Improving Systems to Protect Children in Allegheny County:

A Report of the 2013 Child Fatality/Near-Fatality Reviews

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Allegheny County Department of Human Services

The Allegheny County Department of Human Services (DHS) is dedicated to meeting the human services needs of county residents, particularly the county's most vulnerable populations, through an extensive range of prevention, intervention, crisis management and after-care services.

This report was prepared by the Office of Data Analysis, Research and Evaluation (DARE), an office within DHS. DARE supports and publishes research related to the activities of DHS in a number of categories, including: Aging; Basic Needs; Behavioral Health and Disabilities; Child Development and Education; Children, Youth and Families; Crime and Justice; and Innovation, Reform and Policy.

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TABLE OF CONTENTS

Tables

ACRONYMS

CAC	Child Advocacy Center
CFNF	Child Fatality/Near-Fatality
CYF	Office of Children, Youth and Families
DARE	[DHS Office of] Data Analysis, Research and Evaluation
DHS	[Allegheny County] Department of Human Services
PaDHS	Pennsylvania Department of Human Services
ERM	Emergency Response Meetings
IPV	Intimate Partner Violence (Domestic Violence)
QI	Quality Improvement

GLOSSARY

Behavioral Health Services — services provided for the prevention and treatment of mental illness or substance abuse

Child — a person age 17 or under

Child Abuse[1] — any of the following:

- A recent act or failure to act by a perpetrator that causes non-accidental serious physical injury to a child
- A recent act or failure to act or series of the acts or failures to act by a perpetrator that creates an imminent risk of serious physical injury to or sexual abuse or exploitation of a child
- An act or failure to act (no time limit) by a perpetrator that causes non-accidental serious mental injury or sexual abuse or exploitation of a child
- Serious physical neglect by a perpetrator constituting prolonged or repeated lack of supervision or the failure to provide the essentials of life, including adequate medical care, which endangers a child's life or development or impairs the child's functioning

[1] Although the definition of both child abuse and perpetrator changed at the end of 2014, the incidents described in this report occurred prior to the change and are therefore based upon the earlier definitions.

Child Advocacy Center — a local public agency or nonprofit entity providing a child-focused, facility-based program dedicated to coordinating a formalized multidisciplinary response[2] to suspected child abuse that, at a minimum, either onsite or through a partnership with another entity or entities, assists county agencies, investigative teams and law enforcement by providing services, including forensic interviews, medical evaluations, therapeutic interventions, victim support and advocacy, team case reviews, and a system for case tracking

[2] http://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/23/00.063..HTM

Field Screen — an assessment conducted by a child welfare agency that consists of a field visit to assess each child in a family through observation of the environmental factors of each child's residence to evaluate immediate safety, with consideration for further assessment; in that event, the case is assigned to a caseworker to conduct a full Child Protective Services investigation or General Protective Services assessment. If the Field Screen assessment does not warrant either action, the case is screened out with an Information and Referral Service (I&RS) designation. Allegheny County CYF Field Screen assignment criteria include: all calls involving any child within a family who is age six or younger, and cases not immediately assigned for a CPS or GPS assessment.

Medical Child Abuse — deliberate action on the part of a caregiver that interferes with or causes the need for medical treatment

Near-Fatality — an act that, as certified by a physician, places a child in serious or critical condition

Nolo Contendere — a plea of no contest

Glossary

(continued)

[3] http://pacode.com/secure/data/055/055toc.html

Perpetrator — a perpetrator, as defined by the Pennsylvania Child Protective Services Law (CPSL),[3] has committed abuse and is the parent of the child, responsible for the welfare of the child residing in the same house, or is the paramour of the parent or caretaker of the child. The person responsible for a child's welfare provides permanent or temporary care, supervision, mental health treatment or diagnosis, training, or control of the child in lieu of parental care, supervision or control.

Resource Family — also known as foster family; a family that provides temporary foster or kinship care for children who need out-of-home placement; might eventually provide permanency for the child, including adoption

Substantiated Report — Substantiation is a legal definition that includes two types of child abuse investigation status determinations, *indicated* and *founded*. An *indicated report* is a child abuse report in which a county agency or the Pennsylvania DPW determines that substantial evidence of the alleged abuse exists based on any of the following: (i) available medical evidence; (ii) the child protective service investigation; or (iii) an admission of the acts of abuse by the perpetrator. A *founded report* is a child abuse report whereby there is a judicial finding that a child has been abused or the entry of a plea of guilty or nolo contendere.

EXECUTIVE SUMMARY

Act 33 of 2008 is an amendment to the Child Protective Services Law (CPSL) requiring that circumstances surrounding cases of suspected child abuse resulting in child fatalities and near-fatalities[4] be reviewed at both state and local levels. Allegheny County's Child Fatality/Near-Fatality (CFNF) review process is a component of the continuous quality improvement process of the Allegheny County Department of Human Services (DHS), and is designed to inform practice and systemic changes that will prevent future child injury and death.

