DATA BRIEF: Allegheny County Child Fatality and Near-Fatality Reviews, 2017

The 2008 Act 33 Amendment to the Child Protective Services law requires state and local reviews of all child fatalities and near-fatalities[1] resulting from suspected child abuse.

In response, Allegheny County Department of Human Services (DHS) conducts a comprehensive and multidisciplinary review of child fatalities and near-fatalities in cases where there is suspicion of child abuse or neglect. These reviews are a component of DHS's continual quality improvement process.

While the overall number of Act 33 incidents (12 in 2017) is small, it is important to understand who the children and families are, and how and why these events occur, in order to make practice and systemic changes that will prevent future fatalities or near-fatalities. Members of the review team share best practices and lessons learned, with the aim of improving the safety and well-being of all children and strengthening families.

1 Act 33 of 2008 defines a child near-fatality as "a child's serious or critical condition, as certified by a physician, where that child is a subject of the report of child abuse."

KEY FINDINGS

- There were four child fatalities and eight near-fatalities; this is 10 fewer total incidents than the prior year.
- Fifty-eight percent of victims (N=7) were under one year of age, and one-third (N=4) were under six months old.
- Violent acts and drug ingestions (38% each, N=3 each) were the leading causes of near-fatal injuries. Of the four child fatalities, there were four individual causes noted: abusive head trauma, drug ingestion, gunshot and suffocation.
- Most of the named perpetrators of fatalities (75%) and near-fatalities (59%) were parents of children, and most incidents occurred in family homes.
- Eighty percent of named perpetrators (N=14) and 50 percent of non-offending parents (N=5) had prior involvement with social/human services systems.

METHODOLOGY

Prior to each Act 33 review meeting, the DHS Quality Improvement Team gathers information about the incident from a variety of sources:

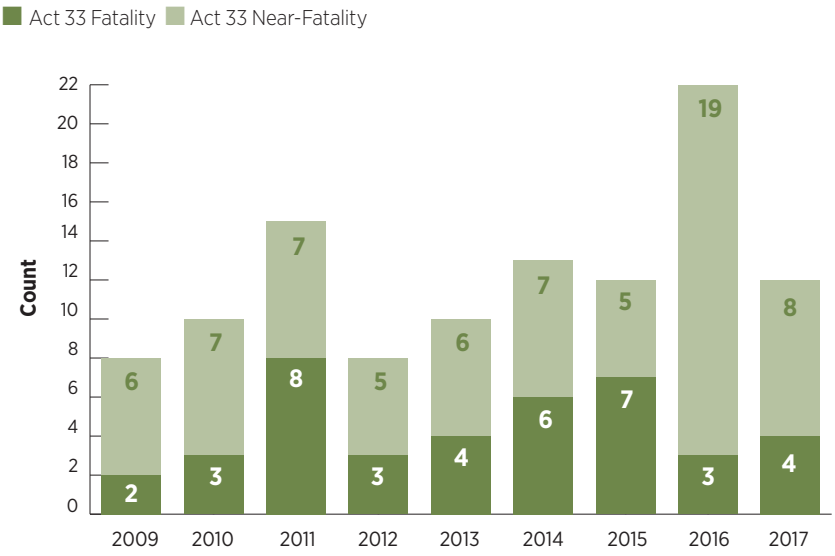
- Case records and all other relevant and available documents/data are reviewed to inform an understanding of the details and cause(s) of the incident; previous social and human services experience; possible actions (prevention or intervention) that could have impacted the outcome(s); case practice and/or systemic issues and potential barriers to addressing those issues; and information about the family's and named 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, to clarify and/or validate information discovered in the 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 named perpetrator.

The Act 33 Review Team — which includes DHS staff, pediatricians, social workers, law enforcement, the courts, and others with a wide range of expertise in the areas of child abuse and neglect — then reviews a written summary of information gathered from case record reviews and interviews and hears oral presentations from child welfare professionals and other systems' partners who are involved with the child and family. The Review Team then identifies practice, policy and system improvement recommendations that serve to improve child welfare service delivery and other child- and family-serving systems, with the goal of preventing future occurrences.

