Improving Systems to Protect Children in Allegheny County

A Report of the Child Fatality / Near-Fatality Review Team, 2011

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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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ACRONYMS

ACHD	Allegheny County Health Department
ALTE	Apparent Life Threatening Event
CFNF	Child Fatality/Near-Fatality
CPS	Child Protective Services
CPSL	Child Protective Services Law
COA	Council on Accreditation
CYF	Office of Children, Youth and Families
DARE	Office of Data Analysis, Research and Evaluation
DHS	Allegheny County Department of Human Services
DPW	Pennsylvania Department of Public Welfare
ERM	Emergency Response Meeting
PBP	Pittsburgh Bureau of Police
PQI	Performance and Quality Improvement
QI	Quality Improvement
SCR	Shared Case Responsibility
UPMC	University of Pittsburgh Medical Center
WPIC	Western Psychiatric Institute and Clinic of UPMC

EXECUTIVE SUMMARY

On July 3, 2008, Pennsylvania Governor Edward G. Rendell signed Act 33 of 2008 into law. An amendment to the Child Protective Services Law (CPSL), Act 33 requires that circumstances surrounding cases of suspected child abuse resulting in child fatalities and/or near-fatalities be reviewed at both state and local levels. Allegheny County has embraced the legislative mandates of Act 33 through the implementation of a local Child Fatality/Near-Fatality (CFNF) review process. CFNF reviews, as part of the quality improvement efforts of the Allegheny County Department of Human Services (DHS), seek to identify systematic changes that will lead to improving service delivery to the children and families of Allegheny County.

Members of the CFNF Review Team share best practices and lessons learned with the aim of improving the health and safety of all children in Allegheny County. In addition, these reviews add greater transparency and accountability to DHS's review process by granting the public access to information related to each child fatality or near-fatality when abuse is suspected.

The CFNF Review Team examined 15 cases of child abuse that resulted in child death or near death during 2011. This report describes the findings from these reviews in order to inform the public of Allegheny County's efforts to protect child victims of suspected abuse and neglect, and to implement case practice and system reforms to reduce the likelihood of future child fatalities or near-fatalities.

Executive Summary
(continued)

Key Findings

Among the 15 cases reviewed by the CFNF Review Team (including eight child fatalities and seven near-fatalities):

- The number of fatalities and near-fatalities (15) increased in 2011 as compared to the previous two years (nine in 2009 and 10 in 2010). Eighty-eight percent of the children were age five years or younger; approximately half of those children were under one year of age. No teenagers were involved in fatal or near-fatal incidents. Almost half of the children were African American, 33 percent were white, and 20 percent were biracial or multi-racial.
- Act 33 requires a review of the regulatory and statutory compliance of the county child welfare agency any time a child is involved in an incident and when the child and family resided in the county within the 16 months preceding the incident. According to this regulation, slightly more than half of the 15 children (eight) were not known to Allegheny County CYF or to the child welfare agency of another county prior to the fatal or near-fatal incident.
    - One-third of the children (five of the 15) were never known to Allegheny County's child welfare agency.
    - Twenty percent of the children (three of the 15) were known to Allegheny County's child welfare agency more than 16 months prior to the fatal or near-fatal incident. One child had a closed family services case; the remaining two children (siblings) had been assessed upon referral, and the investigation determined that services were not necessary at that time.
    - Of the seven children who were known to Allegheny County CYF within the past 16 months:
        — Two children were currently active with CYF at the time of the incident: one active in CYF intake and one involved in ongoing family services.
        — Five were inactive at the time of the incident due to closure of their family services case.
        — A review of statutory and regulatory compliance by CYF in all seven of these cases was conducted by the CFNF Team and by DPW. In those cases where non-compliance was identified, a plan of correction was developed and implemented. These reports are available on the DPW website.
- Abusive head trauma was the leading cause of death or critical/serious injury, responsible for approximately half of all incidents.
- Eighty percent of the fatal or near-fatal incidents took place in the homes of parents.
- Abuse was substantiated in two (13 percent) of the fatalities and five (34 percent) of the near-fatalities; criminal court proceedings are pending in two of the fatality cases.

Executive Summary
(continued)

- All of the perpetrators of abuse were known to the victims; they were birth parents or intimate partners of the parent.
- Eighty-six percent of the perpetrators were known to a child welfare agency as a child (43 percent), parent (14 percent), or both (29 percent).
- Seventy-one percent of perpetrators had a criminal history.
- Eighty-eight percent of perpetrators had a documented history of domestic violence.

The CFNF Review Team made a number of recommendations to mitigate systemic gaps identified during the 2011 review process.

In response to recommendations regarding the need for parents to utilize appropriate caregivers for their children, the CFNF Review Team supported the 2011 Child Abuse Prevention Month campaign, "Choose Your Partner–Caregiver Carefully… Your Baby is Counting on You," promoted by DHS, in partnership with Family Resources, A Child's Place at Pittsburgh Mercy Health System, and other community partners. Public service announcements aired on local radio and television media outlets, and printed campaign materials were distributed locally via partners from the business, educational, health care, government and nonprofit communities.

BACKGROUND

Pennsylvania Act 33 of 2008

In 2008, Pennsylvania amended the state Child Protective Services Law (CPSL), Section 6365 (relating to services for prevention, investigation and treatment of child abuse), through the passage of Act 33 of 2008. The amendments were designed to include specific requirements related to county CFNF Review Teams. Act 33 mandates implementation of county child fatality/near-fatality reviews to understand the circumstances surrounding cases of suspected child abuse and neglect that result in child deaths or near deaths.[1] Act 33 requires the CFNF Review Team to convene by the 31st day of receipt of an oral report related to a child fatality or near-fatality if the status of the abuse investigation is substantiated[2] or if the status determination has not been made yet.

To improve transparency and accountability related to child fatality/near-fatality incidents when there is suspicion and/or substantiation of child abuse, Act 33 requires that the county release a written report on the child fatality or near-fatality. Pennsylvania's Department of Public Welfare (DPW) receives the report within 90 days of the convening of a CFNF review. The written report must also be released to the public no later than 30 days after its submission to DPW. The report includes:

- deficiencies and strengths in compliance with statutes, regulations, and service 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.