[4] Acts that, as certified by a physician, put a child in serious or critical condition.

In 2013, the Allegheny County CFNF Review Team reviewed nine incidents (four child fatalities and five near-fatalities[5]). Seven of the incidents[6] were substantiated as abuse by DHS's Office of Children, Youth and Families (CYF); the other two were not substantiated following an investigation of the circumstances.

[5] Because two of the incidents involved twins who died in a fire, the total number of families reviewed was eight.

[6] Involving six families

Key Findings

Child Demographics

Of the nine children reviewed by the CFNF Review Team:

- all were boys
- the majority were African American
    - all four of the fatal incidents and one near-fatality involved African American children
    - of the other four children involved in near-fatal incidents, three were white and one was biracial
- all were age 4 or younger

Child Welfare Involvement

- Four children and/or their families *were not known* to Allegheny County's child welfare system within the 16 months prior to the fatality or near-fatality.
- Five children and/or their families *were known* to Allegheny County's child welfare system within the 16 months prior to the incident.
    - two of the known families *were active* with CYF at the time of child death

Cause of Injury/Death

- Fatalities were caused by fire (2 children), blunt force trauma (1 child) and chemical burns (1 child).
- Non-fatal injuries were caused by blunt force trauma (1 child), abusive head trauma (1 child), opiate ingestion (1 child), gunshot (1 child), and serious infection resulting from intentional contamination of feeding and IV tubes by the mother (1 child).

Location of Incidents

- Six of the incidents occurred in the child's home (three fatalities and three near-fatalities).
- One occurred in the home of a relative while in kinship care (fatality).
- One occurred in the home of a family friend who was babysitting the child (near-fatality).
- One occurred in the hospital (near-fatality).

Substantiation by CYF

- Abuse was substantiated for seven of the children (four fatalities and three of the five near-fatalities).[7]
- Abuse was unsubstantiated in two of the near-fatality incidents.

[7] Criminal proceedings are currently underway for the nine perpetrators involved in the seven substantiated incidents (four fatalities; three near-fatalities).

CYF Response to Incidents

- FATALITIES: Two of the families (representing three of the children) already had open child welfare cases; the fourth child was not known to child welfare, and no case was opened because there were no surviving children in the household.
- NEAR-FATALITIES: Following each incident, child welfare opened cases for three of the children; the other two were referred to child welfare but no case was opened because the children were assessed as safe in the care of the non-offending parent; safety plans and court-imposed "no-contact" orders are in place to protect these children from the perpetrators.

Perpetrators

There were nine perpetrators identified for the incidents substantiated by CYF (seven children or six cases). One of the cases involved three perpetrators, and one case involved two perpetrators.

Perpetrator Demographics

- Seven of the nine perpetrators were African American, one was white and one was biracial.
- Four were ages 18 through 24, one was between 25 and 29, and four were 30 through 38 years old.
- Six were female; three were male.

Relationship of Perpetrator to Child

All nine perpetrators were known to the children.

- Three were the child's mother (two fatalities [twins]; two near-fatalities).
- One was the child's father (fatality).
- One was the male partner of a parent (near-fatality).
- One was the female partner of a relative (fatality).
- Two were female relatives of the child [one was a kinship caregiver] (one fatality).
- One was a male babysitter (near-fatality).

Social History of Perpetrators

- Six had a criminal history, ranging from receiving stolen property to endangering the welfare of children.
- One had prior involvement in the juvenile justice system.
- Six were involved in child welfare as children.
- Six had a history of Intimate Partner Violence (IPV).[8]
- Five had a history of involvement in the mental health system.
- Four had a history of substance abuse.
- Education
    - one did not complete high school
    - one had a high school diploma or equivalent
    - three had technical certification
    - two had attended college
    - one was unknown
- Six were employed at the time of the incident.

[8] One PFA filed, one police report of IPV incident filed, and four self-reports of involvement in IPV as either a victim or an assailant.

The CFNF Review Team made a number of recommendations designed to address issues identified during the reviews. Recommendations include:

- Continue to provide coaching to child welfare supervisors to maintain Conferencing and Teaming skills and fidelity.
- Improve caseworker ability to assess families with complex needs.
- Improve casework staff's skills related to the Safety Assessment Management Process (SAMP).

