DATA BRIEF:

Allegheny County Child Fatality and Near-Fatality Reviews, 2014 and 2015

June 2016

Act 33 of 2008, an amendment to the Child Protective Services Law, requires state and local reviews of all child fatalities and near-fatalities (CFNF) resulting from suspected child abuse. In Allegheny County, these reviews are coordinated by the Quality Improvement Team within the Department of Human Services (DHS), chaired by Dr. Mary Carrasco, a renowned pediatrician with a specialty in the field of child abuse and neglect, and facilitated by Dr. Elizabeth Winter, Assistant Clinical Professor at the University of Pittsburgh, School of Social Work and Academic Coordinator of the Child Welfare Education for Leadership Program (CWEL).[1] The review team includes representatives with a wide range of expertise in the area of child abuse and neglect:

- DHS representatives, including the Offices of Children, Youth and Families, Behavioral Health, Community Relations and Integrated Program Services
- The Allegheny County Health Department, Medical Examiner and District Attorney
- The Pennsylvania Department of Human Services, Office of Children, Youth and Families, Western Region
- Pittsburgh Bureau of Police and Allegheny County Police Department
- Community providers, including the Children's Hospital of Pittsburgh's Child Advocacy Center
- Community members appointed to the DHS Child Welfare Advisory Board

1 Dr. Edward W. Sites, Professor Emeritus of Social Work, University of Pittsburgh, facilitated the CFNF Review Team from 2009 through 2014.

Prior to each meeting of the CFNF Review Team, the DHS Quality Improvement Team gathers information about the incident from a variety of sources:

- **Case records and all other relevant and available documents/data** are reviewed to inform an understanding of the details and cause(s) of the incident; previous social and human services experience; possible actions (prevention or intervention) that could have impacted the outcome(s); case practice and/or systemic issues and potential barriers to addressing those issues; and information about the family's and perpetrator's service and social histories.
- **Interviews** are conducted with appropriate county and provider agency staff, as well as anyone else with information relevant to the incident, in order to clarify and/or validate information discovered in the document and case record reviews and to ascertain the basis for decision-making in the case process.
- The **Medical Examiner's report** and/or current and past **medical reports** (e.g., hospital, physician) are reviewed for cause of death or injury, for medical history, and for additional information about the child, family and perpetrator

A summary of information is presented at the review meeting and discussion occurs to clarify the events and make practice, policy and system recommendations. Individual incidents are also considered in light of other incidents to determine possible patterns and consider ways to prevent future occurrences.

CHILD FATALITY/NEAR-FATALITY INCIDENTS, 2014 AND 2015

During 2014 and 2015, 25 CFNF incidents were reviewed. Of the 25 incidents, 13 were fatalities and 12 were near-fatalities, although four of the children originally reported as a near-fatality later died as a result of the injuries. With the exception of the drowning deaths of two brothers, the cases involved a single child.

Victim Demographics

Figure 1 shows that more than half of the children were six months of age or younger. The youngest child was one month old and the oldest was 16.