[1] Defined as acts that, as certified by a physician, put a child in serious or critical condition at the time of injury.

[2] The Pennsylvania CPSL mandates the reporting and investigating of suspected child abuse and neglect within required time frames and procedures. 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.

Allegheny County's CFNF Reviews

Allegheny County's CFNF review process builds upon the systemic approach of the Allegheny County Health Department's Child Death Review[3] and the case practice focus of the Emergency Response Meetings (ERMs) conducted by the Office of Children, Youth and Families (CYF). By conducting detailed reviews of child fatalities and near-fatalities and analyses of related trends, the Review Team is able to identify the strengths and challenges of child- and family-serving systems and to identify concrete actions that will serve to protect children from future abuse and neglect.

[3] Visit www.alleghenycounty.us/dhs/accfnf.aspx for more information.

The CFNF review process 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 local university with experience in child welfare practice, education and research. Review preparation is conducted by the DHS Office of Data Analysis, Research and Evaluation's (DARE) Quality Improvement (QI) team that works outside of the operational chain of command for child welfare, reporting directly to the DHS Director.

CFNF Review Team

The CFNF Review Team is composed of members who represent a cross-section of experts in the area of child abuse and neglect.

The standing team includes representatives from:

- Allegheny County DHS
- Allegheny County Health Department
- The Pennsylvania Department of Public Welfare (DPW)
- The Medical Examiner's Office
- The District Attorney's office
- Children's Court
- The CYF Advisory Board
- The Director's Action Line
- The Pittsburgh Bureau of Police (PBP) and the Allegheny County Police Department
- The legal community
- Community providers
- Community Care Behavioral Health Organization
- Child Advocacy Centers (Mercy Health System and Children's Hospital of Pittsburgh)

METHODOLOGY

Case Review Process

Case record review is frequently used in circumstances in which the family had previous involvement with CYF and in cases in which CYF has undertaken a Child Protective Services investigation based on current allegations of abuse or neglect, in order to understand complex processes and systems, particularly when the case is handled by multiple entities. Case reviews can be conducted to understand patterns of incidents within a jurisdiction; to understand causes of incidents and methods of prevention; to identify system-wide issues and barriers to effective service delivery; and to 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 group, as well as the methods used in casework to evaluate their effectiveness.

In conducting a CFNF review, the QI Team obtains all available information regarding the case by reviewing all relevant documents and 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 a CPS investigation related to the fatality or near-fatality under review.

Document Review[4]

The process for document review includes, but is not limited to, the following information:

- a review of the nature, intensity and frequency of services provided
- a review of the nature, quality and frequency of visits with the child and family
- a review of the investigation of prior reports of suspected child abuse and assessment of reports of general protective services
- a determination of whether: 1) the underlying issues were identified and if services were provided to address these issues; 2) a safety assessment was completed in accordance with established safety assessment and management process time frames; 3) the facts of the safety analysis support the safety decision; and 4) the actions taken and the services provided were appropriate to mitigate all identified safety threats and enhance protective capacities
- a determination of whether: 1) the risk assessment was completed in accordance with regulatory time frames; 2) the facts support the level of risk identified; and 3) the actions taken and the services provided were appropriate to the risk indicators identified
- an assessment of the frequency, appropriateness and quality of collateral contacts with agencies providing services to the child or family

[4] Members of the Allegheny County Review Team have been added to Section 6340 (relating to release of information in confidential reports) of the CPSL, which grants them access to child abuse reports and any other reports obtained concerning alleged instances of child abuse.

- the coordination and implementation of the family service plan to determine whether the plan meets the child's and family's individual needs and addresses the safety threats, diminished protective capacities and indicators of risk identified
- regulatory and statutory compliance
- an appraisal of the health and safety of all children in the family
- a review of the level and quality of services provided in accordance with the PA Child Welfare Practice Standards
- a review of the level of supervisory oversight and case monitoring

Interviews

Interviews are conducted with those people involved in the current CPS investigation as well as those involved with the family in cases in which the family had past CYF involvement. The purpose of the interview process is to clarify information contained in the case record and to ascertain the basis for agency decision-making in the case process. This interview process seeks to obtain the following:

- responses to the questions raised by the review of the case record
- confirmation of the validity of the data obtained through the document review
- information related to the interaction among all agencies involved with the case
- information regarding critical events
- case information that was available within the community but not shared with the county agency
- understanding of the relationship between the agency and the family
- understanding of the efforts to engage the family in the case planning process
- information that may not have been recorded in the case record
- information on the level of supervisory oversight and consultation between the county agency supervisor and worker

Those interviewed may include, but are not limited to, the following individuals who may have knowledge related to the case:

- agency caseworkers, supervisors or managers
- private agency caseworkers, supervisors or managers
- health care personnel and hospital social services staff
- subjects of the report, including the alleged perpetrator
- foster parents
- other family members/kin
- non-related household members

- witnesses or observers
- therapists
- law enforcement officials and district attorney
- guardians *ad litem* or court-appointed special advocates
- medical examiner
- educators

DATA ANALYSIS

The following is an analysis of the 15 child fatality and near-fatality incidents that took place in Allegheny County in 2011 in which there was suspicion of and/or substantiation of child abuse; eight of these incidents were fatalities and seven were near-fatalities. Vignettes contained in Appendix A provide an overview of some of these incidents.