BACKGROUND

Pennsylvania Act 33 of 2008

In 2008, Pennsylvania amended the state Child Protective Services Law to include specific requirements related to cases of suspected child abuse and neglect that resulted in child deaths or near deaths. The amendment, known as Act 33, requires that a review team be convened within 31 days of receipt of an oral report of a child fatality or near-fatality if the status of the abuse investigation is substantiated[9] or if the status determination has not yet been made. A written report of the review must be submitted to the Pennsylvania Department of Human Services (PaDHS) within 90 days[10]; the report should include:

- deficiencies and strengths in regard to compliance with statutes, regulations and services to children and families
- recommendations for changes at the state and local levels to reduce the likelihood of future child fatalities directly related to child abuse and neglect
- recommendations for changes at the state and local levels related to monitoring and inspecting county agencies
- recommendations for changes at the state and local levels regarding collaboration of community agencies and service providers to prevent child abuse and neglect

If the district attorney certifies that the release of the report may compromise a pending criminal investigation or proceeding, the district attorney may stay the release of the report to the public.

In addition to submitting mandated reports to the state, DHS voluntarily publishes annual reports about CFNF incidents.

[9] Substantiated reports include those reports where there is a judicial finding that a child was abused (referred to as "founded") and those cases where the county agency or state regional staff find that abuse has occurred based on medical evidence, the investigation results, or an admission by the perpetrator (referred to as "indicated"). If there is a lack of evidence that a child was abused (referred to as "unfounded"), CYF may still accept a case for service, based on the assessment of safety and potential risk of harm to a child.

[10] Individual Act 33 reports (by incident) are available at http://www.dhs.state.pa.us/publications/chiildfatalitynearfatalityreports/index.htm

Annual reports prepared by PaDHS are available at http://www.dhs.state.pa.us/publications/childabusereports/index.htm

Allegheny County's CFNF Review Team

The Allegheny County CFNF review team is chaired by a renowned pediatrician whose specialty is in the field of child abuse and neglect, and facilitated by a professor emeritus of a nationally acclaimed university, who has experience in child welfare practice, education and research. Team members represent a cross-section of experts in the areas of child abuse and neglect, including representatives from:

- DHS
- DHS CYF Advisory Board
- Allegheny County Health Department
- Allegheny County Medical Examiner's Office
- Allegheny County District Attorney's Office
- Allegheny County Children's Court
- PaDHS Office of Children, Youth and Families
- Pittsburgh Bureau of Police and the Allegheny County Police Department
- Community providers with expertise in family violence and child abuse and neglect
- Community Care Behavioral Health Organization

Meetings of the CFNF Review Team, and preparation of review materials, are coordinated by the DHS Quality Improvement Team, a part of DHS's Office of Data Analysis, Research and Evaluation's (DARE). The Quality Improvement Team works outside of the operational chain of command for child welfare, reporting directly to the DARE Deputy Director and to the DHS Director, and is thus an objective convener and facilitator of the process.

METHODOLOGY

Case Review Process

In conducting a CFNF review, the team obtains all available information regarding the case by reviewing all relevant documents and by conducting interviews with appropriate county and private agency staff, any other involved parties, and any person who may have information relevant to the review. Case record reviews are a central source of information for the Review Team, including record reviews of those cases in which the family had previous involvement with CYF and/or of all cases in which CYF is conducting an investigation related to the fatality or near-fatality under review.

Case Record Reviews

Case record reviews are conducted to: understand patterns of incidents within a jurisdiction; understand causes of incidents and methods of prevention; identify systemwide issues and barriers that prevent effective service delivery; and review cases of specific clients or client

groups in an effort to improve outcomes for those individuals or groups. Case reviews can be both proactive and retrospective and can entail examining entire cases or particular parts or processes of casework. Case reviews can also look at outcomes for an individual or a group, as well as the methods used in casework to evaluate their effectiveness.

Document reviews provide information about:

- the nature, intensity and frequency of services provided
- the nature, quality and frequency of visits with the child and family
- results of the investigation of any prior reports of suspected child abuse or neglect
- any underlying issues identified and services provided to address those issues
- any prior safety assessments conducted, and whether they were completed in accordance within established guidelines and used to inform decisions/actions taken to address any identified threats to child safety.
- whether the risk assessment was completed in accordance with regulatory time frames, whether the facts support the level of risk identified and whether the actions taken and the services provided were appropriate to the risk indicators identified
- the frequency, appropriateness and quality of contacts with agencies providing services to the child or family
- whether the family service plan identified the child's and family's individual needs and addressed the safety threats, diminished protective capacities and the risk factors identified
- regulatory and statutory compliance
- an appraisal of the health and safety of all children in the family
- whether services were provided in accordance with PA Child Welfare Practice Standards
- the level of supervisory oversight and case monitoring

Interviews are conducted with individuals involved in the current investigation as well as anyone involved with the family in prior CYF cases. Interviews may clarify and/or validate information found in the record review and/or ascertain the basis for decision-making in the case process.

Data Sources

Cause of injury is cited from the Medical Examiner's report in the event of a fatality; the child's medical record is the source of information in near-fatality incidents.

Perpetrator social history information is obtained through examination of county databases, medical records, medical examiner reports, law enforcement records and child welfare records.