HISTORICAL PERSPECTIVE

Figure 1 shows the number of fatality and near-fatality incidents from 2009 (when Act 33 reviews began in Allegheny County) to 2017. The median number of near-fatalities from 2009 to 2017 is seven per year, and the median number of fatalities is four per year.

FIGURE 1: **Type of Incident by Year, 2009–2017**



CHILD FATALITY/NEAR-FATALITY INCIDENTS, 2017

During 2017, the Act 33 Review Team conducted multidisciplinary reviews for 12 child fatality and near-fatality incidents. Of the 12 cases reviewed, eight were near-fatalities, and four were fatalities. All incidents involved a single child.

Age of Children

One-third of the children reviewed were under the age of six months, and almost 60 percent of all children were under age one (**Table 1**). We note that infants are particularly defenseless victims of abuse, given their high physical vulnerability and total dependence on their caregivers. The youngest child, a victim of a near-fatality caused by physical abuse, was only six weeks old; the oldest child, a victim of a near-fatality caused by stabbing, was 16 years old.

TABLE 1: **Age of Children Who Were Victims in Near-Fatality and Fatality Incidents, 2017**

	NEAR-FATALITY		FATALITY		TOTAL	
	#	%	#	%	#	%
Birth to 6 Months	2	25%	2	50%	4	33%
6 Months to 1 Year	3	38%	0	0%	3	25%
1 Year to 2 Years	1	13%	1	25%	2	17%
2 Years to 5 Years	0	0%	0	0%	0	0%
6 Years and Older	2	25%	1	25%	3	25%
Total Child Victims	**8**	**100%**	**4**	**100%**	**12**	**100%**

Race and Gender of Children

White children made up the largest percentage of both fatal and near-fatal events (accounting for 58% of all fatalities and near-fatalities), while black children were the victims in 25 percent of the incidents and multiracial children were the victims in 17 percent of the incidents (**Table 2**). While the overall number of fatalities and near-fatalities is small, there is evidence of racial disproportionality[2] when compared to the Allegheny County population.

Looking more closely at the reported race of fatality and near-fatality child victims compared to the racial makeup of the County, we find that:

- Black children were victims in a quarter of the fatalities and a quarter of the near-fatalities in 2017 but made up 19 percent of the County's under-18 population.[3]
- Multiracial children were victims in one fatality (25%) and one near-fatality (13%) but made up only five percent of the County's under-18 population.
- White children were involved in 63 percent of the near-fatalities and 50 percent of the fatalities, compared to an under-18 population of 72 percent.

2 For the purposes of this data brief, "disproportionality" refers to the unequal representation of a racial group among children who suffered a near-fatality or fatality, compared to the group's representation in the County as a whole.

3 United States Census Bureau / American FactFinder. DP-1 Profile of General Population and Housing Characteristics: *2010 Census*. U.S. Census Bureau.

TABLE 2: Race of Children Who Were Victims in Fatality or Near-Fatality Incidents, 2017

	NEAR-FATALITY		FATALITY		TOTAL		
	#	%	#	%	#	%	RATE PER 100,000
White	5	63%	2	50%	7	58%	4
Black	2	25%	1	25%	3	25%	7
Multiracial	1	13%	1	25%	2	17%	17
Total Child Victims	**8**	**100%**	**4**	**100%**	**12**	**100%**	

Of the 12 child fatality and near-fatality incidents, 58 percent (7) of children were male, and 42 percent (5) were female (**Table 3**).

