she did not know that the child was out of the house until the police knocked on the door. The mother said that she was overwhelmed since the death of her mother with the care of the children. According to the mother, the half-sister was supposed to be watching the child while she was upstairs. The half-sister said that she was cooking dinner and that 15-year-old girl was supposed to be watching the younger children. The caseworker learned that the five years old opened the door and let the child out of the house. The mother agreed that the child could stay with the maternal great aunt temporarily. The caseworker then met the maternal great aunt and the child at the hospital. She accompanied them back to the great-aunt's home which was found to be appropriate. A follow-up visit was made to the family home on 5/13/11. The parents had made safety changes to the doors and windows and the child returned home. The agency made two more unannounced home visits to see the family and the case was closed on 8/22/11 with the family being involved with community services. The mother was charged with endangering the welfare of a child and was ordered to attend [redacted] by the District Justice.

On 9/3/11, [redacted] officer reported that he was just at the house to serve a warrant on the father. There were five dogs in the home and there was dog feces and urine throughout the house. Three of the children who were under the age five were naked and walking though the dog feces. The house was cluttered with only paths through the house. The bathtub was being used for storage and there was an odor in the home. A caseworker made a home visit within an hour of receiving the report and did not find the reported conditions. There were six dogs in the home as one of the dogs had just had puppies. The mother showed the caseworker documentation that she was attending [redacted] at a community program. If she successfully completed this program then the District Justice was going to drop the charges against her. All eight of the children were seen and did not express any concerns to the caseworker. The case was not accepted for assessment.

Six months later on 3/26/12, the agency received a report of suspected child abuse on the then 6-year-old boy. He reportedly had bruises on his right cheek and on his back. According to the report, the father caused the bruises. A caseworker went to the home that day and determined that the injuries were caused accidentally. The report was not substantiated and the case was closed.

Then on 7/18/12, the agency received a report of suspected child abuse on the child who was two and half years old. The child was found three or four blocks from his home. He was wearing a wet dirty diaper. The child was taken to a local hospital where he was found to have multiple bruises in various stages of healing. He also had some scrapes that could have happened that morning. There was a small circular burn that was scabbed over on the back of his left calf. When the father arrived at the hospital he did not have an explanation for the child's condition. The fifteen-year-old at the time was supposed to be watching the child while the mother was in the shower. A caseworker made an unannounced home visit to the home on this date. An older sibling told the caseworker that the 6-year-old had taught the child to climb up the side of the entertainment center or to jump from the table and climb up the side of the T.V. to get to the window. He had also taught the child to unlock the window. The 6-year-old confirmed this with the caseworker. This incident happened within a month of the mother giving birth to another daughter on 6/23/12. Both parents stated that they were feeling overwhelmed with their parenting responsibilities. Both parents were already on probation for the prior incident with the child. The report was not substantiated but the family was accepted for services. [redacted] worked with the family to find a solution to child proof the windows and to better organize the house so that the mother could better supervise the younger children. [redacted]

By the fall of the 2012 the family was referred to a Truancy program that was focusing on the four oldest children attending school. The focus of this program was the 16-year-old daughter [redacted]. She did not want to attend school and would frequently hide or leave the house in the morning so she would not have to attend school. She was [redacted]. The child was [redacted] at this time. The Truancy Program worked with the family from October of 2012 to May of

2013 when the children's school attendance stabilized. During this time, workers expressed concerns about the conditions of the home, the smell of the home, and the fact that there was black mold in the basement of the home. The family also struggled with budgeting which resulted in utilities being shut off. At one point the electricity was shut off to the home for at least six weeks. The family worked with [redacted] provider as well as with their caseworker to help resolve these issues. While the case was active with the agency the agency received two reports of suspected of physical abuse on one of the boys who was then 7-years-old. The allegations were that the father used physical discipline on him causing an injury to the child. Both of these reports were unsubstantiated. There was also a report on the baby of suspected child abuse for lack of supervision. She was crawling in the living room and tried to pull herself up on a space heater which resulted in a burn on her forehead and burns to her left arm and hand. She received medical care for her burns and they healed. The report was unsubstantiated.