DATA ANALYSIS

The following is an analysis of the nine child fatality and near-fatality incidents that occurred in Allegheny County in 2013. Seven of the nine incidents (four fatalities and five near-fatalities) were substantiated by the child welfare office for suspicion of child abuse and/or neglect. The nine incidents involved eight families, because twin brothers were victims of a fatal fire.

Children Involved in CFNC Incidents

Demographic Information

Table 1 provides demographic information on the nine children. All of the victims were boys and four years old or younger. Five of the children were African American, three were white and one was biracial.

TABLE 1: **Age and Race of Children in CFNF Cases (2013)**

2013	0–12 MONTHS	12–23 MONTHS	2 YEARS	3 YEARS	4 YEARS	TOTAL
Fatality	**1**	**1**	**0**	**2**	**0**	**4**
African American	1	1	0	2	0	4
White	0	0	0	0	0	0
Biracial or Multi-racial	0	0	0	0	0	0
Near-Fatality	**1**	**2**	**0**	**1**	**1**	**5**
African American	0	1	0	0	0	1
White	1	1	0	1	0	3
Biracial or Multi-racial	0	0	0	0	1	1
TOTALS	**2**	**3**	**0**	**3**	**1**	**9**

Prior Child Welfare Involvement of Children

Act 33 requires that a review be conducted into the regulatory and statutory compliance of the county child welfare agency any time a child is involved in an incident and has been known to the agency within the past 16 months. However, Allegheny County's CFNF Review Team reviews every family's history of child welfare involvement as far back as possible and for every jurisdiction for which information is available.

Three of the families involved in CFNF incidents had no history of involvement with child welfare in Allegheny County.

Five of the children (four families) were known to CYF within the 16 months prior to the incident.

- Two of these families had open family services cases at the time of the incident.
    - The open family services case for the family of two of the children, twins who died in a fire, involved unsubstantiated physical abuse of an older sibling by the mother. In-home services were provided in response to this case and were ongoing at the time of the incident.
    - The third child, and his siblings, came to the attention of child welfare when they were found to be outside of their mother's care. She was arrested, and the local police assumed protective custody of the children. The mother gave permission for the children to stay with their maternal aunt; however, upon investigation, the aunt was found to have a criminal history (including endangering the welfare of a child) that precluded the children's placement with her. The children were removed from her care and placed with a resource family, but the court ordered that the children be returned to the aunt's home. Even though child welfare did not recommend her as a suitable caregiver for the children, the court order remained in effect until the time of the child fatality.[11]

- In the other two cases, assessments were conducted upon receipt of the referral and indicated that an investigation was not warranted (and therefore no case was opened) because there were no safety concerns. Details of each:
    - For one child, child welfare received a referral in November 2012, alleging neglect, possession of illegal substances by the father and intimate partner violence (IPV) between the parents. An assessment revealed no safety concerns, and a case was not opened.
    - The family of a second child had an extensive child welfare history dating back to 1995. There were two previous case openings and closures (2002 and 2012, with the most recent case closure in August 2013) and two subsequent child welfare referrals (September and October 2013) alleging inadequate physical care of a seven-year-old male sibling. Both referrals were screened out in intake after the children were assessed as safe in the family home.

[11] The aunt, along with her intimate partner and her daughter, was determined to be the perpetrator of the incident.

TABLE 2: **Involvement with Allegheny County Child Welfare (2013)**

ALLEGHENY COUNTY CHILD WELFARE INVOLVEMENT	FATALITY	NEAR-FATALITY	TOTALS
Not known within 16 months preceding the CFNF event	1	3	4
Known within 16 months preceding the CFNF event	3	2	5
• Active at time of incident	3	0	3
• Not active at time of incident	0	2	0
TOTALS	**4**	**5**	**9**

Cause of Fatality or Near-Fatality

As shown in **Table 3**, causes of injury and death were evenly distributed and ranged from accidental gunshot to fire to a major infection resulting from a mother's deliberate contamination of her child's feeding and IV tubes.

TABLE 3: **Cause of Fatality or Near-Fatality (2013)**

CAUSE	FATALITY	NEAR-FATALITY
Fire (burns and inhalation injury)	2	0
Blunt Force Trauma	1	1
Abusive Head Trauma	0	1
Ingestion (opiate)	0	1
Burns (chemical/bleach)	1	0
Gunshot	0	1
Medical Child Abuse[12]	0	1
TOTALS	**4**	**5**

[12] Medical Child Abuse refers to deliberate action on the part of a caregiver that interferes with or causes the need for medical treatment.

Location of Incident

Six of the nine incidents occurred in the family home — three of the child fatalities and three of the near-fatalities (see **Table 4**, below). The fourth child death occurred in a kinship foster home, and the other two near-fatalities occurred in the home of the babysitter and in a hospital.

Four of the incidents occurred in the City of Pittsburgh, four occurred in the Mon Valley[13] and one occurred in Bellevue Borough.

