DATA BRIEF: Allegheny County Child Fatality and Near Fatality Reviews, 2018

Act 33 of 2008, an amendment to the Pennsylvania Child Protective Services Law (CPSL), requires state and local reviews of all child fatalities and near fatalities resulting from suspected child abuse or neglect. This report describes the findings from Act 33 Reviews conducted in 2018.

KEY FINDINGS, 2018

- The Review Team reviewed a total of 23 cases in 2018 — four child fatalities and 19 near fatalities — which is 11 more total incidents than 2017 and similar to 2016 data.
- Forty-four percent of victims (10) were under one year of age, and of those, eight were under 6 months old. The remaining victims were age 1 (four children), ages 2–5 (five children), and older than 5 (four children).
- Violent acts (48%, 11) were the leading causes of both fatal and near-fatal injuries. Of the four fatalities, the reported causes were inflicted bodily injuries and drug ingestion.
- Most of the named perpetrators of fatalities (75%) and near fatalities (66%) were the parents of the children, and most incidents occurred in family homes.
- Almost 80% of families (18) had either previous or current child welfare system involvement.

ACT 33 REVIEW PROCESS

In Allegheny County, Act 33 reviews are a component of the Department of Human Services' (DHS) continuous quality improvement process and are 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.

The Allegheny County Act 33 Review Team is composed of representatives who have a wide range of expertise in the area of child abuse and neglect, including:

- DHS executive leadership and representatives of the DHS Offices of Children, Youth and Families (CYF); Behavioral Health; and Community Services
- PaDHS Office of Children, Youth and Families, Western Regional Office
- Community members appointed to the DHS Office of Children, Youth and Families' Advisory Board
- Allegheny County Department of Health, the Office of the Medical Examiner, and the Office of the District Attorney
- Allegheny County Police Department and City of Pittsburgh Bureau of Police

- Children's Hospital of Pittsburgh's Child Advocacy Center
- Community service providers, including early intervention, child and family violence experts, and behavioral health service agencies

METHODOLOGY

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

- Case records and all other relevant and available documents are reviewed to inform an understanding of the details and cause(s) of the incident. This review includes families' and named perpetrators' service and social histories; possible actions (prevention or intervention) that could have affected the outcomes; and case practice and/or systemic issues and potential barriers to addressing those issues.
- Interviews are conducted with county and provider agency staff, as well as with others who have information relevant to the incident, to clarify and/or validate information researched in the case record reviews and to ascertain the basis for decision-making in the case process.
- Reports from the Office of the Medical Examiner, current and past physical health records, and health department birth record data are reviewed for causes of death or injury, health histories, and other relevant health information regarding the child, family members, significant parties and named perpetrator(s).

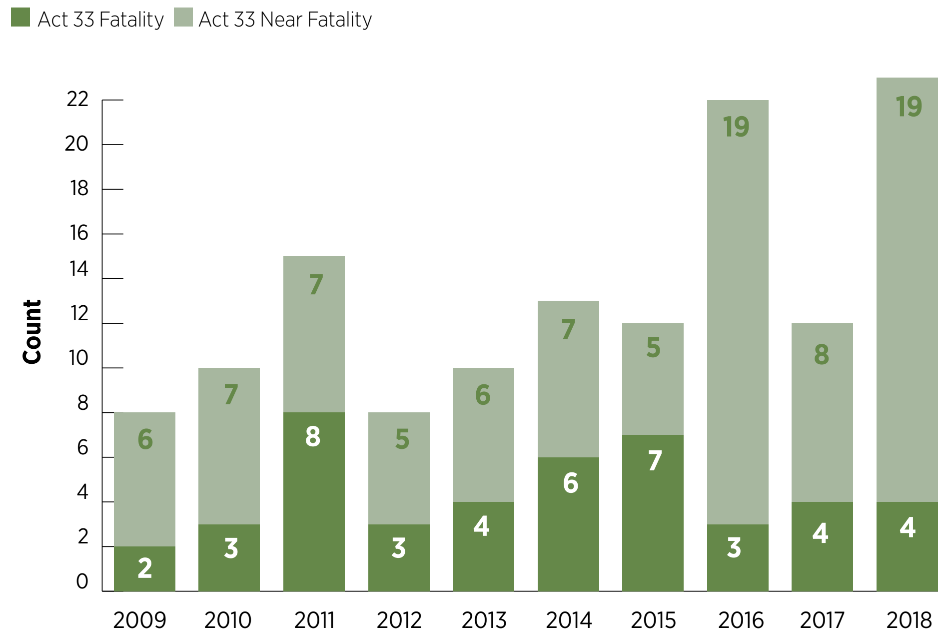
The Act 33 Review Team reviews a written summary of information gathered from case record reviews and interviews and hears oral presentations from child welfare professionals and other system partners who are involved with the child and family. The Review Team then identifies practice, policy and system improvement recommendations that serve to improve child welfare service delivery and other child- and family-serving systems, with the goals of preventing future occurrences and enhancing child and family outcomes.

