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REPORT ON THE NEAR FATALITY OF:



Date of Birth: April 3, 2011
Date of Near Fatality: June 7, 2011

**The family was not known to
Allegheny County Office of Children, Youth & Families**

Date of Report: August 15, 2012

This report is confidential under the provisions of the
Child Protective Services Law and cannot be released
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law
(23 Pa. C.S. 6349 (b))

Reason for Review

Senate Bill 1147, Printer's Number 2159, was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim	04/04/ 2011
[REDACTED]	Mother	[REDACTED] 1980
[REDACTED]	Father	[REDACTED] 1982
[REDACTED]	Brother	[REDACTED] 2008
[REDACTED]*	Paternal Grandfather	[REDACTED] 1962
[REDACTED]*	Paternal Grandmother	[REDACTED] 1961

*Not living in the home

Notification of Child (Near) Fatality

On June 9, 2011, Allegheny County Office of Children, Youth and Families received a Child Protective Services report [REDACTED] indicating that a two-month old child, [REDACTED], arrived at [REDACTED] on June 7, 2011 due to concerns for [REDACTED]

After a thorough medical evaluation, it was determined that [REDACTED] [REDACTED] [REDACTED] reported that abusive head trauma was a definite possible explanation of the injuries and determined that the [REDACTED] definitely were caused by a shearing event. [REDACTED] reported that the child may have experienced two separate injuries based on the results of the medical evaluation.

Summary of DPW Child Fatality Review Activities

The Western Region Office of Children, Youth and Family Services Program Representative, [REDACTED], made initial contact with Allegheny County Supervisor, [REDACTED], on June 23, 2011 to discuss any updates in the child's condition and in the investigation. The assigned Western Regional Program Representative, [REDACTED], began ongoing communication with the caseworker after that date and continued to maintain ongoing contact with the county agency. The Department attended the internal review conducted by Allegheny County on July 21, 2011 where copies of medical reports were reviewed. Also in attendance at the internal review were

the Allegheny County caseworkers, [REDACTED] supervisors [REDACTED] representative, law enforcement, [REDACTED], and [REDACTED]. The assigned program representative reviewed all current case records pertaining to the [REDACTED] family.

Summary of Services to Family

Children and Youth Involvement Prior to Incident

This family had no previous involvement with Allegheny County Office of Children, Youth and Families or any other child welfare agency. However, it should be noted, that [REDACTED] was receiving [REDACTED] through the [REDACTED] since April 2011.

Circumstances of Child Near Fatality

On June 4, 2011, the family consisting of the mother, father, three-year-old sibling, [REDACTED], and the victim child, [REDACTED], had all attended a family party with approximately 15 individuals from 4:00 pm to approximately 7:30 pm. Throughout the party, [REDACTED] was passed around to almost everyone at the party. The father reported that he never lost sight of [REDACTED] while being held by the other family members. Nothing was reported as unusual in [REDACTED] condition after this family event.

Nothing unusual was reported concerning [REDACTED] condition on Sunday, June 5, 2011. The father, however, did report that he had not seen his children on this particular Sunday due to not waking up until 1:00 pm because he attended a bachelor party the evening of June 4, 2011. As soon as he awoke, he left for work as a security guard at a local hospital and did not return until 10:00 pm that evening. He reported that he did not see either of his children that day.

On the morning of June 6, 2011, the mother left for work at 6:40 am. Prior to leaving for work, she saw [REDACTED] awake and alert and nothing appeared to be out of the ordinary. She worked at the answering service until 5:30 pm that evening. She claimed that she did not receive any messages from her husband reporting that [REDACTED] was ill.

The father reports that he was caring for [REDACTED] and [REDACTED] on Monday, June 6, 2011. He claimed that he was only away from [REDACTED] approximately 15 minutes that entire day. He ran downstairs to switch the laundry during those 15 minutes of separation.