[13] Two deaths occurred in North Braddock Borough, one in Homestead and one in McKeesport.

TABLE 4: **Location of Children in CFNF Incidents (2013)**

LOCATION OF CFNF INCIDENTS	2013
Home of Parent	6
Home of Maternal Aunt (Kinship Care)	1
Home of Babysitter	1
Hospital	1
TOTALS	**9**

Child Welfare Substantiations

Of the nine incidents reviewed by the CFNF team, seven (four fatalities and three near-fatalities) were substantiated as resulting from abuse or neglect. The other two near-fatalities were determined to be unsubstantiated as abuse.[14] Criminal proceedings are underway for the perpetrators involved in the seven incidents.

[14] In one case, the incident was caused accidentally by a minor; in the other case, the investigation did not reveal substantial evidence (as required by law) of prolonged lack of supervision or serious physical neglect.

TABLE 5: Cases Substantiated by CYF (2013)

	2013
FATALITY	
Substantiated	4
Unsubstantiated	0
NEAR-FATALITY	
Substantiated	3
Unsubstantiated	2
TOTALS	**9**

PERPETRATORS

Nine perpetrators were identified in the seven substantiated incidents; three perpetrators were involved in one fatal incident, two perpetrators were involved in another near-fatality, and one perpetrator was responsible for the fatal incident (fire) that claimed the lives of twin brothers. All perpetrators were known to their victims.

TABLE 6: Relationship of Perpetrator to Child (2013)

	NUMBER
Mother	3
Father	1
Male Partner of Mother	1
Female Partner of Relative	1
Maternal Aunt (kinship provider)	1
Female Relative residing in Maternal Aunt's household	1
Male Babysitter	1
TOTALS	**9**

Perpetrator Demographics

Seven of the perpetrators identified as African American, one as white and another as biracial. Four were ages 18 through 24, one was between the ages of 25 and 29, and four were 30 through 38 years old.

Social Histories of Perpetrators

The following represents the social history for the nine perpetrators substantiated in 2013, as available through record review or self-report.

TABLE 7: **Social History of Perpetrators (2013) N=9**

SOCIAL HISTORY	NUMBER OF PERPETRATORS
Criminal history	6
Prior involvement in juvenile justice system	1
Involved in child welfare system as a child[15]	6
History of Intimate Partner Violence (IPV)[16]	6
Prior involvement in the mental health system	5
History of substance abuse[17]	4
Educational History:	
• No high school diploma	1
• High school diploma or equivalent	1
• Technical or other training certification	3
• College, university or professional school	2
• Educational attainment unknown	2
Employed at time of incident	6

[15] "Child Welfare Involvement as a Child" includes involvement in child welfare in any jurisdiction.

[16] For the purposes of this report, a prior history of intimate partner violence includes: (i) a report of law enforcement; (ii) a filed Protection from Abuse Order; or (iii) self-report of victim or perpetrator.

[17] One or more of the following: (i) diagnosis of substance dependency; (ii) participation in clinical treatment; or (iii) self-report.

SYSTEM RESPONSES TO CFNF INCIDENTS

When a report is received about an incident in which a child is seriously injured or hurt, CYF responds immediately. Caseworkers conduct thorough investigations and assessments and do whatever is necessary to ensure the safety of each child in the home; this may include locating relatives or other resource families with whom the children can stay, if necessary. County child welfare offices, child advocacy centers (CAC), county children and youth agencies, child and family advocates, medical and human service providers, law enforcement and local courts work collaboratively[18] to protect the surviving children and all siblings, to identify and address the causes of the abuse, and to bring perpetrators to justice. Appendix A provides a comprehensive list of services provided, by a number of systems, to each family as well as to some of the perpetrators.

[18] True collaboration may at times be hampered by the timing of initial incident reporting and successful coordination of the joint investigation.

Child Welfare Involvement

As discussed previously, the families of three of the children in fatal incidents were actively involved with Allegheny County's child welfare system at the time of the incident. The fourth child was not known to child welfare, and there was no further involvement with the family because, following the child's death, there were no surviving children in the home.

Three of the children with non-fatal injuries were accepted for service by CYF. The other two children with non-fatal injuries were determined to be safe in the care of the non-offending parent so, although safety plans were developed and the perpetrators were ordered to have no contact with the children, CYF did not open an active case.

The following table provides information about CYF's subsequent involvement in each case. Below the table are descriptions of each of the incidents and CYF's actions in each.

TABLE 8: **CYF Response to CFNF Referrals (2013)**

	FATALITY	NEAR-FATALITY	TOTALS
Already Open in Family Services	3	0	2
Accepted for Family Services	0	3	3
Closed at Intake	1	2	3
TOTALS	**4**	**5**	**9**

Incident One: Child Fatality with Open Child Welfare Case

CYF received a report that a 20-month-old child had died while in the home of his maternal aunt (kinship placement). The cause of death was serious burns caused by exposure to chlorine bleach. The deceased child's siblings and cousins were also at the residence at the time of the child's death. CYF immediately removed all five of the children from the home. Four were placed in either shelter care or with resource families, and the fifth went to live with his father out-of-state.