HISTORICAL PERSPECTIVE

Figure 1 shows the number of child fatality and near fatality incidents from 2009 (year of the enactment of PA Act 33 of 2008 statute) through 2018. While the number of reports increased from 2017 (N=12) to 2018 (N=23), 2018 cases are similar to 2016 cases (N=22) in number and in descriptive characteristics. The 2018 reports involve four near fatality reports associated with alleged medical neglect, representing the highest number of reports associated with this allegation type since the start of the review process.

The median number of fatalities is four per year from 2009 to 2018, and the median number of near fatalities is seven.

FIGURE 1: **Type of Incident by Year, 2009–2018**



CHILD FATALITY/NEAR FATALITY INCIDENTS, 2018

During 2018, the Act 33 Review Team received a total of 29 initially certified reports (seven fatalities, 22 near fatalities, with all cases involving a single child) that met the criteria for community review through the Act 33 process. Act 33 requires multidisciplinary reviews of child fatality and near fatality incidents when CYF has determined that either (1) abuse has occurred or (2) a final investigative determination has not been made within 30 calendar days from the date of the incident. In 2018, there were six reports of fatalities or near fatalities that CYF found to not meet the criteria for abuse. Therefore, the Review Team conducted multidisciplinary reviews for 23 fatality and near fatality incidents.

Age of Children

Thirty-five percent (eight) of the children reviewed were under the age of six months, and 44% (10) of all children were under age one (**Table 1**). Infants are particularly defenseless victims of abuse, given their high physiologic vulnerability and total dependence on their caregivers for their every need. The youngest child, a victim of a near fatality caused by physical abuse, was only three weeks old; the oldest child, a victim of a near fatality caused by medical neglect, was 16 years old.

TABLE 1: **Age of Children Who Were Victims in Fatality and Near Fatality Incidents, 2018**

	FATALITY (N=4)		NEAR FATALITY (N=19)		TOTAL (N=23)	
	#	%	#	%	#	%
Birth to 6 Months	0	0%	8	42%	8	35%
6 Months to 1 Year	0	0%	2	11%	2	9%
1 Year to 2 Years	2	50%	2	11%	4	17%
2 Years to 5 Years	2	50%	3	16%	5	22%
5 Years and Older	0	0%	4*	21%	4	17%
Total Child Victims	**4**	**100%**	**19**	**100%**	**23**	**100%**

**Note: For children 5 years and older, victims' ages were as follows: 5, 12, 15 and 16 years old.*

Race and Legal Sex of Subject Children

Black children made up the largest percentage of both fatal and near-fatal incidents (accounting for 70% of all fatalities and near fatalities), while White children were victims in 26% of all incidents. Multiracial children were victims in 5% of the incidents (**Table 2**). While the overall number of fatalities and near fatalities remains small, there is evidence of racial disproportionality[1] when compared to the Allegheny County population.