[REDACTED] reportedly ate normally that morning and at approximately 12:30 pm, the father took both children to their paternal uncle [REDACTED] home where paternal great aunt [REDACTED] was also present. According to the father, the adults mostly talked during this visit and [REDACTED] held [REDACTED] the majority of the visit. The paternal great aunt explained to the father that [REDACTED] felt warm to the touch and questioned why [REDACTED] soft spot of his head seemed full, but the father could not provide an explanation. The mother arrived at the

paternal uncle's home around 5:30 pm and picked up the father and the two children and returned home.

Around 6:00 pm, after the family returned home, the parents realized that [REDACTED] was slightly sleepier than normal and fed him three ounces of formula. According to the parents, he drank this bottle less vigorously than normal and they felt he was warmer than normal. The mother took his temperature rectally and it was 100.6 degrees. She gave him a bath in an attempt to bring down the temperature. The parents opted not to contact the child's pediatrician, [REDACTED], due to their older child having high temperatures in the past.

The father left the residence for approximately 30 to 45 minutes due to taking [REDACTED] to the local park. When the father returned, he noticed that [REDACTED] right eye appeared to be droopy. The father discussed this with the mother and decided that they would keep a close eye on [REDACTED]

At approximately 9:30 pm, the father fed [REDACTED]. The child only ate one ounce of formula which was abnormal for him. [REDACTED] temperature was taken then and it was 99 degrees. The father wrapped him up in a blanket and put him to bed for the evening. The mother commented that [REDACTED] was making little grunting noises prior to going to sleep. The parents decided to watch him throughout the night. [REDACTED] was still sleeping in his parent's bedroom in a baby cradle. Around midnight, the father checked on [REDACTED] due to him making some noises. [REDACTED] was not fed at this time nor was his temperature taken.

Around 3:30 am, the parents were awakened by [REDACTED] making some noises. The father went to check on him and picked him up. He noticed that [REDACTED] felt warm and took his temperature rectally and it was 101 degrees. He attempted to feed [REDACTED] but the baby would not suck the bottle. The parents then made the decision to take [REDACTED] to [REDACTED]. The mother opted to remain at the home with [REDACTED] while the father transported [REDACTED] to the hospital.

[REDACTED] arrived at [REDACTED] Emergency Department at 4:53 am on June 7, 2011. Soon after admittance to the ER, [REDACTED] began [REDACTED] and the medical staff provided [REDACTED]. He was [REDACTED] and admitted to the [REDACTED]. The medical evaluation completed upon arrival at the ER determined [REDACTED] had [REDACTED]. All the injuries were limited to the back of the head and neck, and the injuries varied in different ages. The [REDACTED] had to be surgically removed on the day of admittance to the hospital. [REDACTED] also had a significantly enlarged head size. His head circumference had increased by 75% from his measurements in May 2011 which were 14.5 inches. He also had significant [REDACTED] which are indicative of an inflicted injury of shaking/shearing forces according to [REDACTED]. Additional findings included [REDACTED]

██████████ reported that almost definitively there had been a previous ██████████ shaking/shearing injury to the brain more than a week before hospitalization. However, within 24 hours of presentation to the hospital the child would have sustained another injury that resulted in ██████████. These injuries would explain the ██████████ and current hospital course of treatment.

The parents reported that ██████████ never had any jerking motions, breathing problems nor was he limp. The parents reported that there was no family history of genetic disorders, bleeding disorders or fragile bones, nor was there a history of non-explained baby deaths on either side of the family. The parents explained that the mother received an ultrasound at 18 weeks of pregnancy and it was determined that she would be having twins. However, she was also diagnosed with ██████████

██████████ was born three months later via C-section at 5 lbs, 3 oz. He spent one week in the ██████████ prior to release. However, ██████████ reported that nothing in the child's birth history appeared to be relevant to his condition when admitted on June 7, 2012.

The parents denied inflicting any trauma to ██████████ nor did they report any known accidents that involved ██████████. The parents refused to believe that the injuries were the result of maltreatment. Hospital staff was in contact with ██████████ pediatrician, ██████████ from the ██████████ claimed that ██████████ was seen frequently and no major concerns were raised during these doctor visits. The pediatrician reported that the parents were exemplary in their care of their two children. ██████████ was seen by the pediatrician on April 13, 2011, April 27, 2011, May 18, 2011 and June 1, 2011.