FIGURE 1: **Age of Children, CFNF Incidents, 2014 and 2015**

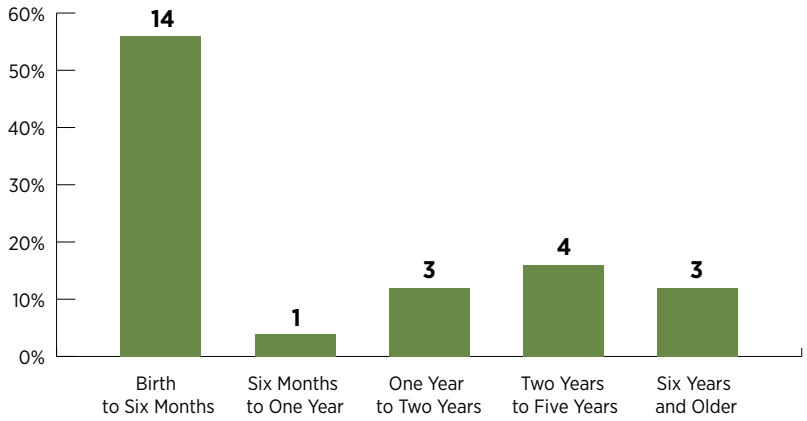
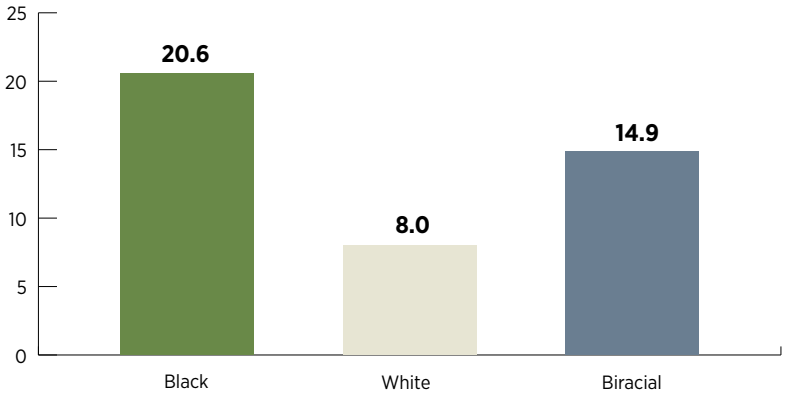


Figure 2 shows combined child fatalities and near-fatalities per 100,000 population by race to adjust for the total population of black, white and biracial children in Allegheny County (2010 U.S. Census). White children were more often the victim of a fatal incident while black and biracial children were more likely to be involved in a non-fatal incident.[2] Many child victims of non-fatal incidents will continue to experience significant health and other consequences.

2 See Appendix for demographic details about fatalities and non-fatal incidents.

FIGURE 2: **Race of Children, by Rate per 100,000, 2014 and 2015**[3]



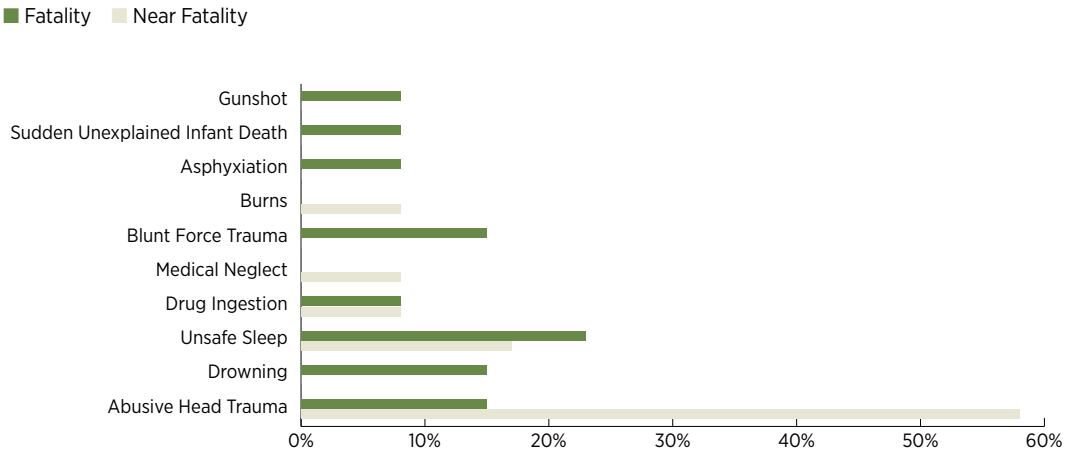
3 Rates were calculated using the total number of Allegheny County children, birth through 18, in each race category: 43,792 black children, 174,448 white children and 13,401 biracial children.

Of the 25 fatality and near-fatality cases, 56 percent (14) were male and 44 percent (11) were female.