Looking at the reported races of child fatality and near fatality victims compared to the racial composition of Allegheny County, we find that:

- Black children were victims in all four fatalities and over 60% of near fatalities in 2018 but comprised only 17% of the County's under-18 population, a rate of 36 fatalities and near fatalities per 100,000 children.[2]
- White children were involved in 32% of the near fatalities, compared to an Allegheny County under-18 population of 71%, a rate of four near fatalities per 100,000 children. White children were not victims in any of the fatalities.
- Multiracial children were victims in one near fatality (5%) and comprised 7% of the County's under-18 population, a rate of nine near fatalities per 100,000 children.

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

2 United States Census Bureau / American FactFinder. Children Characteristics: *U.S. Census Bureau. 2013-2017 American Community Survey 5-Year Estimates*

TABLE 2: Reported Race of Children Who Were Victims in Fatality and Near Fatality Incidents, 2018

	FATALITY		NEAR FATALITY		TOTAL		
	#	%	#	%	#	%	RATE PER 100,000
Black	4	100%	12	63%	16	70%	36
White	0	0%	6	32%	6	26%	4
Multiracial	0	0%	1	5%	1	4%	9
Total Child Victims	**4**	**100%**	**19**	**100%**	**23**	**100%**	

Of the 23 child fatality and near fatality incidents reviewed in 2018, 57% (13) of children were identified as male at birth, and 43% (10) as female (**Table 3**).

TABLE 3: Legal Sex of Children Who Were Victims in Fatality and Near Fatality Incidents, 2018

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Male	2	50%	11	58%	13	57%
Female	2	50%	8	42%	10	43%
Total Child Victims	**4**	**100%**	**19**	**100%**	**23**	**100%**

Review of Birth Records

Reviewers obtained birth records for 21 of the 23 subject children reviewed. Mothers of subject children attended an average of 11 prenatal visits; the minimum number of visits was two; the maximum number of visits was 15. On average, mothers of subject children met the recommended number of prenatal contacts.[3] Six children were evaluated with low birth weight, all of whom were admitted to the neonatal intensive care unit[4] at the time of birth. About half of all mothers smoked cigarettes during pregnancy. Almost half of the mothers (10) reported receiving assistance from the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[5]

Causes of Fatalities and Near Fatalities

A violent act, specifically inflicted bodily injury, was the leading cause of deaths (75%). Violent acts (42%), medical neglect (21%) and physical abuse (21%) were the leading causes of incidents resulting in near-fatal injuries (**Table 4**).

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

4 The World Health Organization defines low birth weight (LBW) as a birth weight of less than 2,500 g or 5.5 lbs, regardless of gestational age.

5 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 4: **Cause of Death in Fatality and Near Fatality Incidents, 2018**

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Violent Acts[6]	3	75%	8	42%	11	48%
Abusive head trauma	*0*	*0%*	*6*	*32%*	*6*	*26%*
Inflicted bodily injuries[7]	*3*	*75%*	*2*	*10%*	*5*	*22%*
Medical Neglect	0	0%	4	21%	4	17%
Physical Abuse	0	0%	4	21%	4	17%
Drug Ingestion	1	25%	2	11%	3	13%
Malnutrition	0	0%	1	5%	1	4%
Total Acts	**4**	**100%**	**19**	**100%**	**23**	**100%**

Location of Incidents

Nineteen of the 23 fatal and near-fatal incidents (83%) occurred in family homes. One incident occurred at the victim child's babysitter's home, another incident occurred in the child's aunt and uncle's home (where she was residing at the time), and the remaining two incidents occurred at fathers' homes, where the children were visiting.

Demographics and Social Histories of Named Perpetrators

Case reviews examined 31 named alleged perpetrators responsible for the fatal and near-fatal incidents. **Table 5** shows the demographic and social histories of these named perpetrators. As shown, most named perpetrators (64%) were under age 30. Named perpetrators of the fatal and near-fatal incidents were more often Black (100% for fatalities and 56% for near fatalities). The majority of named perpetrators in all cases were female (100% in fatality cases and 52% in near-fatality cases).