TABLE 3: Gender of Children Who Were Victims in Fatality or Near-Fatality Incidents, 2017

	NEAR-FATALITY		FATALITY		TOTAL	
	#	%	#	%	#	%
Male	5	63%	2	50%	7	58%
Female	3	38%	2	50%	5	42%
Total Child Victims	**8**	**100%**	**4**	**100%**	**12**	**100%**

Causes of Fatalities and Near-Fatalities

Violent acts (38%) and drug ingestion (38%) were the leading causes of incidents resulting in near-fatal injuries (**Table 4**). Each fatality was determined to have a different cause of death (abusive head trauma, drug ingestion, gunshot and suffocation).

TABLE 4: Cause of Death in Fatality and Near-Fatality Incidents, 2017

	NEAR-FATALITY		FATALITY		TOTAL	
	#	%	#	%		
Violent Acts[4]	3	38%	1	25%	4	33%
Abusive Head Trauma	*1*	*13%*	*1*	*25%*	*2*	*17%*
Inflicted Bodily Injuries	*2*	*25%*	*0*	*0%*	*2*	*17%*
Drug Ingestion	3	38%	1	25%	4	33%
Gunshot	0	0%	1	25%	1	8%
Suffocation	0	0%	1	25%	1	8%
Medical Neglect	1	13%	0	0%	1	8%
Drowning	1	13%	0	0%	1	8%
Total acts	**8**	**100%**	**4**	**100%**	**12**	**100%**

4 A "violent act" is a category of abuse that includes abusive head trauma and inflicted bodily injuries, resulting in child fatalities or near-fatalities.

Location of Incidents

Eleven of the 12 fatal and near-fatal incidents (92%) occurred in family homes. The remaining one fatality occurred in the child's paternal family's home, where the family was residing at the time of the incident.

Demographics and Social Histories of Named Perpetrators

Case reviews examined 17 named perpetrators involved with the fatal and near-fatal incidents. **Table 5** shows the demographic and social histories of these named perpetrators. As shown, most named perpetrators were under age 30 (88%). Named perpetrators of the near-fatal and fatal incidents were more often white (69% for near-fatalities and 50% for fatalities). The majority of named perpetrators in all cases were female (almost 70% in near-fatality cases, and 50% in fatality cases.)

Birth records were obtained for all the child subjects of Act 33 reviews. Mothers of subject children had an average of 11 prenatal visits; the minimum number of visits was seven, and the maximum number of visits was 15. On average, mothers of subject children met the recommended number of contacts.[5] While one child who was evaluated had a low birth weight, none of the other infants had any other documented birth complications. In addition, over 50 percent of mothers (7) reported receiving assistance from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[6] From 2008 to 2017, each year, one quarter of mothers reported receiving WIC.

5 The World Health Organization recommends eight or more prenatal visits for a positive pregnancy experience.

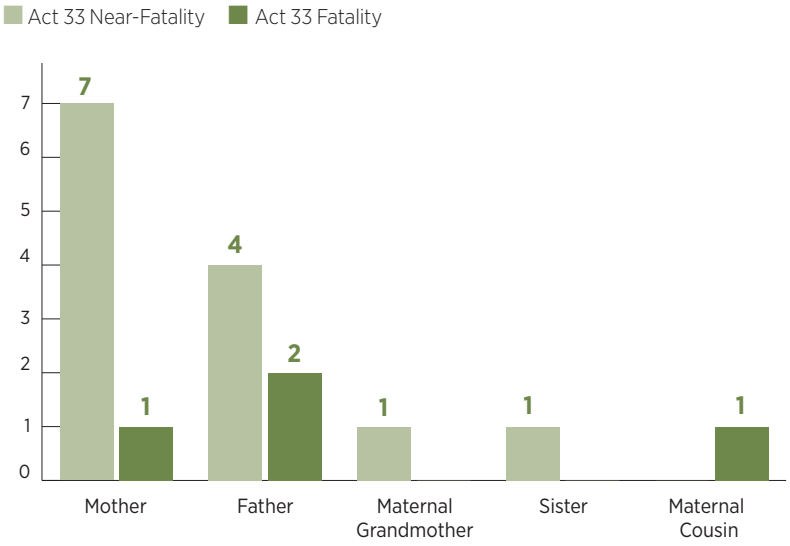
6 WIC provides nutrition services, breastfeeding support, health care and social service referrals, and healthy food to pregnant women, mothers, and caregivers of infants and young children.