Cause of Fatalities and Near-Fatalities

Figure 3 shows the causes of all fatalities and near-fatalities, as determined by the Medical Examiner's Office and/or medical reports. Abusive head trauma was cited most frequently, accounting for 58 percent of near-fatalities and 15 percent of fatalities. Twenty-three percent of fatalities were due to unsafe sleep situations, and one or both caregivers in each of these cases had untreated or inadequately treated substance use disorders. Caregivers' impaired judgment and/or inability to awaken — and resulting inability to respond quickly enough to prevent brain injury or death — posed significant safety threats to the children.

FIGURE 3: **Causes of Fatalities and Near-Fatalities**



Location of Incidents

Seventy-two percent (18) of all incidents occurred in the child's home[4] and 20 percent occurred in the home of a relative or intimate partner. Among the remaining two incidents, one fatality occurred in a licensed group home facility and one fatality involved a child found deceased in a wooded area.

4 In one incident, the near-fatality occurred in the home because the mother removed the child from the hospital against medical advice.

Perpetrator Demographics and Social History

Not all perpetrators were known, but of those who were known:

- Age ranged from 14 to 53, with 44 percent of named perpetrators falling within the ages of 25 through 34
- Fifty-nine percent were white and 30 percent were black
- Fifty-eight percent were male and 42 percent were female

- Their relationship with the child included parent, parent's intimate partner, caregiver and unknown.
  - 34 percent (11) were identified as mothers
  - 34 percent (11) were identified as fathers
  - nine percent (three) were identified as intimate partners of parents
  - 13 percent (four) were identified as caregivers, including one staff member in a licensed facility, one unpaid kinship caregiver and two pre-adoptive parents through a private adoption agency
  - nine percent (three) were identified as unknown perpetrators

- Seventy-six had a history of involvement with social/human services systems, determined by a combination of methods, including case record reviews, interviews, and review of client data from the DHS Data Warehouse and other public data sources.
  - 38 percent had been involved with the criminal justice system
  - 35 percent had a history of intimate partner violence, either as a perpetrator or a victim
  - 28 percent had been involved with mental health services
  - 26 percent had been involved with child welfare as a child
  - 22 percent had been involved with substance use services

Educational and employment histories showed that 44 percent of known perpetrators had completed high school and 41 percent were unemployed at the time of the incident.

Non-Offending Parent Demographics and Social History

Information about the non-offending parents is helpful in more fully describing the characteristics of those adults responsible for the child's safety.

- Age ranged from 14 to 59, with 37 percent falling within the ages of 25 through 34
- Sixty-one percent were white and 39 percent were black
- Fifty-two percent were female and 48 percent were male
- Seventy percent had a history of involvement with other social/human services systems, determined by a combination of methods, including case record reviews, interviews, and review of client data from the DHS Data Warehouse and other public data sources:
  - 39 percent had been involved with the criminal justice system
  - 30 percent had been involved with child welfare as a child
  - 26 percent had a history of intimate partner violence, either as a perpetrator (two) or a victim (five)[5]
  - 22 percent had been involved with mental health services
  - nine percent had been involved with substance use services