CFNF Subject Children

Demographic Information

Table 1 provides demographic information on the subject children. Eleven of the 15 children (73 percent) were male. Forty-seven percent of the children were African American, 33 percent were white, and 20 percent were of two or more races. Eighty percent of the children were younger than age four, which is consistent with 2010 national statistics, wherein 79 percent of the children who died from maltreatment were younger than age four.[5]

[5] Children's Bureau, U.S. Department of Health and Human Services (2011) in *Child Maltreatment 2010* www.childwelfare.gov/can/fatalities.cfm

TABLE 1: Age, Race and Sex of Children in CFNF Cases (2011)

	AGES									
	0–1		2–5		6–12		13–17		TOTAL	
African American	**2**	**13%**	**4**	**27%**	**1**	**7%**	**0**	**0**	**7**	**47%**
Females	1	7%	0	0	0	0	0	0	1	7%
Males	1	7%	4	27%	1	7%	0	0	6	40%
White	**3**	**20%**	**1**	**7%**	**1**	**7%**	**0**	**0**	**5**	**33%**
Females	2	13%	0	0	1	7%	0	0	3	20%
Males	1	7%	1	7%	0	0	0	0	2	13%
Two or more races	**2**	**13%**	**1**	**7%**	**0**	**0**	**0**	**0**	**3**	**20%**
Females	0	0	0	0	0	0	0	0	0	0
Males	2	13%	1	7%	0	0	0	0	3	20%
TOTALS	**7**	**47%**	**6**	**40%**	**2**	**13%**	**0**	**0%**	**15**	**100%**

Prior Child Welfare Involvement of Children in CFNF Cases

Act 33 requires a review of 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.[6] By this definition, eight of the 15 children were not known to the child welfare system prior to the fatal or near-fatal incident.[7] One-third (five of the 15) were never known to the agency. Twenty percent of the children (three of the 15) were known more than 16 months prior to the fatal or near-fatal incident. Of those three, one child had a closed family services case following successful completion of in-home services by the parents. The other two children (siblings) had been assessed upon referral, and the investigation determined that services were not necessary at that time. The original referral was screened out because it was determined that the older child (the mother's only child at the time) was safe in that mother's care; the eventual perpetrator in the CFNF case, who subsequently became the father of the second child, was not involved in the original referral.

Of the seven children who were known to CYF within the past 16 months, two were currently active with CYF: one active in CYF intake and one involved in ongoing family services at the time of the incident. Five were inactive at the time of the incident due to closure of their family services case; all had a history of multiple contacts with CYF.

Although Act 33 requires that a review of statutory and regulatory compliance of CYF be completed for cases known to CYF within 16 months of the incident, the CFNF Team conducted these reviews on all 15 CFNF cases. The Review Team paid particular attention to the delivery of child welfare services to affected families prior to the event. In those cases where non-compliance was identified, a plan of correction was developed and implemented. These reports are available on the DPW website.

[6] For the purposes of both the CFNF review process and this report, examination of CFNF cases begins with the initial referral to CYF, in order to understand and improve decision-making along all possible points of intervention.

[7] Pa. C.S. §6343 relating to investigating performance of county agency mandates review of statutory and regulatory compliance by the county agency where the fatality occurred and the child resided within the 16 months preceding the fatality or near-fatality.

TABLE 2: **Involvement with Allegheny County Child Welfare (2011)**

CHILD WELFARE PRIOR KNOWLEDGE	FATALITY		NEAR-FATALITY		TOTALS[8]	
Not known within 16 months preceding the CFNF event	**4**	**27%**	**4**	**27%**	**8**	**53%**
• No involvement with agency	1	7%	4	27%	5	33%
• Closed case more than 16 months prior	1	7%	0	0	1	7%
• Referral not accepted for services following assessment more than 16 months prior to CF/NF event	2	13%	0	0	2	13%
Known within 16 months preceding the CFNF event	**3**	**20%**	**4**	**27%**	**7**	**43%**
• Active at time of Incident	0	0%	2	13%	2	13%
• Closed family services cases/inactive at time of incident	3	20%	2	13%	5	33%
TOTALS	**7**	**47%**	**8**	**53%**	**15**	**100%**

[8] Percentages throughout the report may not sum to 100 percent due to rounding.

Child Fatality or Near-Fatality Incidents

Cause of Injury or Death

In near-fatality incidents, the cause of injury is taken directly from the child's medical record. Cause of death in fatal incidents is cited from the medical examiner's report. In approximately half of the cases reviewed, the cause of injury or death was abusive head trauma.

TABLE 3: **Cause of Injury or Death in CFNF Incidents (2011)**

2011	FATALITY	NEAR-FATALITY
Abusive head trauma	0	7
House fire (anoxic brain injury and carbon monoxide/cyanide)	2	0
Gunshot (homicide)	2	0
Gunshot (self-inflicted)	2	0
Infection (hemorrhagic pneumonia)	1	0
Ingestion (methadone)	0	1
TOTALS	**7**	**8**

Location of Incident

In all but three of the cases, the injuries occurred in the home of the parent. One incident occurred in the home of a relative, and one occurred in kinship care (licensed out-of-home placement). In one case, the location of the event could not be determined due to the number of locations in which the child was present during the timeline for injuries. Since 2009, most CFNF events (involving 25 of 34 children) have occurred in the home of a parent. **Appendix B** depicts the municipality of residence of all children involved in CFNF incidents.

TABLE 4: **Location of Children in CFNF Events (2011)**

LOCATION OF CFNF EVENTS	2011
Home of parent	12
Home of relative	1
Kinship care (licensed out-of-home placement)	1
Unknown	1
TOTALS	**15**

Childline Status Determinations

In 2011, the CFNF Review Team examined 13 cases, comprising 15 children (including two families in which two siblings died). All but one CFNF event was investigated by CYF; the one case active with CYF Family Services at the time of the near-fatality incident required investigation by the Pennsylvania Department of Public Welfare (DPW), Office of Children, Youth and Families (CYF), as the child was in the care of her relative, a CYF-licensed day care provider.

Of the seven fatalities, abuse was substantiated[9] in one case involving two sisters (29 percent of fatalities). CYF unsubstantiated the abuse report in three of the cases (42 percent of fatalities) in which perpetrators could not be established because evidence did not meet the CPSL standard for serious physical neglect. An abuse determination is still pending (as of 12/30/11) substantiation by criminal court for another case involving two brothers (29 percent of fatalities).

The CPS investigation resulted in an abuse determination being made in all of the eight near-fatality cases. Abuse was substantiated in five of the cases (63 percent of near-fatalities) including the abuse investigation by DPW in which the child and her sibling were removed from the home of their kinship caregiver and placed in foster care. Abuse determinations were unsubstantiated in three cases (27 percent of near-fatalities) as the perpetrators could not be determined, and the actors remain unknown.