TABLE 5: Demographics of Named Perpetrators

	NEAR-FATALITY		FATALITY		TOTAL	
	N	%	N	%	N	%
Age						
Under Age 20	3	23%	1	25%	4	24%
20–29	5	38%	2	50%	7	41%
30–39	3	23%	1	25%	4	24%
Over 40	2	15%	0	0%	2	12%
Race						
White	9	69%	2	50%	11	65%
Black	4	31%	1	25%	5	29%
Biracial	0	0%	1	25%	1	6%
Gender						
Female	9	69%	2	50%	11	65%
Male	4	31%	2	50%	6	35%

Seventy-five percent of the named perpetrators of fatalities and 85 percent of named perpetrators of near-fatalities were parents of the children (**Figure 2**). The remaining perpetrators included a grandmother, a sister and a cousin.

FIGURE 2: Relationships of Named Perpetrators to Child



Almost all named perpetrators (80%) had histories of involvement with social/human services systems[7], identified through case record review, interviews and review of client data in the Allegheny County Data Warehouse[8] (**Table 6**). All of the named perpetrators of fatalities had prior criminal justice system involvement, and three-quarters of perpetrators had a history of intimate partner violence.

7 Social history information for both named perpetrators and non-offending parents was obtained through examination of county databases, medical records, medical examiner reports, law enforcement records and child welfare records. Self-reported information from interviews was also included when available.

8 The Allegheny County Data Warehouse brings together and integrates client and service data from a wide variety of sources both internal and external to the County. It was created by consolidating publicly funded human services data (e.g., behavioral health, child welfare, intellectual disability, homelessness and aging) and, over time, expanded to include data from other sources.

TABLE 6: Prior Social History and Human Services Involvement of Named Perpetrators

	NEAR-FATALITY		FATALITY		TOTAL	
	N	%	N	%	N	%
Educational Status						
Some High School	3	23%	1	25%	4	24%
Graduated High School/ Obtained GED	6	46%	1	25%	7	41%
Unknown	4	31%	2	50%	6	35%
Employment Status						
Unemployed	9	69%	2	50%	11	65%
Employed	4	31%	2	50%	6	35%
Adult Criminal Justice System[9]	6	46%	4	100%	10	59%
Juvenile Justice System[10]	1	8%	2	50%	3	18%
History of Intimate Partner Violence, either as Victim or Perpetrator	4	31%	3	75%	7	41%
Mental Health System[11]	7	54%	4	100%	11	65%
Substance Use System	4	31%	3	75%	7	41%
Prior Child Welfare System Involvement						
As Parents	4	31%	3	75%	41%	41%
As Children	5	38%	3	75%	47%	47%

9 Adult Criminal Justice involvement includes jail, probation, criminal charges and criminal court proceedings in any jurisdiction in Pennsylvania.

10 The Data Warehouse contains Juvenile Probation data from 2007 to the present. Information on involvement is limited to parents born after 1989.

11 Mental health and substance use system involvement includes: 1) use of publicly funded systems as recorded in the Data Warehouse; and, 2) mental health or substance use treatment as reported by individuals during interviews (may include both publicly funded and privately funded services).

Demographics and Social Histories of Non-Offending Parents

Information about non-offending parents was examined for 10 individuals (**Table 7.**) This information is helpful in more fully describing and understanding the characteristics of those adults responsible for the child's safety and well-being.

Most of the non-offending parents in fatality incidents were under age 30, whereas most of the non-offending parents in near-fatalities were between 30 and 40 years old. Most non-offending parents were fathers in the near-fatality incidents (80%) and most were mothers in the fatality incidents (60%).