6 A "violent act" is a category of abuse that includes the diagnosis of abusive head trauma (AHT) and inflicted bodily injuries, resulting in fatal or near-fatal injuries. Serious traumatic brain injury in young children is largely the result of abuse (after falls and motor vehicle accidents) and results in significant morbidity and mortality (range of 20 to 30 cases per 100,000 nationally). Deaths due to AHT peak at ages 1 to 2 months due to higher physiologic vulnerability; assaults at ages 3 to 4 months have greater likelihood of survival, yet can result in long-term consequences.

7 One of the two near-fatal injuries from inflicted bodily injury was caused by an intentional gunshot.

TABLE 5: **Demographics of Named Perpetrators, 2018**

	FATALITY (N=4)		NEAR FATALITY (N=27)		TOTAL (N=31)	
	#	%	#	%	#	%
Age						
Under age 20	0	0%	2	7%	2	6%
Ages 20–29	4	100%	14	52%	18	58%
Ages 30–39	0	0%	5	19%	5	16%
Over 40	0	0%	6	22%	6	20%
Race						
White	0	0%	12	44%	12	39%
Black	4	100%	15	56%	19	61%
Legal Sex						
Female	4	100%	14	52%	18	58%
Male	0	0%	13	48%	13	42%

Health and Human Services System Involvement of Named Perpetrators

Almost all named perpetrators (92%) had histories of involvement with social/human services systems,[8] identified through case record review, interviews and review of client-level data from the Allegheny County Data Warehouse[9] and other public data sources (**Table 6**). All named perpetrators of fatalities were unemployed at the time of the critical incident, while more than half of named perpetrators of near fatalities were employed.

Research has shown an association between perpetrators' mental health status and fatal child maltreatment.[10] In 2018, almost three-quarters of named perpetrators in fatalities and near fatalities had histories of publicly funded mental health service involvement. Social and economic stressors, such as poverty, housing challenges and the prevalence of intimate partner violence, are also associated with increased risk for child maltreatment.[11] Consistent with research, named perpetrators of fatalities and near fatalities were involved with systems that reflect social and economic stress (e.g., housing services, Medicaid eligibility and other public benefits).

8 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 and third-party information from interviews and collateral sources was also included, when available. Social history information examines involvement prior to and at the time of the critical incident.

9 The Data Warehouse integrates client and service data from a wide variety of sources that are internal and external to Allegheny County. The Data Warehouse was created by consolidating publicly funded human services data (behavioral health, child welfare, intellectual disability, community services including homelessness, and aging) and, over time, expanded to include data from other sources.

10 Yampolskaya, S.; Greenbaum, P. E.; and Berson, I. R. 2009. "Profiles of Child Maltreatment Perpetrators and Risk for Fatal Assault: A Latent Class Analysis." *J Fam Viol* 24, 337–348.

11 Douglas, E. M. 2016. "Testing if Social Services Prevent Fatal Child Maltreatment Among a Sample of Children Previously Known to Child Protective Services." *Child Maltreatment*, 21(3), 239–249.

TABLE 6: **Social History and Human Services Involvement of Named Perpetrators, Prior to Incident or at Time of Incident, 2018**