The child's mother entered substance abuse treatment and moved into a therapeutic transitional housing program. Seven months after the fatal incident, she regained custody of two of her surviving children (the third remains with his father) and continues to participate in substance abuse treatment and supportive services. Four months after reunification with her children, CYF closed her case. The child's cousins returned to their mother's care after she completed mental health treatment and parenting classes; she also received in-home services and participated in substance use screenings. Her CYF case has also been closed.

Incidents 2 & 3: Child Fatalities with Open Child Welfare Case

Three-year-old twin boys died when a fire broke out in the home in which they were left unattended. A half-sibling, who was not in the home at the time of the fire, was removed from her mother's care and placed in kinship care. She has since exhibited a number of behaviors requiring intervention from multiple systems and is currently in a juvenile detention center in another county. Because the mother is incarcerated and the father is deceased, CYF continues to seek other family members who might offer her a kinship placement.

Incident 4: Near-Fatality Resulting in Re-Opened Child Welfare Case

A three-year-old child sustained a serious injury when his seven-year-old sibling picked up a CO_2-powered pellet gun belonging to an adult sibling. The gun discharged and struck the three-year-old in the face. The parents, who were home at the time of the incident, had an extensive history with child welfare; CYF had received 43 referrals on the family since 1995. The majority of referrals involved neglect (e.g., lack of supervision, truancy and substance abuse), although physical abuse was also alleged. The most recent case closure was achieved only three months prior to the incident.

CYF re-opened the case and instituted a safety plan that required all weapons to be removed from the home. CYF also re-instituted in-home services with a goal of establishing more structure in the home and convened the Integrated Service Planning Process to ensure the involvement of multiple systems relevant to the case; other services included connecting the family to community resources, linking the family with truancy intervention services, and enrolling the younger children in daycare. Although the incident was deemed an accident, and no criminal charges were filed against the seven-year-old sibling, the CYF case remains open.

Incident 5: Near-Fatality Resulting in Opening of Child Welfare Case

A one-year-old child nearly died from impaired breathing after he ingested what was believed to be an opiate while in the care of his father. The child was determined to be safe in the care of his mother and was released to her care upon discharge from the hospital, at which time they moved in with a relative. A child welfare case was opened and crisis in-home services were instituted to address housing issues, improve life skills and parenting skills, and provide treatment for parental substance use and IPV-related trauma. After seven months, Family Court granted primary custody to the mother, and CYF closed the case.

Incident 6: Near-Fatality Resulting in Opening of Child Welfare Case

A four-year-old child sustained critical internal injuries from inflicted trauma while in the care of his mother and her intimate partner. CYF opened a new case and implemented a safety plan dependent upon the mother's agreement to keep her partner away from the child. Because it was determined that the child's safety could not be assured, he was subsequently removed from his mother's care and placed with kin. After an arrest warrant was issued for the mother's

partner, the child was returned to her care. Mother sought support from her family and provided for the child's needs while he continued to receive mental health treatment. The CYF case was closed after three months.

Incident 7: Fatality/No Child Welfare Case Opened

A five-month-old child died while in the care of his father; he was found unresponsive in the morning after sleeping with his father. The post-mortem examination confirmed suspicion of prior abuse. CYF involvement ended at the conclusion of the investigation; no case was opened because there were no surviving children in the household. Criminal proceedings against the father are ongoing.

Incident 8: Near-Fatality/No Child Welfare Case Opened

A six-month-old child nearly died from infections caused by his mother tampering with his IV line and feeding tubes. The child and his two-year-old sibling are in the care of their father and paternal relatives; they have agreed to abide by a safety plan that prohibits any contact by the mother. The investigation was closed with no case opening. Criminal proceedings against the mother are ongoing.

Incident 9: Near-Fatality/No Child Welfare Case Opened

Emergency medical services transported a two-year-old child to the regional pediatric hospital where, upon admission, he was evaluated to be in critical condition and was not initially expected to survive. His injuries were sustained while in the sole care of a babysitter, who denied inflicting any injury; medical evidence demonstrated that his injuries could not have been caused by falling down stairs, as was claimed. The child and his seven-year-old sister were assessed and determined to be safe in the care of their mother and the investigation was closed without a case being opened. Criminal proceedings against the babysitter are ongoing.

OVERARCHING THEMES

A complete list of recommendations resulting from the 2013 CFNF reviews can be found in **Appendix B**. However, in addition to specific recommendations, the CFNF Review Team has identified three overarching themes that together have the potential to make a significant impact on children's safety; these include improvements in processes related to Safety Assessment Management and Assessment/Service Planning as well as enhanced collaboration among child-serving systems. The following section summarizes some of the actions taken in support of these key reforms.