9 "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 where a county agency or 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 (plea of no contest).

TABLE 5: **Percentage of Substantiated Abuse Determinations by Children in CFNF Cases (2011)**

	2011	TOTAL PERCENTAGE
Fatality		
Substantiated	2 siblings	13%
Unsubstantiated	3	20%
Pending criminal court proceedings	2 siblings	13%
Near-Fatality		
Substantiated	5	33%
Unsubstantiated	3	20%
Pending criminal court proceedings	0	0
TOTALS	**15**	**100%**

Perpetrators

There were six cases in which eight actors were determined to be perpetrators. In two of the six cases in which abuse was substantiated, there was more than one perpetrator.

All of the perpetrators were known to the child victims of maltreatment. They were either a birth parent or an intimate partner of a parent or relative. For the purposes of this report, perpetrators are unique and counted only once regardless of the number of children the perpetrator is associated with maltreating or the number of records associated with a perpetrator.[10]

[10] Description of unique perpetrator taken from: Children's Bureau, U.S. Department of Health and Human Services (2011) in *Child Maltreatment 2010* www.childwelfare.gov/can/fatalities.cfm

TABLE 6: Relationship of Substantiated Perpetrator to Child in CFNF Incidents Resulting from Child Abuse and Neglect (2011)

	NUMBER	PERCENT
Mother	1	13%
Father	3	38%
Male intimate partner of parent	2	25%
Male intimate partner of relative	1	13%
Female intimate partner of parent	1	13%
TOTALS	**8**	**100%**

Demographic Information

The majority (86 percent) of perpetrators were male. Forty-two percent of perpetrators were between the ages of 26 and 33, and another 29 percent were under the age of 25.

According to case record reviews, four of the perpetrators were white and four were African American.

TABLE 7: Age, Race and Sex of Perpetrators in CFNF Cases in Allegheny County (2011)

	AGES											
	18–25		26–33		34–41		42–49		50 + OLDER		TOTALS	
African American	**1**	**13%**	**3**	**38%**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**50%**
Females	0	0	1	13%	0	0	0	0	0	0	1	13%
Males	1	13%	2	25%	0	0	0	0	0	0	3	38%
White	**1**	**13%**	**1**	**13%**	**0**	**0**	**2**	**25%**	**0**	**0**	**4**	**50%**
Females	1	13%	0	0	0	0	0	0	0	0	1	13%
Males	0	0	1	13%	0	0	2	25%	0	0	3	38%
TOTALS	**2**	**25%**	**4**	**50%**	**0**	**0**	**2**	**25%**	**0**	**0**	**8**	**100%**

Social Histories of Perpetrators

Social history information was obtained through examination of county databases, medical records, medical examiners' reports, law enforcement records and the CYF record. A perpetrator may not have volunteered information on one or more of the domains examined below.

TABLE 8: **Social History of Alleged Perpetrators in CFNF Cases in Allegheny County (2011)**

SOCIAL HISTORY	PERCENTAGE OF PERPETRATORS
Criminal history	71%
No criminal history	29%
Child welfare involvement[11]	
History of involvement as child or parent	86%
Known to CYF as a child	43%
Known to CYF as a parent	14%
Known to CYF as a child and parent	29%
Not known to CYF prior to event	14%
Domestic violence[12]	
History of domestic violence	88%
Protection from abuse (PFA) order filed	12%
No known history of domestic violence	12%
Substance abuse[13]	
History of substance abuse	25%
No known history of substance abuse	75%
Education	
High school diploma or equivalent	25%
No high school diploma or equivalent	25%
Technical or other training certification	0%
College, university or professional school	25%
Educational attainment unknown	25%
Employment	
Employed at time of event	75%
Not employed at time of event	25%
Behavioral health[14]	
History of involvement with mental health system	50%
Received mental health services	38%
No history of involvement with mental health system	50%

N = 8

[11] "Child welfare involvement" means that, through CYF case record review or disclosure by the perpetrator, it became known that a child welfare agency in the United States, not limited to Allegheny County CYF, opened an ongoing services case on the family of the perpetrator as a child or the family of the perpetrator as a parent.

[12] For the purposes of this report, a prior history of domestic violence includes: (i) a report of law enforcement; (ii) a filed protection from abuse order; or (iii) self-report of victim or perpetrator.

[13] Substance abuse treatment includes: (i) a diagnosis of substance dependency; (ii) participation in clinical treatment; or (iii) self-report.

[14] Behavioral health involvement includes mental health treatment and substance abuse treatment. Mental health treatment includes one or a combination of the following: (i) a confirmed mental health diagnosis; (ii) current or past participation in clinical treatment; and/or (iii) self-report of current or past participation in mental health services.

Child Welfare System Response

Open Child Welfare Case

Of the fatality and near-fatality cases reviewed, one was already open for ongoing family services. The child and her older sibling were removed from their kinship foster home and, after a brief respite with another family member, the sibling was placed in the home of a non-relative foster family. The child was discharged from the hospital to a foster home trained to care for medically fragile children. Despite placement in separate homes, the children continue to visit each other weekly. Criminal court proceedings are ongoing in this case.

Cases Opened by Child Welfare

CYF opened family services cases on eight (69 percent) of the cases reviewed, including one that was already undergoing a General Protective Services (GPS) assessment at the intake level and was later accepted for ongoing family services. CYF opened a Family Services case in response to two fatalities to ensure the safety of the surviving siblings. In one of these two deaths in which the CPS investigation did not reveal substantial evidence of neglect, a child had succumbed to infection after a delay in seeking medical care by his kinship caregivers through informal arrangement. The older sibling remained in the care of a relative that was already caring for the child through informal family arrangement prior to her sibling's death. The mother later consented to permit that relative to become her surviving child's legal guardian.

The second fatality involved a child who sustained a self-inflicted gunshot wound from using the handgun belonging to a houseguest. The mother and the surviving sibling moved in with a relative for support.

CYF opened Family Services cases for six of eight children suffering serious injuries. In half of these near-fatality incidents, abuse was substantiated. Criminal court proceedings were ongoing for all three cases. In one of the three cases, the child was discharged from the hospital to the care of his mother. CYF opened a case to assist the mother with housing and follow-up medical appointments. The children in the other two cases were placed into kinship care foster homes and participate in supervised visitation with their mothers.