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Educational Status						
Some high school	2	50%	4	15%	6	19%
Graduated high school/obtained GED	0	0%	11	41%	11	35%
Some college credit, but no degree	1	25%	3	11%	4	13%
Graduated college	0	0%	2	7%	2	6%
Unknown	1	25%	7	26%	8	26%
Employment Status						
Unemployed	4	100%	7	26%	11	35%
Employed	0	0%	15	56%	15	48%
Unknown	0	0%	5	19%	5	16%
Mental Health Services	4	100%	18	67%	22	71%
Substance Use Services	0	0%	11	41%	11	35%
Medicaid Eligible	4	100%	20	74%	24	77%
Public Benefits (SNAP, TANF, SSI)	4	100%	19	70%	23	74%
Child Welfare (as parent)	4	100%	16	59%	20	64%
Child Welfare (as child)	2	50%	9	33%	11	35%
Adult Criminal Justice Involvement	3	75%	14	52%	17	55%
Juvenile Probation	1	25%	10	37%	11	35%
Homeless/Housing Services	3	50%	8	30%	10	32%
Intimate Partner Violence[12]						
as perpetrator	0	0%	0	0%	0	0%
as victim	0	0%	5	19%	5	16%

Seventy-five percent of named perpetrators of fatalities and 67% of named perpetrators of near fatalities were biological parents of the children (**Table 7**). The remaining perpetrators included parents' intimate partners, foster parents and other individuals in caregiving roles.

12 IPV information for named perpetrators and non-offending parents was obtained through examination of law enforcement and child welfare records. The data only captures reported IPV and is likely an underrepresentation of the prevalence of intimate partner and familial violence, as many cases are unreported or underreported.

TABLE 7: **Relationships of Named Perpetrators to Child, 2018**

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Biological Mother	3	75%	9	33%	12	40%
Biological Father	0	0%	9	33%	9	27%
Mother's Intimate Partner	0	0%	4	15%	4	13%
Babysitter	0	0%	1	4%	1	3%
Foster Mother's Intimate Partner	0	0%	1	4%	1	3%
Mother's Former Intimate Partner	0	0%	1	4%	1	3%
Adoptive Mother	0	0%	1	4%	1	3%
Father's Intimate Partner	1	25%	0	0%	1	3%
Foster Mother	0	0%	1	4%	1	3%
Total	**4**	**100%**	**27**	**100%**	**31**	**100%**

Demographics and Social Histories of Non-Offending Parents

Information about non-offending parents was examined for 21 individuals (**Table 8**). This information is helpful in more fully describing and understanding the characteristics of those adults responsible for the child's safety and well-being.

All non-offending parents in fatality incidents were under age 30, and half of non-offending parents in near fatalities were under age 30. Most non-offending parents were mothers in near fatality incidents (56%) and were fathers in fatality incidents (80%).

TABLE 8: **Demographics of Non-Offending Parents, 2018**

	FATALITY (N=5)		NEAR FATALITY (N=16)		TOTAL (N=21)	
	#	%	#	%	#	%
Age						
Ages 20–29	5	100%	8	50%	13	62%
Ages 30–39	0	0%	5	31%	5	24%
Ages 40–49	0	0%	2	13%	2	10%
Unknown	0	0%	1	6%	1	5%
Race						
White	1	20%	4	25%	5	24%
Black	4	80%	11	69%	15	71%
Unknown	0	0%	1	6%	1	5%
Legal Sex						
Male	4	80%	7	44%	11	52%
Female	1	20%	9	56%	10	48%
Relationship to Victim						
Father	4	80%	7	44%	11	52%
Mother	1	20%	9	56%	10	48%

Health and Human Service System Involvement of Non-Offending Parents

All non-offending parents had histories 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 Allegheny County Data Warehouse and other public data sources (**Table 9**).

TABLE 9: **Health and Human Services Involvement of Non-Offending Parents, Prior to Incident or at Time of Incident, 2018**