Safety Assessment Management Process

- Development of a Safety Academy designed to enhance caseworker knowledge, understanding and application of safety and risk assessments as decision-support tools for service planning and to track safety outcomes
- Participation of one CYF trainer in a train-the-trainer program to become a certified "safety expert" (funding provided by Casey Family Programs)
- Monthly targeted training in CYF regional offices, with a focus on safety and risk, to assist casework staff in applying effective strategies to actual cases

Assessment and Service Planning Processes

- Full implementation of DHS Conferencing and Teaming across the regional offices (achieved 2014 along with continuous improvement process launched to support fidelity to the DHS practice model)
- Implementation of supervisor coaching supported by Child Welfare Policy and Practice Group consultants to enhance skill and create consistency across the agency regarding supervision of the Conferencing and Teaming model
- Establishment of monthly forums in CYF regional offices where caseworkers can meet with a psychiatrist or domestic violence specialist to consult about issues such as mental health, domestic violence and substance abuse issues
- Issuance of a Request for Proposals (RFP) to design and implement decision-support tools and predictive analytics in human services
    - RFP issued for a contracted vendor in February 2014
    - Contracting and implementation process began in September 2014

Communication and Collaboration Across Public and Private Agencies

- Convening of a stakeholder group charged with 1) assessing Allegheny County's home visiting programs serving families with children ages five and below, and 2) publishing a report that will identify systemwide challenges and opportunities. Preliminary work by the stakeholder group has identified a number of potential recommendations: improve the coordination of home visiting programs, particularly through Family Support Centers; expand the use of evidence-based programming; and utilize shared data to track outcomes and determine the most effective way to serve families.
- Assessment of DHS's capacity to adequately meet the needs of parents involved with child welfare who are in need of and/or receiving addiction and recovery services. The assessment resulted in a number of recommendations, including improved alignment of services with population needs, enhanced quality of services, and strengthening of appropriate referral pathways. Using this preliminary assessment as a foundation, Allegheny County is now a participant in In-Depth Technical Assistance (IDTA), a two-year project supported by the

National Center on Substance Abuse and Child Welfare. Project goals include: development of cross-systems values, principles, goals and objectives for serving substance-affected families; increase in timely access to services, including education, for substance-affected families; maximization of knowledge and use of existing best practice treatment and resources; and encouragement of awareness and utilization of sustainable supports for lifetime recovery.

APPENDIX A: SERVICES PROVIDED

A variety of skill-building and support services were offered to families whose child was involved in a CFNF incident. Those services included:

- Anger management services
- Behavioral health rehabilitation services
- Child care and medical day care
- Developmental screenings
- Grief counseling
- Housing assistance
- In-home services
- IPV counseling
- Justice-related services
- Medical Assistance Transportation
- Parenting classes
- Psychological evaluations
- Substance abuse treatment
- Victim and witness assistance services

Appendix A
(continued)

The following table shows the specific services provided to each family and/or perpetrator. Services provided prior to the CFNF event describes those services received within 12 months prior to the fatal or near-fatal incident.

	SERVICES WITHIN 12 MONTHS PRIOR TO CFNF INCIDENT		SERVICES PROVIDED AFTER CFNF EVENT	
	FAMILY	PERPETRATOR(S)	FAMILY	PERPETRATOR(S)
INCIDENT 1	• Behavioral Health • Family Support • Family Group Decision Making • Housing Assistance • Inua Ubuntu • Kinship Care	• Behavioral Health • Child Welfare • Family Support Center • Juvenile Justice • Transportation Services	• Behavioral Health • Child Advocacy Center • Child Profile Services • Daycare • Early Intervention • Family Support Center • Kinship Care • Parenting Classes • Transportation Services	• Behavioral Health • Family Support Center • Crisis In-Home • Parenting Classes • Early Intervention • Child Advocacy
INCIDENTS 2&3	• Behavioral Health • Criminal Justice • Crisis In-home • Early Intervention • Subsidized Housing	• Behavioral Health • Child Welfare • Public Assistance • Subsidized Housing	• Behavioral Health • Child Advocacy • Congregate Care • Family Support Center • Housing Assistance • ID Service Coordination • Independent Living • Juvenile Probation • Kinship Care • Summer Program • Transportation Services	• Child Welfare • Criminal Justice
INCIDENT 4	• Behavioral Health	• None	• Child Advocacy Center • Early Intervention • Integrated Services • Transportation Services • Truancy Prevention	• None

Appendix A

(continued)