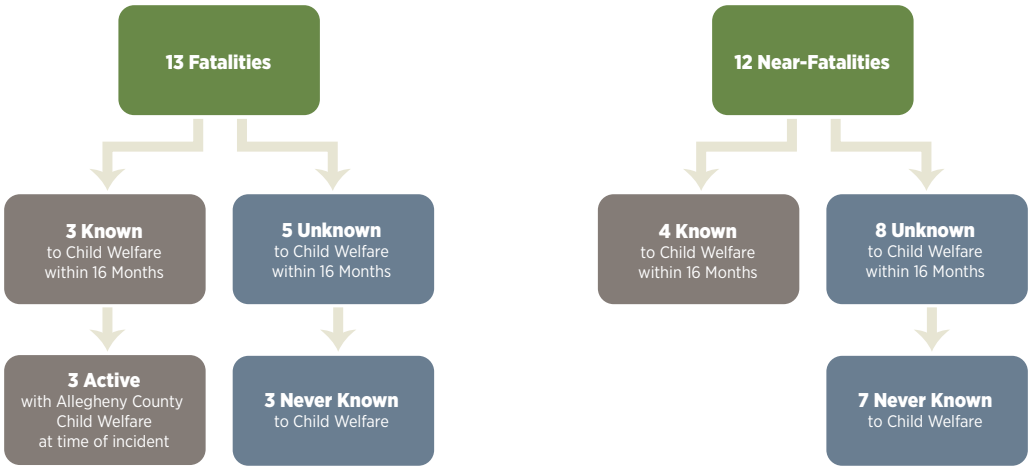
5 One parent had been both a victim and a perpetrator of Intimate Partner Violence.

Twenty-one percent of non-offending parents were college-educated, while 17 percent had completed some high school. Thirty-five percent of non-offending parents were unemployed.

Family Involvement in Child Welfare

An important component of the review is to determine whether the family had prior or current child welfare involvement at the time of the incident. The CFNF Review Team looks at whether families had involvement with any child welfare office within 16 months preceding the event and what that involvement entailed. **Figure 4** details this involvement:

FIGURE 4: **Child Welfare Involvement Prior to Incident**



The following describes the circumstances of the three cases with which Allegheny County child welfare was involved at the time of the fatality:

- A 16-year-old boy had been active with the Allegheny County child welfare system for two months prior to his death. He had been placed in a congregate care setting because of significant behavioral challenges and died after sustaining injuries in an altercation with two other boys in the facility.
- A three-month-old male infant died as a result of an unsafe sleep situation at the family home. The family was active with child welfare at the time of his death, and had been involved with child welfare and other human services for more than a year. Both parents were known to have substance use disorders, and the deceased infant's two siblings had been in out-of-home placement because of parents' inability to care for them. The child welfare system had not sought dependency status for the infant prior to his death as one sibling had recently been returned home and planning was underway for the other sibling to be returned. Both parents pled guilty to criminal charges associated with the infant's death.

- A one-month-old male infant, exposed to illegal substances and born prematurely, died as the result of an unsafe sleep situation while in the custody of a relative. The infant was found sleeping with both parents in a twin bed at the home of his kinship caregiver. The family had been referred to child welfare at the time of the infant's birth because of active parental substance use and his mother's lengthy history with child welfare. The agency was in the process of assessing the family's needs at the time of the fatality, and a dependency petition for the infant was pending. The law enforcement investigation into the infant's death remains ongoing.

Child welfare pursued the following course of action in regard to the remaining 22 cases:

- Family Service cases were opened on 15 families after the incident (four fatalities and 11 near-fatalities).
- Family Service cases were not opened for the other seven cases (six fatalities and one near-fatality). Cases were not opened on these families, either because there were no surviving children (in four cases) or because a safety plan was implemented that assured that the child was with either a non-offending parent or a legal guardian. However, abuse was substantiated and criminal court proceedings remain ongoing in four of the seven cases.

CONTENT AND ANALYSIS
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APPENDIX: DEMOGRAPHICS OF CHILDREN BY FATALITY AND NEAR-FATALITY

Age of Children by Incident Type

AGE RANGE	FATALITIES	NEAR-FATALITIES
Birth – Six Months	6	8
Six Months – One Year	0	1
One Year – Two Years	3	0
Two Years – Five Years	2	2
Six Years – Older	2	1

Gender of Children by Incident Type

GENDER	FATALITIES	NEAR-FATALITIES
Male	7	7
Female	6	5

Race of Children by Incident Type

RACE	FATALITIES	NEAR-FATALITIES
White	9	5
Black	4	5
Biracial	0	2