On June 9, 2011, Allegheny County received a Child Protective Service report ██████████ stating that a two-month old child had been taken to ██████████ on June 7, 2011 and arrived with ██████████. The injuries appeared to be abusive in nature. Allegheny County caseworker, ██████████ was assigned to meet the two hour response time. Upon arrival at the hospital, it was determined that ██████████ was in the ██████████ and on a ██████████. ██████████ had face-to-face contact with ██████████ and the father. Due to having an unidentified perpetrator and the majority of the extended family having access to ██████████ during the time frame of injury, a decision was made that ██████████ would be ██████████.

██████████. The case was transferred to Allegheny County caseworker, ██████████, who is a caseworker in the North Regional Office. In addition, ██████████ from the Allegheny County Detective Bureau were assigned to the case.

On June 13, 2011, [REDACTED]

On June 16, 2011, [REDACTED] underwent a [REDACTED] hi [REDACTED].

[REDACTED] was released from the hospital on June 21, 2011. He was prescribed an [REDACTED] and follow up treatment with his pediatrician. Prior to his release from the hospital, Allegheny County conducted a home assessment of the paternal grandparent's home, [REDACTED]. The home was determined to be appropriate and had all necessary supplies to adequately meet the needs of [REDACTED]. He was placed into his paternal grandparent's home on June 21, 2011. Also on this date, [REDACTED] participated in a forensic interview. [REDACTED] did not provide any disclosures of [REDACTED] for himself or for [REDACTED].

On July 1, 2011, [REDACTED]

[REDACTED] was readmitted to [REDACTED] on July 11, 2011 due to his head circumference being slightly larger than normal. The child had a [REDACTED] on this date to [REDACTED].

On August 4, 2011, an unfounded status determination was made and a CY-48 report was filed with ChildLine. The agency staff was unable to definitively determine who was responsible for the injuries inflicted onto [REDACTED].

Current Case Status

On July 1, 2011, [REDACTED]

[REDACTED]. The county agency offered supports to the kinship caregivers who declined services.

After the status was determined to be unfounded, the parents began to participate in unsupervised contact with their sons. The parents participated with [REDACTED] and parenting instruction, and attend [REDACTED] medical appointments.

On October 12, 2011, [REDACTED]

[REDACTED] The case was officially closed on February 10, 2012.

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

Act 33 of 2008 requires that county children and youth agencies convene a review when a report of child abuse involving a child 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 convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths

The review team identified no statutory or regulatory compliance issues. The agency caseworker responded immediately to the report, conducted a thorough investigation and instituted a safety plan for the child and his three-year old sibling.

In addition, the family was not involved with the agency at the time of the near fatality report. The older sibling received a forensic interview at a regional child advocacy center for a witness interview. The older child did not disclose maltreatment during the interview. The injured child was receiving [REDACTED] at the time of the near fatality due to his premature birth.

Deficiencies

None were noted.

Recommendations for Change

The review team had no recommendations for the local agency.

Recommendations for Change at the State Level

The review team recommended consideration for changes in the Pennsylvania Child Protective Services Law regarding data collection of indicated abuse determinations when a perpetrator cannot be identified but abuse has been established in order for accurate measurement for purposes of resource allocation and epidemiological studies.

Department Review of County Internal Report

The Western Region Office of Children, Youth and Families received the Allegheny County Internal Report on October 7, 2011. The Department is in agreement with the findings of the County Review Team. The agency responded quickly and conducted a thorough review of the allegations.

Department of Public Welfare Findings

County Strengths

Allegheny County caseworkers took prompt action in ensuring the safety of [REDACTED]. The agency conducted the Act 33 meeting within the guidelines established within the bulletin. The Act 33 meeting provided all invested parties an opportunity to gather additional pertinent information.

County Weaknesses

None determined.

Department of Public Welfare Recommendations

The agency took appropriate action to ensure the safety of [REDACTED] and to investigate this incident. The Department does not have any recommendations based on the review of this child near fatality.