	SERVICES WITHIN 12 MONTHS PRIOR TO CFNF INCIDENT		SERVICES PROVIDED AFTER CFNF EVENT	
	FAMILY	PERPETRATOR(S)	FAMILY	PERPETRATOR(S)
INCIDENT 5	• None	• None	• Behavioral Health • Child Advocacy Center • Crisis In-Home • Housing Assistance	• Behavioral Health
INCIDENT 6	• None	• None	• Behavioral Health • Child Advocacy Center	• None
INCIDENT 7	• None	• Behavioral Health	• Child Advocacy Center	• None
INCIDENT 8	• None	• None	• Child Advocacy Center	• Behavioral Health • Criminal Justice • Family Support • Jail Collaborative
INCIDENT 9	• Early Intervention • Family Support	• None	• Child Advocacy Center • Rehabilitative Services	• Criminal Justice

APPENDIX B: CFNF RECOMMENDATIONS

Professional Development

- Review supervisory and staff development supports to enhance assessment and understanding of co-occurring disorder by caseworkers and providers with direct case management responsibilities.
- Improve staff's ability to assess/address the impact on children of IPV behavioral health involvement by caregivers.
- Enhance professional training in the area of medical child abuse for child protection workers, physical health providers, community service providers and public safety professionals in order to better prevent, assess, understand and intervene with children who may experience this type of abuse.
- Promote the use of re:solve Crisis Network by agency providers, as appropriate, for 24-hour mental health crisis intervention and stabilization services. Enhance training of frontline staff regarding the need for prompt and accurate completion of legally executed releases of information, to allow access to information from protected health records.

Policy and Practice

- Enhance tracking of multiple referrals to the agency, including exploration of a decision-support tool connected to the electronic case management system that would flag multiple referrals within a specific time frame.
- Case record reviews of previous CYF involvement indicated that at least one family had multiple referrals in which the agency investigations noted similar family stressors that persisted over time and that had the potential to negatively impact child safety. The Review Team recommended consideration of filing dependency petitions for children in this type of situation, when there has been no resolution of the underlying problems or family stressors.
- Implement a strategy that allows child protection agencies to obtain third-party information, in absence of parental authorization, when that information is germane to an investigation, assessment and/or planning to ensure child protection.
- Formalize use of natural supports in family service planning, including safety and crisis planning.
- Implement a policy that calls for further assessment, including medical evaluations and consideration of forensic evaluations, of children involved with child welfare services who engage in developmentally inappropriate sexualized behaviors.
- Strengthen staff training and supervisory oversight on the imperative to obtain information from collateral contacts as a standard practice, including utilization of DHS databases to identify other systems that may be involved with consumers for case assessment and case planning purposes.

Appendix B
(continued)

- Perform an immediate administrative review of the policy for reauthorization of provider services as well as supervisory decisions related to timing of case transfer.
- Review and revise policy, procedures and training regarding staff discussion with families on gun safety and safety of staff in the family residence, as a component of the safety management protocol.
- Review and reinforce policies related to timelines for face-to-face visitation with children; Section 3490.61(a) of the PA CPSL.
- Enhance the safety checklist, used to assess family home environments for safety, to include the status of appliances, including asking whether appliances have been disconnected by utility companies because of safety hazards.

Intersystem Issues

- Greater adherence to the joint investigative protocol between law enforcement and the local child welfare agency in cases of suspected child abuse; this recommendation reflects the fact that, during the investigation process, the two systems appeared to be working independently of one another, rather than collaborating as per the protocol
- Establishment of an internal DHS committee, with multi-office representation, to create internal pathways to speed service access and delivery, and to improve coordination and communication across offices
- Further discussion about the challenges of court-ordered placements in uncertified homes and the need for CYF appeals of case decisions in which there are identified risks
- Consideration of the development of procedures to determine when a hospital notifies their own public safety officers versus the local or county jurisdiction's law enforcement officers in the event of suspected medical child abuse to ensure timely and comprehensive investigation and response
- Further discussion with law enforcement about the possible implementation of a policy of maintaining open investigations until receipt of final findings from the medical examiner's office, in cases where police are investigating a child death

Resource Capacity

- Establish a protocol or system to address unacceptable delays (often up to six weeks, depending upon demand and limited resource capacity) in scheduling appointments following referrals to behavioral health services.
- Implement a plan for CYF to temporarily reassign cases to an identified caseworker when the assigned caseworker is on leave for an extended period of time, in order to ensure service continuity.

Appendix B

(continued)

Public Awareness

- Promotion of "When Families Grieve," a guide for parents and caregivers, created by Sesame Workshop and the Highmark Caring Place (a center for grieving children, adolescents and their families)
- Additional research in the area of medical child abuse, including diagnosis, treatment and prevention strategies
- Education on the risks associated with toileting and child abuse
- Continued public awareness around dangers of leaving children home alone and fire safety
- Promotion of Asking Saves Kids (ASK) campaign, developed in collaboration with the Center to Prevent Youth Violence and the American Academy of Pediatrics, which encourages asking parents about the presence of firearms where their children play, as well as support of other community awareness activities regarding gun safety