In May of 2013, the agency received two more referrals from [redacted] that the children were outside unsupervised. One of the boys, age 16, had a toy gun and was running around the neighborhood pretending to shoot people. The gun may be a pellet gun according to the reporting source. These reports were not substantiated and the case was close on 8/5/13.

In September and October of 2013, the agency received referrals that the son who was 8-years old at the time had to gone to school and was sleeping in class. Reportedly the mother had given him [redacted] before sending him to school. The agency made home visits after referral and the case was not accepted for assessment.

Circumstances of Child Near Fatality and Related Case Activity:

On 11/10/13, two agency caseworkers went to the family home in response to the General Protective Services report the agency received on 11/9/13. There was no one at home. They then went to Children's Hospital of Pittsburgh. When they arrived at the hospital one of the physicians treating the child approached them and told them that based on what the parents had told the hospital staff they had concerns about the supervision in the home. The report was certified as a near fatality report. The child was in stable but serious condition. No decision had been made on whether he would need [redacted] If the pellet had been over 5mm the child would have died. The caseworkers saw the child who was sleeping. He had on a neck brace and there was a visible injury to his eye.

The mother was interviewed by one of the caseworkers. She reported that she was in the bathroom when the incident occurred. They had just returned home from a birthday party, so she was changing into comfortable clothing. She states that she knew that her oldest son had a pellet gun, but he kept it in a small drawer that had no handle so it was too difficult for the younger children to open. She states that her son was always supposed to store the gun empty.

The other caseworker interviewed the father. The father reported that his son was planning on going out to hunt with the gun. The father did not want him to go out hunting because he needed help with laundry. The boy placed his gun on the stairs. The 14-year-old [redacted] picked up the gun. The older boy told his younger brother to take the gun back to his bedroom. The father reported that at that time, he turned to go back into the kitchen to finish dinner. He was told that his 8-year-old son grabbed the gun from the 14-year-old. The father understood that when his son grabbed it, the gun accidentally went off. The father claimed that the victim child was sitting on the couch below the stairs. The child was hit with the bullet from the pellet gun.

The caseworkers discussed with the parents the agency's concern of the numerous reports that they had received concerning lack of supervision of the children. The parents were asked if there were any other adult family members who help them during this crisis and they said that the half-sister who was 23 was willing to assist them with the children. The caseworker spoke to her to see if she agreed to this. The parents reported that the local police had taken the pellet gun. There were no other guns in the house.

The caseworkers proceeded to the family home and met with the half-sister and the other children. All the children were present expect for one of the girls. The home was cluttered and there was an odor but the caseworkers did not observe any safety concerns. The half-sister said that she was willing to assist the parents with the care of the children. She did not want to see her siblings be placed in foster care. Except for the oldest boy, who was 18 and refused to be interviewed and the 8-year-old who was asleep, the other children were interviewed. The children who saw the incident supported their parent's statements. A few hours after the caseworkers left the home [redacted] reported that two of the children were outside without adult supervision.

On 11/12/13, the Child Protective Services caseworker went to the home to interview the family members about the incident. All the family members except for the child and the mother were at home. The father told the caseworker that the reason that the pellet gun was out of the drawer where kept was that the oldest boy intended to go hunting that day. The father said that since he had to go to the laundry mat that day, he enlisted his son to go with him to do laundry. His son kept the pellet gun in a dresser drawer that does not have a handle on it. A screw driver is needed to get the drawer open. The father and the son were at the laundry mat from 3:30 to 5:30 pm. The mother and the younger children had gone to a birthday party earlier in the day. They had left the home around 2:00 pm and returned around 6:00 pm. The half-sister had come to the home around 5:00 pm to start dinner for the family. The father said that when he returned home he went to the kitchen to help with dinner. When the mother and the younger children came back, she went upstairs to change clothes. The father said that he heard the older boy tell his younger brother to take that back upstairs. The father then reported hearing a boom and ran into the living room, the child had been on the couch sleeping but now he was crying and bleeding from the nose. The mother called 911 while he tried to pinch the child's nose to stop the bleeding. The EMT's came to the home and transported the child to a local hospital and he was then transported by helicopter to Children's Hospital of Pittsburgh. The local police were at the home for about a half an hour interviewing the