Of the three unsubstantiated cases, the one open for assessment in intake involved a child who ingested his mother's methadone at home while the mother and older sibling were sleeping. Both children were adjudicated dependent. While the other two children suffered significant injuries, the CPS investigation was unable to determine the alleged perpetrators. One child was placed in foster care and later placed with relatives. The other child was placed with kin and later returned to the care of his parents. The law enforcement investigation remains ongoing in this case.

Cases Not Opened by Child Welfare

For the remaining six children (four of 13 total cases), CYF involvement ceased upon conclusion of the CPS investigation at intake level. It should be noted that the CYF involvement ended upon the conclusion of the CPS investigation in five of the child fatality cases because there were no surviving children in the household. (There were two sibling groups: two sisters who died from gunshot wounds and two brothers who died in an apartment fire; the fifth child accidently killed himself in his family home with his father's handgun while his parents were in another room.) Regarding the near-fatality closed at intake, abuse was substantiated against the mother's intimate male partner, and the child was released to the care of his mother upon his discharge from the hospital.

TABLE 9: **Child Welfare Response to CFNF Referrals by Fatality or Near-Fatality (2011)**

	FATALITY	NEAR-FATALITY	TOTALS
Already open in Family Services	0	1	1
Accepted for Family Services	2	6	8
Closed at intake	5	1	6
TOTALS	**7**	**8**	**15**

All of the families whose child suffered a fatality or near-fatality were offered services to address a host of issues. Those services included:

- Grief counseling
- Anger management services
- Housing assistance
- Family Group Decision Making
- Substance abuse treatment
- Developmental screenings
- Behavioral health rehabilitation services
- Parenting classes
- Child care and medical day care
- In-home services
- Coordination of supports for people with intellectual disabilities
- DHS justice-related services
- Medical assistance transportation
- Psychological evaluations
- Victim and witness assistance services

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In a continuing effort to protect children from abuse and neglect, Allegheny County has supported the legislative mandates of Act 33 through the implementation of a local CFNF Review Team process that is chaired by an independent expert in the area of child abuse and neglect. This process has become a foundation for determining root causes of suspected child abuse and neglect that result in tragedies for children, their families and the community. By conducting detailed reviews of child fatalities and near-fatalities, the CFNF Review Team has been able to delve into the specific circumstances and events that led to the devastating outcome, resulting in a better understanding of Allegheny County's child-serving systems' strengths and challenges and identifying concrete actions that serve to protect children from future abuse and neglect.

Recommendations

The CFNF Review Team's recommendations for reducing the likelihood of fatality and near-fatality incidents caused by abuse and neglect focus on the need for improved education and training, communication and collaboration, and service delivery among public and private organizations. The CFNF Review Team plans to build upon the efforts of this mandated process to robustly protect the children of Allegheny County from abuse.

CFNF Recommendations: Key Themes

Timeliness of Reporting to CYF and Law Enforcement Agencies

- The team recommended that the PA Crimes Code §5106, Failure to Report Injuries by Firearm or Criminal Act, be amended to specify a required timeline for reporting.

Review of Joint Investigative Protocol

- The Allegheny County Office of the District Attorney facilitated a collaborative meeting with CYF, the District Attorney's Office, law enforcement and child advocacy centers to review the Joint Investigative Protocol related to: joint interviewing and investigative procedures; planning and implementation of videoconferencing with two regional Child Advocacy Clinics; prompt hospital reporting to local law enforcement agencies and reinforcement of reporting to local law enforcement agencies; and cross-systems training on the protocol (June 2011).

Safety Assessment Management Process

- All CYF staff at regional offices completed training on both DataVue, a DHS database of county services provided to Allegheny County consumers, and on diligent search methods for families whose whereabouts are not immediately known (May 2012).
- CYF casework staff received additional training on: development of individualized, assessment-based Family Service Plans; the Child and Adolescent Needs and Strengths (CANS) assessment tool; and the Safety Assessment Management Process (May and June 2012).
- CYF administration and internal quality assurance staff reviewed internal and external case closure documents and found that they align. Established protocol is regularly reviewed during Permanency Planning Conferences; at trainings, NGA and other interdisciplinary team reviews; and at supervisory reviews, as well as at orientation and ongoing training (required) for all casework staff.
- State Training Documents on Safety, Risk, Case Closure and Case Closure for Sexual Abuse have been posted to a networked policy portal for CYF casework staff to review for guidance, and Family Group Decision Making's and Inua Ubuntu's Case Closure Guidelines are shared with provider staffs.
- All CYF casework staff received additional training on risk and safety assessments and plans, service selection, and provision to further reinforce case closure guidelines (October 2011).
- KIDS electronic case management User Manuals and Job Aids have been developed and updated to assist casework staff in data entry.
- CYF administration issued Practice Memoranda with revised directions on visiting children at home and in foster care, standards for frequency of visits with infants, and tiered management solutions to help staff correctly track visits with children (April 2010).
- In an effort to assist in decision-making, the CYF Training Department developed a Safety Assessment Management Process checklist, which has been posted for staff use until the state issues final guidelines.
- DHS is in the process of implementing Safe Measures, a reporting tool developed by the Children's Research Center and designed to support ongoing accountability and quality improvement processes. Using this tool, CYF supervisors and caseworkers will monitor their work to ensure compliance with local case practice standards, as well as with state and federal standards, to measure outcomes.