TABLE 7: Demographics of Non-Offending Parents

	NEAR-FATALITY		FATALITY		TOTAL	
	N	%	N	%	N	%
Age						
Under Age 20	0	0%	1	20%	1	10%
20–29	0	0%	2	40%	2	20%
30–39	4	80%	2	40%	6	60%
Unknown	1	20%	0	0%	1	10%
Race						
White	3	60%	2	40%	5	50%
African American	1	20%	2	40%	3	30%
Unknown	1	20%	1	20%	2	30%
Gender						
Male	4	80%	2	40%	6	60%
Female	1	20%	3	60%	4	40%
Relationship to Victim						
Father	4	80%	2	40%	6	60%
Mother	1	20%	3	60%	4	40%

Fifty percent (5) of non-offending parents had a history of involvement with other social/human services systems, as determined by a combination of methods, including case record reviews, interviews, and review of client data from the Data Warehouse and other public data sources (**Table 8**). Fifty percent of non-offending parents had a history of intimate partner violence, and 40 percent had a history of involvement in the substance use services system.

TABLE 8: Social History and Human Services Involvement of Non-Offending Parents

	NEAR-FATALITY		FATALITY		TOTAL	
	N	%	N	%		
Educational Status						
Some High School	1	20%	3	60%	4	40%
Graduated High School/Obtained GED	2	40%	2	40%	4	40%
Unknown	2	40%	0	0%	2	20%
Employment Status						
Unemployed	1	20%	1	20%	2	20%
Employed	3	60%	3	60%	6	60%
Unknown	1	20%	1	20%	2	20%
Adult Criminal Justice System	3	30%	0	0%	3	30%
Juvenile Justice System	0	0%	0	0%	0	0%
History of Intimate Partner Violence, either as Victim or as Perpetrator	2	40%	3	60%	5	50%
Mental Health System	1	20%	1	20%	2	20%
Substance Use System	3	60%	1	20%	4	40%
Child Welfare System						
As Children	0	0%	2	40%	2	20%
As Parents	1	20%	1	20%	2	20%

Family Involvement in Child Welfare System

An important component of these reviews is to determine whether the family (i.e., parents as children and/or as parents) had prior child welfare involvement or had current child welfare involvement at the time of the near-fatality/fatality. The Act 33 Review Team looks at whether families were involved with any child welfare jurisdiction preceding the event and what that involvement entailed (**Table 9**). Three families had active child welfare cases at the time of the fatality or near-fatality.

TABLE 9: Previous and Current Child Welfare System Involvement of Families Involved with Fatal or Near-Fatal Incidents

	NEAR-FATALITY		FATALITY		TOTAL	
	N	%	N	%	N	%
Never known to agency	1	13%	1	25%	2	17%
Previous involvement with Child Welfare Services	5	63%	2	50%	7	58%
Active case involving child and/or family members	2	25%	1	25%	3	25%

For those with previous involvement with child welfare services, the average amount of time between the prior referral until the near-fatality/fatality referral was five months.

Child Welfare Decisions Resulting from the Investigation of the Act 33 Incident

Child welfare agencies are required to make a determination as to the outcome of a child protective services investigation. Over 80 percent (10) of all Act 33 reports in 2017 were indicated.[12] One report was unfounded,[13] and one report was pending criminal charges.

Allegheny County pursued the following course of action regarding the nine families who were not active with the agency at the time of the incident:

- The agency accepted four families for service (i.e., opened a child welfare case) for the following reasons:
  - The allegations for these four families were substantiated, and three of the four children were removed from the care of their parents and placed in out-of-home placement.
- The agency did not accept the remaining five families for service for the following reasons:
  - One family was assessed as able to safely care for the child without child welfare involvement. The family was participating in parenting educational services to reinforce child development and age-appropriate supervision of the children.
  - Two families were actively involved with Juvenile Probation and receiving services through that system.
  - One child was in the guardianship of another caregiver.

