pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

BORN: October 29, 2013
DATE OF INCIDENT: December 30, 2013
DATE OF ORAL REPORT: December 30, 2013

FAMILY WAS NOT KNOWN TO:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
March 20, 2015

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 Office of Children, Youth and Families 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	10/29/2013
[redacted]	Mother	[redacted]1984
[redacted]	Father	[redacted]1986
[redacted]	Half-Sister	[redacted]2010
[redacted]	Half-Sister	[redacted]2006
[redacted]	Paternal Great Aunt	[redacted]1959
[redacted]	Household Member	[redacted]2001
* [redacted]	Maternal Grandmother	[redacted]1963
* [redacted]	Maternal Aunt	[redacted]1985
* [redacted]	Maternal Aunt's Partner	[redacted]1984

*indicates that these individuals are non-household members who had access to the victim child.

Notification of Child (Near) Fatality:

On December 30, 2013, a referral came into Allegheny County Office of Children, Youth and Families (ACOCYF) that a 2 month old child was transported to Children's Hospital of Pittsburgh (CHP) via ambulance due to the child's head quivering late on December 29, 2013. The child also had stopped eating.

Upon examination at CHP it was determined that child had [redacted] The child also had a [redacted] which was found on the child's thumb. There was no history of trauma. Dr. [redacted] from Children's Hospital of Pittsburgh indicated that the injuries were concerning for inflicted abuse. The child was listed in critical condition and could have long term impairment from the injuries.

The child's parents were unable to provide an explanation for child's injuries. The doctor indicated that the injuries were concerning for inflicted physical abuse.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family.

The Western Region Office of Children, Youth and Families Program Representative reviewed the investigation case documents provided by ACOCYF. The file included: CPS referral forms, CY 47, CY 48, and medical documentation. ACOCYF caseworker and supervisor assigned to the investigation case were also interviewed on several different occasions regarding the incident.

The Regional Office also participated in the County Internal Fatality Review Team meeting that occurred on February 27, 2014 where a review of the case file was discussed and where the case was headed.

Children and Youth Involvement prior to Incident:

The family was not known to Allegheny County Office of Children, Youth and Families. However, with that stated the mother had been placed into several different placement facilities due to parent-child conflict and truancy.

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

On December 30, 2013, ACOCYF received a Child Protective Service report [redacted] The report stated that the child had been transported via ambulance to Children's Hospital of Pittsburgh [redacted] on December 30, 2013 around 4 am due the child's head appearing to be distorted in shape and his lip kept quivering. Upon evaluation it was determined that the child had [redacted] and had a seizure.

Prior to the evening of December 30, 2013, the child had been taken to CHP's [redacted] on December 11, 2013 due to him having a temperature of 105 degrees. He was treated for his fever and was sent home with no other injuries being noted.

The treating physician who saw the child on December 30, 2013 reported that the child could have sustained the [redacted] up to ten days prior to the child's visit to the [redacted]. Hence, the [redacted] could have existed during his December 11, 2013 visit to [redacted].

The father claimed that on December 26, 2013, he spent the entire day with the child and he was eating and sleeping fine. His bodily functions were normal as well.

On December 27, 2013, the mother had taken the child to work with her that morning and met the maternal aunt's boyfriend who transported the child to the maternal grandmother's home to watch the child while the mother was a work. At 4:00 pm the father met the mother at the maternal grandmother's home and walked approximately three miles home with the child. When the parents removed the child from the car seat they observed that the child's leg kept bouncing, they thought that the child was cold from the walk home. They decided in an attempt to warm him up to give him a warm bath. Around 7 pm the child ate between 2 to 4 ounces normally and was laid down to

sleep. The child slept until 1 am. When he woke up he was shivering and shaking, and his hands were pulled to his chest. He was given a bottle and the child fell back asleep.

The child woke up around 7:30 am on December 28, 2013, and both of the child's legs were still shaking. The father discerned that the child was more "jumpy" and began to eat less. He also detected that the child appeared drowsy and his eyes were a little "puffy". The child slept most of the day and that his lips were quivering. The father explained that the child had gone to sleep around 9:30 pm and slept through the night.