Domestic Violence

- Women's Center and Shelter committed to continuing to provide education and training for local law enforcement agencies (2009).
- CYF launched a CFNF Implementation Plan in response to recommendations made by the CFNF Review Team. Among the first issues addressed was the need to bolster provider capacity regarding safety planning in families in which domestic violence is present. In response, contract requirements were adjusted for provider agencies. Service descriptions now include detailed processes regarding assessment, intervention and treatment referrals. Providers have been instructed to inform CYF caseworkers when signs of domestic violence are observed. Evaluations by the CYF Contract Monitoring Unit broadened in scope to include domestic violence services for adolescents, youth participating in Independent Living and residential services, and teen mothers and fathers. Quality improvement efforts continue to encourage development of services for providers lacking services to address domestic violence, accessibility of services, and expansion of services to at-risk populations (e.g., fathers in care, teen parents and transition-aged youth ages 16–21) (October 2009).
- The Center for Victims of Violence and Crimes and WomenSpace East provided training to CYF providers. Domestic violence risk factors are a component of domestic violence training for all CYF staff (Spring 2009).
- The Allegheny County Court of Common Pleas launched a review of domestic violence programming for court-referred offenders. DHS will: conduct the quality improvement process evaluation to determine the effectiveness of the programs to which clients are referred; review best practices in the handling of domestic violence cases; and evaluate how those programs to which convicted offenders are referred by the court incorporate these practices and standards (Spring 2012).

Communication and Collaboration across Public and Private Agencies

- DHS's Office of Behavioral Health performed an assessment of on-site behavioral health services within the juvenile detention facility. The evaluation indicated that the current hours of service, along with the mobile crisis team from Western Psychiatric Institute and Clinic (WPIC) of UPMC, were adequate to address the needs of youth in the facility. WPIC works together with detention center administration to provide mental health training that enhances the ability of staff to aid youth (June, July 2009).
- CYF and Juvenile Probation Office staff received training to introduce new Shared Case Responsibility (SCR) policy. SCR policy establishes collaborative planning and service provision guidelines for CYF staff working with youth and families who are served by both agencies, and addresses the following: joint case management; notification of case closure; confidentiality and information sharing; and combined court proceedings when the case is active with both agencies (August–September 2011).

Community Education on Child Development, Gun Safety and Family Violence Prevention

- The Allegheny County Health Department (ACHD) issued a Web-based press release, "Stopping Unintentional Shooting Starts with Gun Education," reminding residents that unintentional firearm deaths, especially involving children, can be prevented by taking simple precautions. Those precautions are listed on the ACHD website (August 2011).
- Children's Hospital of Philadelphia granted permission for DHS to post on its website and to reprint the hospital's gun safety brochures, *Gun Safety: A Monster in the Closet is the Least of Your Concerns* and *Seguridad con las armas de fuego — Un monstruo en el armario es en realidad su menor preocupación*, offering suggestions for staying safe when firearms are present in living quarters.
- In recognition of Child Abuse Prevention Month, DHS launched the "Choose Your Partner Carefully…Your Baby is Counting on You" Campaign, in collaboration with Family Resources and Pittsburgh Mercy Health System and with the support of other community partners, to raise awareness about prevention of child abuse. The campaign was created to remind parents that choosing an appropriate caregiver for a child, including a care-giving partner, is one of the most important decisions a parent can make. Campaign materials — brochures, posters, flyers and bus cards — are available on the DHS website and have been distributed locally and across the state by community partners (March 2011).

APPENDIX A: SAMPLES OF CFNF CASE INCIDENT VIGNETTES

A seven-year-old female child and a fifteen-month-old female who were siblings died as a result of a gunshot wound at their home. Emergency services received telephone calls reporting that gunshots were heard in the vicinity of the family residence. Witnesses reported hearing a domestic incident inside the home moments leading up to the gunshots. Law enforcement responded to the scene and found the two children, their mother and the mother's intimate partner deceased in the family home. Law enforcement determined that the mother's intimate partner, who was the father of the younger child, was the perpetrator of the triple homicides and had inflicted a gunshot to himself. CYF indicated the child abuse reports against the deceased perpetrator. The family had previous involvement with CYF.

Recommendation

- Increased education about domestic violence issues

Outcomes

- Women's Center and Shelter committed to continue providing education and training for local law enforcement agencies (2009).
- *Violence Prevention and Help for Those Affected by Violence* resource guide, contained within the DHS Community Referral Packet, is published online on the DHS website.

A two-year-old male child was in the sole care of his mother when she discovered him as unresponsive, with an empty bottle of methadone. The mother surmised that the child had ingested methadone that belonged to her as part of her medication maintenance treatment program. The mother contacted emergency medical services after first soliciting advice from a relative who was medically trained. EMS responded to the home, induced vomiting, treated the toddler with Narcan, and then transported him to the local pediatric hospital. The hospital treated the toddler with another dose of Narcan, transferred him to the intensive care unit for observation, and discharged him two days later to the home of a relative while CYF continued its assessment of the family home. The child required no medical follow-up. CYF CPS investigation related to the mother's alleged lack of supervision that resulted in the medication ingestion revealed no substantial evidence to support repeated or prolonged lack of supervision of the child. CYF instituted community in-home services to address the family's needs, and the mother reportedly cooperated with the services. The injured child was temporarily placed with a relative while CYF conducted further assessment and worked to strengthen the mother's parenting abilities. CYF also filed a dependency petition for both children. The family had previous involvement with CYF.

Recommendations

- Communication with narcotic treatment providers that use methadone for maintenance of people deemed appropriate by a narcotic treatment physician in consultation with substance abuse treatment staff involved in patient's care to ensure that safety precautions for medication storage are shared with consumers, particularly those consumers with children in the home
- DHS staff training on use of DHS data sources to better identify other systems that may be involved with consumers for family finding, case assessment and case planning purposes
- Administrative review of cases that involve families who cannot be located and/or contacted to conduct timely on-site assessments of child safety

Outcomes

- Narcotic Treatment Program Standards issued by the Pennsylvania Department of Public Health are prescriptive and establish a host of controls for circumstances in which patients have achieved the at-home medication administration level.
- Community Care Behavioral Health Organization (CCBHO), the county's behavioral health managed-care agency, is reviewing the issue of safety around methadone take-home privileges within two workgroups: a methadone and benzodiazepine group led by the CCBHO medical director, and a Drug and Alcohol Providers group that develops best-practice standards.
- All CYF staff at regional offices completed training on both DataVue, a DHS database of county services provided to Allegheny County consumers, and on diligent search methods for families whose whereabouts are not immediately known (May 2012).
- DHS Office of Data Analysis, Research and Evaluation is to conduct an evaluative study on safety assessment to assess fidelity to current policies and procedures and understand operational strengths and deficiencies in efforts to inform administrative decision-making (Fall 2012).