One family had no surviving children.

12 A child abuse report made under the CPSL if an investigation by the county agency or the Department determines that substantial evidence of the alleged abuse exists based on any of the following: available medical evidence; child protective services investigation; an admission of the acts of abuse by the perpetrator.

13 A child abuse report made under the CPSL if an investigation by the county agency or the Department determines that there was a lack of evidence that the child was abused.

DISCUSSION AND RECOMMENDATIONS

Data from the 2017 Act 33 reviews show that:

- A third of victims were infants under six months of age.
- Violent acts were the primary cause of fatalities and near-fatalities.
- Most perpetrators were parents of the child.
- Most incidents occurred in the family home.
- Almost all perpetrators and the majority of non-offending parents had prior involvement with social/human services systems, including behavioral health services.

A key component to the Act 33 review process is making recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near-fatalities related to abuse and neglect. In 2017, the Act 33 Review Team identified three main areas for continued improvement: 1) child welfare practices that involve children ages three and younger, 2) prevention and intervention service development and expansion, and 3) enhanced integration of the substance use and child welfare systems.

1. Supports for children, particularly those from birth through age three

Act 33 case reviews continue to inform and improve child welfare practices for children, particularly those ages birth to three years — the most vulnerable children served. With the support of DHS quality improvement staff, child welfare leaders are in the process of developing a quality assurance process that provides real-time staff clinical supports, monitoring and tracking of families whose younger children are at high risk for future maltreatment.

2. Prevention and intervention services

Act 33 review findings have also informed DHS's continued investment in building an array of prevention and intervention services that address child maltreatment before a child death or near-death occurs, and in providing high-risk families with supports that improve their safety, well-being and social connections. Service development and expansion include: expansion of the Family Support Centers[14]; development of a prevention model that focuses on the needs of new mothers, their babies and families; expansion of afterschool and summer programs for teens in communities with high needs; and additional support for the afterschool network with social and emotional needs coordinators.

14 Family Support Centers are a network of 27 neighborhood-based hubs where parents with young children attend programs, access resources and connect with other parents.

3. Integration of the child welfare system and the substance use treatment system

Parental substance use continues to be a contributor to child fatalities and near-fatalities.[15] Act 33 review findings have informed DHS's responses to families involved with substance use and child welfare systems. DHS is working across systems to implement a coordinated response that will improve and expand access to prevention, treatment and recovery services and that will promote safety and well-being. While the effects of the opioid epidemic continue to devastate the lives of children and families, DHS is implementing innovative programs, including:

- Use of an evidence-based model that offers in-home therapy and substance use disorder treatment to help parents overcome substance use disorders, while improving the parent–child relationship
- Implementation of a recovery-oriented and trauma-informed residential drug treatment program for families with a parent in critical need of treatment for unhealthy substance use.
- Provision of rapid rehousing for families who have a parent/caregiver with a history of substance abuse
- Bridging the knowledge gap between child welfare and substance use/behavioral health through the addition of a Substance Use Consultant Specialist and Behavioral Health Specialists who inform decisions and help improve access to treatment for families struggling with substance use disorders or co-occurring disorders
- Continuation of Care Coordination services through The Children's Institute[16] that target children from birth through five years old who were born to mothers with substance use disorders
- Expansion of the POWER Connections[17] program to provide peer support to fathers, in addition to mothers, suffering from a substance use disorder

15 According to the 2015-2016 Opioid-related Overdose Fatalities Report, 27 individuals who overdosed were listed as parents on open child welfare cases, 87 children were potentially affected by the person's death, and 68 children were under age 18 at the time of death.

16 The Children's Institute is a nonprofit organization that provides a continuum of services to children with special health care needs and their families.

17 POWER Connections is a community-based program that provides substance use assessment, peer support and other recovery services to parents served by CYF and other individuals in need of these services.

CONTENT AND ANALYSIS
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