family members. There had been three guns in the home, one B.B. gun and two pellet guns. The police took the pellet gun that was used in the incident. The other two guns were taken to the half-sister's house. The father said that he did not want the guns in the house anymore. The father acknowledged past ACOCYF involvement due to the lack of supervision of the children and truancy. They had received services for truancy. The two oldest children in the home were no longer attending school since they were over the age of seventeen. [redacted]

The father said that he had fixed the windows so that the children could no longer get out of them; which had been one of the previous referrals to ACOCYF. The father said that it was his understanding that ACOCYF would be referring the family for services and that they would be willing to accept the services.

The oldest boy reported that the child was shot with his "CO2" gun. He said that the gun is stored on a top shelf in his room where the younger children cannot reach it. He said that gun is never stored with the "CO2" or the pellets in the gun. He was planning to go hunting that day which is why there were pellets in the gun. He said that he saw his 14-year-old with the gun and told him to take the gun back upstairs. That is when his 8-year-old brother grabbed the gun and it went off with the shot hitting the child in the face. Those two boys were on the steps when the incident occurred.

The 14-year-old reported that the 8-year-old was bringing the gun down the steps when it went off. He kept saying that the incident was a terrible mistake. The 8-year-old reported that the 14-year-old had the gun and he went to grab it when it went off. He said that it was an accident. The victim child was sleeping on the couch when the incident happened.

The half-sister and the other children in the home were interviewed. She was in the kitchen when the incident occurred, and said that it happened so fast. She said that she had the other two guns at her house. Even though she does not live in the family home she is there daily to help with the children. The other children were also interviewed and their statements supported the father's statement of the events that occurred that day. All the children said that they felt safe in the home. The caseworker observed that the home was cluttered and there were bags of clothing scattered around the house.

The CPS caseworker learned that the victim child was to [redacted] home from Children's Hospital of Pittsburgh later that day. The treating physician told the caseworker that the child had a [redacted]

The CPS caseworker went to see them again on 11/13/13. The child had a small circular injury to his face and a black eye. He was very excited to be home and was playing with

his five-year-old. The mother was folding laundry while she talked with the caseworker. The mother stated that she and the younger children had returned home from a birthday party. She went upstairs to change her clothes when she heard a boom. The 18-year-old had been told that he was to store the gun without the pellets in the gun. The mother acknowledged the family's past involvement with the agency. She said that they have an ongoing issue with [redacted] who calls the agency whenever he sees the children outside. Another issue that the family has is that the landlord does not make repairs on the house. There is a sewage leak in the basement which has resulted in a $1,000.00 sewage bill. Mother said that the landlord lives next door to them.

The CPS caseworker contacted the children's medical care providers and schools. The children were receiving routine medical care. From the contact with the schools the caseworker learned that the 16-year-old daughter had excessive unexcused abstinences' and that the matter had been referred to the District Justice. The 12-year-old son was now hiding and missing the bus to school.

The CPS caseworker made another home visit on 11/26/13. The child no longer had visible injuries to his face. The caseworker discussed with the mother the agency's concerns about the children being truant from school. The mother told the caseworker that she only had enough money to pay either the rent or the sewage bill. [redacted]

The Child Protective Service Investigation Report was completed on 12/9/13. The report was "Unfounded".