A three-year-old male child died as a result of a gunshot wound at his home. The child was in the care of his mother and father at the time of the fatal event. The child fatally shot himself with his father's handgun that was left unsecured in his parents' bedroom. Law enforcement and emergency medical services responded to the family residence where the child was pronounced dead at the scene. The CPS investigation did not reveal serious physical neglect, and the abuse determination was unfounded. The parents have no other children. The family had previous involvement with CYF.

Recommendation

- Development and promotion of a community public awareness campaign on gun safety

Outcomes

- The Allegheny County Health Department issued a Web-based press release, "Stopping Unintentional Shooting Starts with Gun Education," reminding residents that unintentional firearm deaths, especially involving children, can be prevented by taking simple precautions. Those precautions are listed on the Health Department's website (August 2011).
- Children's Hospital of Philadelphia granted permission for DHS to post on its website and to reprint the hospital's gun safety brochures, *Gun Safety: A Monster in the Closet is the Least of Your Concerns* and *Seguridad con las armas de fuego — Un monstruo en el armario es en realidad su menor preocupación*, offering suggestions for staying safe when firearms are present in living quarters.

A three-year-old male child died in 2011 as a result of a gunshot wound at his home. The maternal grandmother called 911 when she heard shots fired inside the building while sitting outside with other relatives and with the mother's boyfriend. Police responded to the family home where the child was pronounced dead at the scene. The mother stated that she was unaware that the brother of her boyfriend was in possession of a gun when she gave him permission to stay overnight. After lying on the children's bed with both children present, the visitor reportedly joined the mother in another room and later heard a gunshot from the bedroom. The visitor fled the home with the gun prior to emergency response personnel's arrival. The mother was named as the alleged perpetrator of the ChildLine report for failure to provide adequate supervision. This report was determined to be unfounded. The visitor was later arrested and pled guilty to Involuntary Manslaughter and Reckless Endangerment of Another Person. He was sentenced to five years of probation. CYF immediately instituted a safety plan for the deceased child's sibling, and both the mother and the child moved in with the maternal grandmother after CYF assessed the home's safety. The family had pevious involvement with CYF.

Recommendations

- Promotion of a gun safety campaign to promote community access to gun safety locks and increased community awareness of safe practices with guns
- CYF review and reinforcement policies related to: timelines for face-to-face visitation with children; *Section 3490.61(a)* of the OA CPSL, related to supervision of reports of suspected child abuse; and *Section 3490.232(e)* of the PA CPSL, related to completion of assessments within 60-calendar days

Outcomes

- See above for gun safety educational outreach to community
- CYF administration issued Practice Memoranda with revised directions on visiting children at home and in foster care, standards for frequency of visits with infants, and tiered management solutions to help staff correctly track visits with children (April 2010).
- CYF casework staff received additional training on the Safety Assessment Management Process (May and June 2012).

APPENDIX B: MAP OF HOUSEHOLD ADDRESS OF CHILDREN IN CFNF INCIDENTS

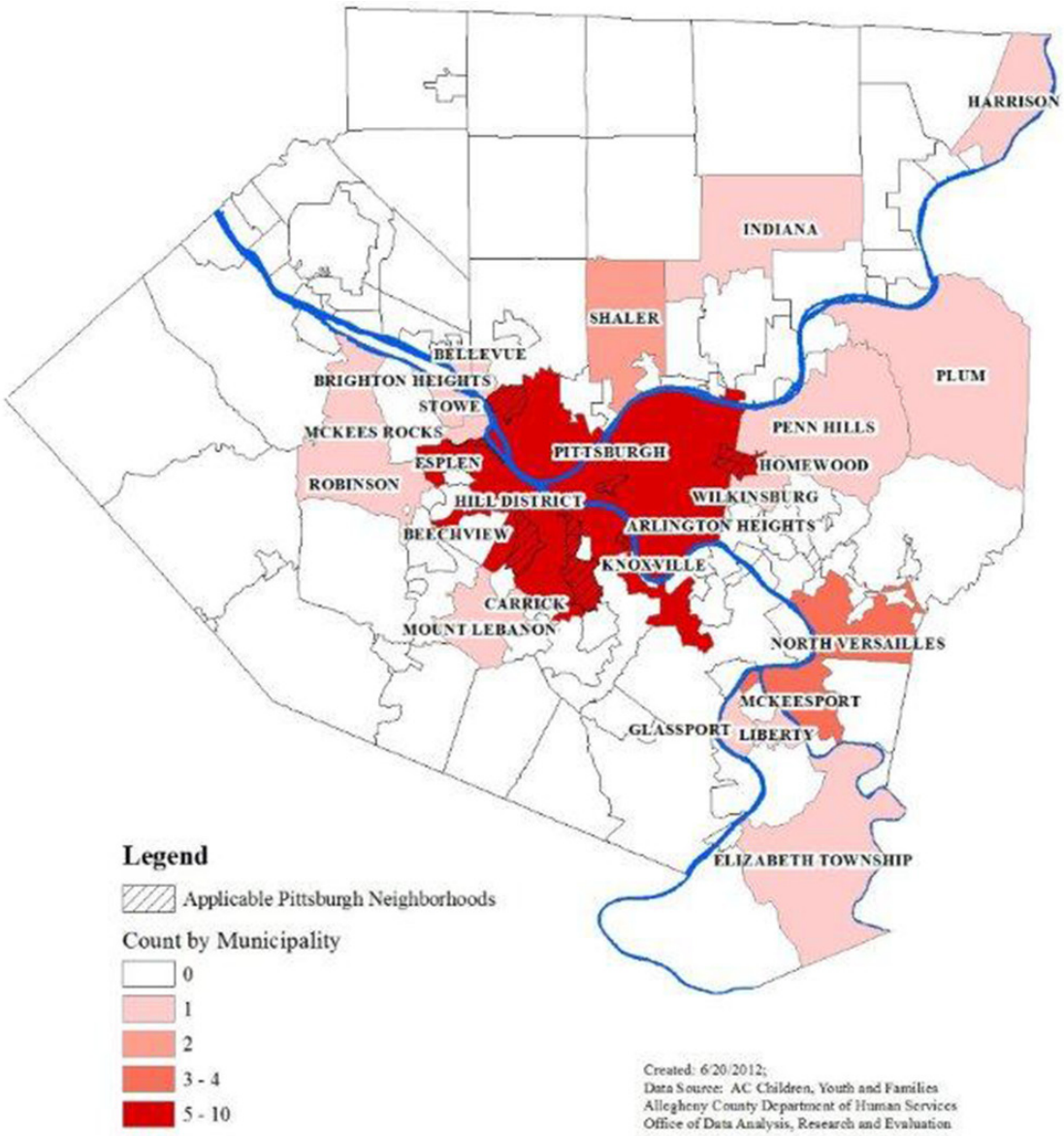
Of the 34 children involved in a fatal or nearly fatal incident resulting from suspected maltreatment since 2009, 33 resided within Allegheny County. One child dwelled out of state and suffered serious injuries while visiting his father. Mapping provides a visual representation of data useful in the identification of trends across geographic regions. The spatial analysis of CFNF data demonstrated no correlation between the community of residence and the likelihood of that child being involved in a CFNF event. Localities of child residency were varied among boroughs, cities and townships. Pittsburgh is the most populous municipality in the county; therefore, it is unsurprising that nearly a third of all children (10) resided in Pittsburgh. Regarding neighborhoods within the City of Pittsburgh, there were two CFNF incidents in Homewood and one event in each of the following neighborhoods: Allentown, Arlington Heights, Beechview, Brighton Heights, Carrick, Esplen, Knoxville and the Hill District.