The child woke up a little before 9 am on December 29, 2013 and refused to eat. The parents reported that the child's eyes were open and he looked as though he was dazed. His lips were quivering, and the parents ascertained that the child's head appeared to be misshapen. The parents stated that they were worried about their son's condition. The father contacted his sister-in-law regarding the child's behaviors. She instructed the father to take the child to the emergency room if the child's symptoms did not improve. The parents called 911 for assistance around 4 am. The child was then transported via ambulance to Children's Hospital of Pittsburgh.

The parents were unable to provide an explanation as to how the children sustained the injuries. [redacted]

[redacted]

The siblings were taken to Children's Hospital of Pittsburgh to have medical evaluations [redacted] There were injuries found on either child. While traveling to the hospital, the eldest child reported that her step father smokes K2 and that mother smokes marijuana in the basement.

The oldest sister's father, who resides in [redacted] was contacted on December 30, 2013 to see if he could care for his daughter. [redacted] he is unable to care for her at this time. Both children were placed with a maternal aunt.

The child [redacted] from Children's Hospital of Pittsburgh on January 9, 2014 and was placed into the home of a different maternal aunt than where his sisters were placed. He was unable to be placed with his siblings given that their caregiver had maximized her living space by having the child's siblings placed with her. ACOCYF did not recommend this placement due to marijuana use by this aunt and prior involvement with ACOCYF with her own children. [redacted]

A CY-48 was filed on February 27, 2014 and was unfounded given that the agency could not discern who was responsible for the child's injuries given that the child was with multiple caregivers over the period of time that the injuries would have occurred.

Current Case Status:

Currently both parents are estranged and living in separate homes. The father has obtained a Protection from Abuse court order on the mother and says that she has been harassing him with phone calls and threatening bodily harm once case is over.

Both parents are working with [redacted] to address [redacted]. The permanency goal is reunification.

The child has started to progress and has gained weight since being placed with his maternal aunt. The long term affects are yet to be seen; however, [redacted] As of July 31, 2014, he is developmentally on target, but doctors are still unsure of the long-term effects.

The police investigation was ongoing for several months and there had been no alleged perpetrator name since there were multiple caretakers during the time of the incidents. In April 2014 both parents were charged with Endangering Welfare of Children-Parent/Guardian/Other Commits Offense.

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

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- Strengths:
  - 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.
  - Agency was able to identify kinship placements for children [redacted]

- Deficiencies:
  - There were no deficiencies noted for change as identified by the County's Near Fatality Report. The family was not known to the agency prior to the report.

- Recommendations for Change at the Local Level:
    - There were no recommendations for change at a local level.
- Recommendations for Change at the State Level:
    - The State recommends that the County continues to inform the families of the importance of being made aware of the dangers of shaking a child.

Department Review of County Internal Report:

The County's Internal Reports are sent to the Department as draft reports. There is a delay in receiving the finalized report.

Department of Human Services Findings:

- County Strengths:
    - There were several strengths identified in the review of this child fatality. The County was diligent in their investigation, and worked collaboratively with law enforcement, medical professionals and a neighboring County children and youth agency. The case documentation completed by the County caseworker was detailed and well organized. Safety and risk assessments were completed at the correct intervals, and tailored to suit the safety and well-being of the child.
    - The County was able to place the sibling child into a Kinship placement that was safe and nurturing to the child. However, it was not recommended by the county due to serious issues with the maternal aunt.
- County Weaknesses:
    - The Department did not identify any weaknesses in the review of this case.
- Statutory and Regulatory Areas of Non-Compliance:
    - There were no issues of non-compliance and an LIS was not issued to the ACOCYF.

Department of Human Services Recommendations:

- The Department recommends that the County continues to collaborate with medical professionals and City/County Police during investigations. The County worked exceptionally well with both the home health professionals and the County Police to allow for transparent communication regarding the safety of the children they serve.