Current Case Status:

[redacted] The caseworker met with the parents who were fearful that the children would be removed from the home. The parents requested services to help with budgeting and organizing a daily routine in the home. They also requested truancy services for the children. They had received notice that there would be a Truancy Hearing in front of the District Justice and there was a possibility of being fined for the truancy. A referral was made to the truancy program that had worked with the family previously. In February of 2014, a truancy hearing was held in front of the District Justice. The District Justice did consider the fact that the mother was working cooperatively with the service providers. The 16-year-old was fined $350.00 for her truancy. A fine was not issued for the 12-year-old's truancy.

[redacted] provider began working with the family on budgeting since they were again getting shut off notices for the electricity and sewage. They also assisted the mother in having the youngest three children [redacted] He also continued to be followed by Children's Hospital of Pittsburgh and was not showing

any lasting impairment from the incident. [redacted]

During the spring of 2014, the focus of the case was the children's truancy. The truancy program was able to work with daughter to attend school even though she was sometimes tardy. The son began to hide from the family and service provider in order not to go to school. The service provider did learn from the boy that he felt that he was being bullied on the school bus and had problems with peers in school. The mother attended a meeting at the school with the service provider. The school was reluctant to acknowledge that her son was being bullied. He was referred and was attending the Truancy Program's summer program. An issue identified by the Truancy program is that the mother often times supports the children's non-attendance by claiming that they are sick.

As in prior years summer has brought another rash of referrals from [redacted] that the children are unsupervised and are out past curfew vandalizing neighborhood property. Since the beginning of June of 2014, the agency has received six referrals. The agency has made a home visit to the family home after each report. The parents have told the caseworkers that their teenage children are to be supervising the younger children when they are outside. The case remains open with the agency.

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

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 even though the report was unfounded within 30 days of the date of the oral report.

- Strengths: At the time the report was received the agency was not active with the family. Agency saw all the family members within twenty-four hours of receiving the report. A safety plan was established and the agency ensured that all of the firearms that the family owned were no longer in the residence. The agency referred the family to a [redacted] provider as well as to [redacted] and community resources.

- Deficiencies: The agency did not identify any deficiencies

- Recommendations for Change at the Local Level: The agency needs to establish a trigger for an administrative review of cases of families that have had multiple referrals to the agency during an established period of time. These families should have an immediate referral to Allegheny County's DHS Integrated Service

Planning Process to coordinate cross-systems assessment, service planning, and tracking of the family. Allegheny County DHS will establish a work group to identify ways to improve service access, delivery and to improve coordination and communications across systems. Review and revise the policy, procedures, and training in how caseworkers talk to parents about gun safety. A review and reinforcement of the joint investigative protocol developed by the Office of the District Attorney, Law Enforcement and ACOCYF.

- Recommendations for Change at the State Level: The Review Team requests an update on the Department's recommendations.

Department Review of County Internal Report:

Allegheny County was not required to submit a Near Fatality Report to the Department from this incident.

Department of Human Services Findings:

- County Strengths: Whenever the agency received a referral on the family concerning the lack of supervision of the children; the agency has conducted a field visit to the home. Over the years the family has received numerous services from the agency and their provider agencies, [redacted] and community resources.

- County Weaknesses: Historically the agencies that have worked with the family through the different systems have not had the best communication with each other. The agency was often unaware that a service provider from a different system or the community had ended their involvement with the family.

- Statutory and Regulatory Areas of Non-Compliance:
There are no regulatory regulations.

Department of Human Services Recommendations:

The frustration with this case is that whenever the agency has ended their involvement with the family, the family has returned to their past behavior. They have not internalized what they had learned from their work with service providers. The younger children start to exhibit the problematic behavior that the older siblings have exhibited and the cycle continues. The parents love and are bonded with their children and the children love and are bonded with their parents and their siblings. The family home is maintained minimally. The parents are overwhelmed with the care of the children. System intervention occurs when a crisis happens. These types of cases are a struggle for the different systems that serve these families. Improved communication between the different systems that serve the family will lead to better outcomes for this family.