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Educational Status						
Some high school	3	60%	0	0%	3	14%
High school graduate/obtained GED	1	20%	7	44%	8	38%
Some college credit, but no degree	0	0%	3	19%	3	14%
Unknown	1	20%	6	38%	7	33%
Employment Status						
Unemployed	0	0	4	25%	4	19%
Employed	5	100%	10	63%	15	71%
Unknown	0	0	2	13%	2	10%
Mental Health Services	2	40%	8	50%	10	48%
Substance Use Services	0	0%	4	24%	4	19%
Medicaid Eligible	3	60%	12	78%	15	62%
Public Benefits (SNAP, TANF, SSI)	3	60%	11	69%	14	67%
Child Welfare (as parent)	1	20%	7	44%	8	38%
Child Welfare (as child)	3	60%	6	38%	9	43%
Adult Criminal Justice	2	40%	10	63%	12	57%
Juvenile Justice	0	0%	6	38%	6	29%
Housing/Homeless Services	0	0%	3	19%	3	15%
Intimate Partner Violence						
As perpetrator	1	20%	4	25%	5	24%
As victim	0	0%	3	19%	3	14%

Family Involvement in Child Welfare System

A prior report to child welfare is an independent risk factor for child injury mortality before the age of five years.[13] Therefore, an important component of these reviews is to determine whether the family was involved with child welfare either previously or at the time of the Act 33 incident.[14] The Act 33 Review Team reviews family involvement with any child welfare jurisdiction preceding the incident and what that involvement entailed. A parent's previous child welfare involvement could be as a parent of a child or as a victim child.

Table 10 details child welfare system involvement. More than three-quarters (18) of families had either previous or current child welfare system involvement.

TABLE 10: **Previous and Current Child Welfare System Involvement of Families Involved with Fatal or Near-Fatal Incidents, 2018**

	FATALITY		NEAR FATALITY		TOTAL	
	#	%	#	%	#	%
Never known to child welfare	0	0%	5	26%	5	22%
Prior involvement with child welfare	3	75%	8	42%	11	48%
Active child welfare case at time of fatality/near fatality	1	25%	6	32%	7	30%

CHILD WELFARE DECISIONS RESULTING FROM INVESTIGATIONS OF ACT 33 REVIEWS

Child welfare agencies are required to make determinations as to the outcome of child protective service (CPS) investigations. Allegheny County CYF conducted 21 of the investigations, while the PaDHS Office of Children, Youth and Families (state child welfare agency) conducted investigations for two referrals, as the victim children resided in Allegheny County–subsidized resource homes (one adoptive and one foster home).

Almost three-quarters (17) of the Act 33 referrals for 2018 were "indicated" (substantiated). Four reports were "unfounded," and the remaining two reports were pending criminal charges.

13 Putnam-Hornstein, E. 2011. "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study." *Child Maltreatment*, 16(3), 163–174.

14 Act 33 of 2008 requires each county to review the delivery of services to the child, the child's family and/or the (alleged) perpetrator that are provided by the county agency in each county where the child resided within the 16 months preceding the fatality or near fatality.

Cases Active with CYF at the Time of the Act 33 Incident

Of the 23 fatality or near fatality incidents in 2018, Allegheny County CYF was active with seven families at the time of the incident, and CYF continued to provide services to those families.

- **Report Determinations:** CYF substantiated abuse allegations for six of the seven active families. CYF made an abuse determination of "pending criminal charges" for the remaining child fatality, as a law enforcement investigation was ongoing at the time of review.
- **Placement Decisions:** CYF placed six subject children in out-of-home care due to safety threats that could not be eliminated; one subject child remained at home with a plan to ensure safety.

Cases Not Active with CYF at the Time of the Act 33 Incident

The agency was not active with the remaining 16 families at the time of the fatality/near fatality incident.

- **Report Determinations:** CYF substantiated abuse allegations for 12 of the 16 inactive families; CYF unfounded (did not substantiate) three reports and the remaining report is pending criminal charges.
- **Placement Decisions:** CYF placed four of the 16 subject children in out-of-home care due to safety threats that could not be eliminated; nine children remained in their homes. The other three cases were fatalities with no surviving siblings.
- **Families accepted for service:** CYF accepted nine of the 16 families for service. Among the seven families not accepted for services, four families were assessed as able to safely care for their children without CYF involvement, and three families had no surviving children.

CONTENT AND ANALYSIS
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