TABLE 10: **Municipality of Residence of Children in CFNF Incidents (2011)**

MUNICIPALITY	COUNT
Avalon Borough	1
Bellevue Borough	1
Elizabeth Township	1
Glassport Borough	1
Harrison Township	1
Indiana Township	1
Borough of Liberty	1
McKees Rocks Borough	1
McKeesport	4
Mount Lebanon	1
North Versailles Township	3
Other (Norfolk, VA)	1
Penn Hills Township	1

MUNICIPALITY	COUNT
Pittsburgh	10
Allentown	1
Arlington Heights	1
Beechview	1
Brighton Heights	1
Carrick	1
Esplen	1
Hill District	1
Homewood	2
Knoxville	1
Plum Borough	1
Robinson Township	1
Shaler Township	2
Stowe Township	1
Wilkinsburg	1
TOTAL	**34**

Allegheny County Act 33 Fatalities and Near-Fatalities by Primary Address of Child (2009–2011)



GLOSSARY

Child: A person under 18 years of age

Child Abuse: 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 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 failure to provide the essentials of life, including adequate medical care, that endangers a child's life or development or impairs the child's functioning

Child Care Service: A child day care center, a group or family day care home, or a residential facility

ChildLine: The Pennsylvania Department of Public Welfare Office of Children, Youth and Families' ChildLine and Abuse Registry

Failure to Act: When a person knowingly allows a child to be abused by another person, or the person places the child in a situation in which they know that the child will be at risk of abuse and abuse does occur

Founded Report: A report, if there has been any judicial adjudication, based on a finding that a child who is a subject of the report has been abused, including the entry of a plea of guilty or nolo contendere or a finding of guilt to a criminal charge involving the same factual circumstances involved in the allegation of child abuse

Indicated Report: A report of child abuse if an investigation by CYF or DPW determines that substantial evidence of the alleged abuse exists based on any of the following:

- Available medical evidence (photographs or x-rays may be used, but injuries do not have to be visible or current)
- The Child Protective Services (CPS) Investigation (statements of the child, parents)
- An admission of the acts of abuse by the perpetrator

Glossary *(continued)*

Law Enforcement Official: The Attorney General, a County District Attorney, a State Police Officer, a County Sheriff, a County Police Officer, a County Detective, or a Local or Municipal Police Officer

Medical Neglect: Withholding of medically indicated treatment (including appropriate nutrition, hydration and medication) or failure to seek appropriate medical or dental care that results in a condition or impedes functioning

Nolo Contendere: A plea of no contest

Pending Court Activity: When status determination of a ChildLine report cannot be made within 30 calendar days because of pending Juvenile (for juvenile alleged perpetrators) or Criminal Court charges

Perpetrator: Those who can be named as an alleged perpetrator of a ChildLine report are: a parent of a child, a paramour of a child's parent, a person 14 years of age or older residing in the same home, a person responsible for the child's welfare [see definition below], a school employee who has direct contact with the student, or a person who is employed by or acting as a volunteer for a child care service, including a child day care center, a group or family day care home, or a residential facility

Person Responsible for a Child's Welfare: Person who provides permanent or temporary care/supervision, a person who provides a mental health diagnosis or treatment, or a person who provides training or control of a child in lieu of parental care, supervision and control

Recent Act or Failure to Act: An act or a failure to act committed within two years of the date of the report of suspected child abuse

Serious Bodily Injury: Bodily injury that creates a substantial risk of death or causes serious permanent disfigurement or protracted loss or impairment of function of any bodily member or organ

Serious Mental Injury: A psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment, that:

- renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that his or her life or safety is threatened, or
- seriously interferes with a child's ability to accomplish age-appropriate developmental and social tasks

Serious Physical Neglect: A physical condition caused by the act or failure to act of a perpetrator that endangers a child's life or development or impairs a child's functioning, and is the result of prolonged or repeated lack of supervision or failure to provide essentials of life, including adequate medical and dental care

Glossary *(continued)*

Status Determination: Results of the ChildLine investigation, whether indicated, founded, unfounded or pending court action

Substantial Evidence: Evidence that outweighs inconsistent evidence and that a reasonable person would accept as adequate to support a conclusion

Substantiated Report: "Substantiation" is a legal term that includes two types of child abuse investigation status determinations: *indicated* and *founded*. An *indicated* report is a child abuse report where 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 Services 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

Unfounded Report: A report that is not true or cannot be proven, or the report does not meet the legal definition of child abuse or student abuse