



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**BUREAU OF CHILDREN AND FAMILY SERVICES**  
WESTERN REGION

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**REPORT ON THE NEAR FATALITY OF:**



**Date of Birth: 08/09/2011**

**Date of Near Fatality Incident: 11/08/2011**

**FAMILY WAS NOT KNOWN TO  
ALLEGHENY COUNTY CHILDREN, YOUTH AND FAMILIES**

**REPORT FINALIZED ON: August 16, 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 Child	08/09/2011
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Father	[REDACTED] 1993

**Family Supports**

[REDACTED]	Maternal Grandmother	[REDACTED] 1969
[REDACTED]	Paternal Grandmother	[REDACTED] 1975
[REDACTED]	Paternal Great-Great Aunt	[REDACTED] 1966
[REDACTED]	Paternal Great-Great Aunt	[REDACTED] 1958

**Notification of Child Near Fatality**

On November 8, 2011, the father reported that the child went limp and became unresponsive. The father then contacted the mother, who called 911 emergency services. The City of McKeesport Police Department responded, as well as ambulance services, which transported the child via ambulance to [REDACTED]. The child was transferred to [REDACTED] at 4:00pm on the same date.

While at the [REDACTED], the emergency room treating doctors recognized an abnormal head CT scan, which showed several injuries, including a [REDACTED]. Initially, the child was not considered to be in serious or critical condition. The child's condition quickly deteriorated, and she was [REDACTED]. At this point, the child was considered to be in critical condition, and the near fatality was registered.

The injuries to the child occurred while the father was the sole caretaker of the child, as the mother was confirmed to have been at work.

### **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 from Allegheny County Children, Youth and Families, as well as the service provider agencies that are currently involved with the family.

The Regional Office also participated in the Allegheny County Internal Fatality Review Team meeting that occurred on January 12, 2012.

### **Summary of Services to Family**

At the time of the child near fatality, the family was not receiving any services.

### **Children and Youth Involvement prior to Incident**

Prior to the near fatality incident, the family did not have any involvement with Allegheny County Children, Youth and Families, nor did they have any involvement with any other child welfare agency.

### **Circumstances of Child Near Fatality and Related Case Activity**

On November 8, 2011, the mother reported that she fed the child at 4:00am, and the child appeared normal. The mother reports that she attempted to feed the child again at 8:00am, and reported that the child did not want to eat. The mother reported that the child presented with ongoing feeding problems; specifically that the child often eats fast, sometimes chokes, and then spits up. The mother then left the home at 9:15am for work.

It was reported by the father that the child cried when the mother left for work, and eventually fell asleep on the couch around 10:00am, sleeping until 12:50pm. The father reported that he had attempted to feed the child, but was unsure of the time, and she would not eat. He stated he tried again at 12:50pm and the child ate. The father reports that while he was feeding the child, the child choked. The father reports that he positioned the child to burp her, and as he did, the child "stiffened and went limp."

At this same time, the mother reported that she was on a break from work, and called home to check on the child and father. The mother reports that she heard the child crying in the background, and reports that the crying "sounded normal for the child". The mother reports that the father called her back immediately, stating that the child had gone limp. The mother hung up the phone with the father and immediately contacted 911 emergency services.

The father reported that he laid the child on the couch, and attempted to perform mouth-to-mouth because "she was not breathing normally." The paramedics then contacted the father and instructed him to place the child on the floor. The father reported that he quickly moved the child to the floor, and because of her limp physical state, he hit her head on the floor.

Ambulance Rescue Services were dispatched to the home at 1:18pm, and arrived at to the child's home at 1:22pm. When the paramedics arrived, it was believed that the child was suffering from possible [REDACTED]. Paramedics report that the child was lethargic however was not [REDACTED]. The child and father were transported via ambulance to UPMC – [REDACTED], arriving at 1:31pm.

Upon arrival, the child was seen by [REDACTED], who reported that the child arrived at the hospital unresponsive, actively [REDACTED] and in need of [REDACTED] immediately. The doctor reports that there were no visible signs of trauma. Blood tests were completed and reviewed, which prompted the medical staff to believe the child was having a [REDACTED]. Arrangements were made to transfer the child to [REDACTED] immediately.

Upon arrival to [REDACTED] Emergency Department, a head CT scan was completed, which presented abnormal findings suggesting moderate to severe disability. At this time, the child was given medication to prevent [REDACTED] was breathing and thought to be in stable condition.

The child was diagnosed with [REDACTED]

The child was electively [REDACTED] in the Emergency Department, and admitted to the [REDACTED] for observation. On November 10, 2011, the child began to have active [REDACTED], with at least four witnessed jerking spells, one of which was a [REDACTED]. The child was [REDACTED]; however the child continued to [REDACTED] on November 11, 2011. MRI results showed [REDACTED], and the decision was made to [REDACTED] in order to relieve pressure from the child's brain. The child [REDACTED]. These [REDACTED] were removed three days later.

A [REDACTED] report dated November 14, 2012, completed by [REDACTED], notes that it was her medical assessment that the child had been a victim of physical abuse, inflicted injury of a shaking/shearing nature to the child's brain. It was also noted that the type of injury inflicted on the child had occurred on more than one occasion, and at some point, there was an impact to the child's head causing a [REDACTED]. The doctor also reports that the injury, outside of the [REDACTED], would have occurred immediately prior to the child becoming non-responsive.

On November 22, 2011, Allegheny County CYF [REDACTED] of the child. The child was then [REDACTED] from [REDACTED] to [REDACTED], a rehabilitation facility, on November 23, 2011, to

continue her care and rehabilitation. She was then [REDACTED] to the paternal great-great aunt on December 6, 2011.

### **Current Case Status**

The perpetrator (father) is awaiting a non-jury trial on 8/22/12 regarding charges of aggravated assault, endangering the welfare of children and recklessly endangering another person. He is residing with the paternal grandmother.

[REDACTED] was returned to her mother's care on 5/15/12 with [REDACTED] services for both parents. They are currently residing with the maternal grandmother. [REDACTED] is receiving [REDACTED] through [REDACTED]. There is currently a no contact order for the father, with which he has been compliant. The father completed parenting classes, and completed an intake appointment for [REDACTED]. [REDACTED] mother is in the process of completing parenting classes and has been attending [REDACTED].

### **County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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 in accordance with Act 33 of 2008 related to this report.

- **Strengths:** ACOCYFS has developed a review team that is inclusive of the needed entities in order to complete a thorough review of the Act 33 cases. The agency also provides a detailed summary of the CPS investigation and intake assessments completed when Act 33 reports are received.
- **Deficiencies:** There were no deficiencies noted.
- **Recommendations for Change at the Local Level:** There are no recommendations for change.
- **Recommendations for Change at the State Level:** There are no recommendations for change.

### **Department Review of County Internal Report**

The Department was in receipt of the County Internal Report. While it did not identify any strengths or deficiencies, there were several strengths noted by the Department in this case. This feedback was provided to the County verbally on January 12, 2012.

**Department of Public Welfare Findings:**

- County Strengths: The agency staff completed a thorough investigation and assessment regarding the circumstances of the near fatality incident. The agency has provided the necessary services to the parents to address the concerns identified during the investigation/assessment, and they have closely monitored [REDACTED] progress, as well as the parent's participation in the services.
- County Weaknesses: No weaknesses were identified.
- Statutory and Regulatory Areas of Non-Compliance: There are no statutory or regulatory areas of non-compliance identified.

**Department of Public Welfare Recommendations:**

Based on the review completed by the Department, there are no recommendations at this time.