DATA BRIEF: Allegheny County Child Fatality and Near-Fatality Reviews, 2016

The 2008 Act 33 amendment to the Pennsylvania Child Protective Services law requires state and local reviews of all child fatalities and near fatalities[1] resulting from suspected abuse or neglect. Allegheny County's Child Fatality/Near-Fatality (CFNF) review process, a component of the continuous quality improvement process of the Allegheny County Department of Human Services (DHS), is designed to inform practice and systemic changes to reduce the likelihood of future child fatalities and near fatalities.

1 A "child near-fatality" is defined 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."

While, overall, an incident in which a child is a victim of a fatality or a near-fatality in Allegheny County is a rare occurrence, it is important to understand who the children and families are and how and why these events occur. Members of the Act 33 Review Team share best practices and lessons learned with the aim of improving the safety and well-being of all children while strengthening families.

This report describes the findings from Act 33 Reviews conducted in 2016.

KEY FINDINGS

- Fifty percent of victims were under six months of age.
- Violent acts[2] were the cause of 74 percent of near-fatalities and were the cause of five percent of fatalities.
- Most of the perpetrators of fatalities (80%) and near-fatalities (58%) were a parent of the child, and most incidents occurred in the family home.
- Ninety-two percent of perpetrators and 69 percent of non-offending parents had prior involvement with social/human services systems.

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

METHODOLOGY

Case Review Process

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 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 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 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.

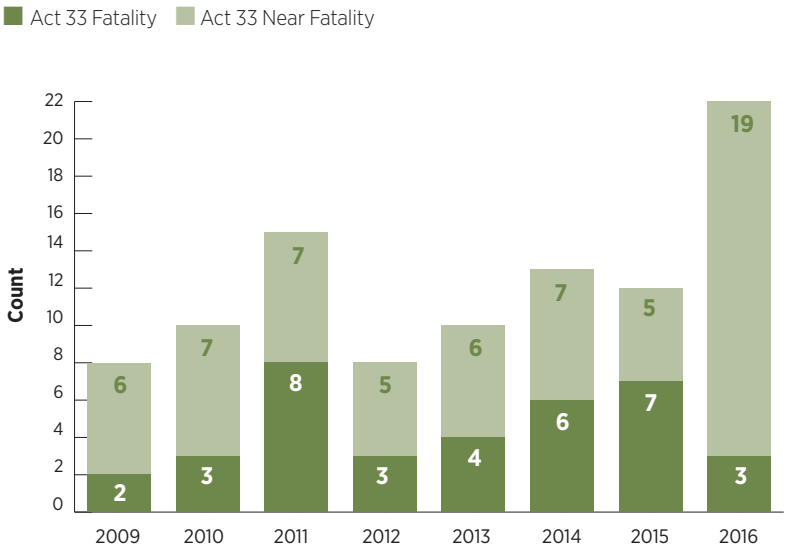
Data Sources

Cause of injury was determined from the Medical Examiner's report in the event of a fatality; the child's medical record was the source of information in near-fatality incidents. Perpetrator social history information was obtained through examination of county databases, medical records, medical examiner reports, law enforcement records and child welfare records.

HISTORICAL PERSPECTIVE

Figure 1 shows the number of fatality and near-fatality incidents from 2009 (when Act 33 reviews began in Allegheny County) to 2016. Of note, the number of near-fatality incidents increased from five in 2015 to 19 in 2016; in contrast, the number of fatal incidents decreased from seven in 2015 to three in 2016. One possible explanation for the increase in near fatality incidents between 2015 and 2016 is substance ingestion, though it was not the sole contributor. The analysis below provides more detail about the 2016 incidents.

FIGURE 1: **Type of Incident by Year, 2009–2016**



CHILD FATALITY/NEAR-FATALITY INCIDENTS, 2016

During 2016, the Act 33 Review Team conducted reviews for 22 child fatality and child near-fatality incidents. Of the 22 cases reviewed, 19 were near-fatalities and three were fatalities. All incidents involved a single child.

Victim Demographics

Half of the children reviewed were under the age of six months, and almost three quarters of all children were under age one (see **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 was only two weeks old and was the victim of a near-fatality caused by abusive head trauma, which is injury to the skull or intracranial contents due to blunt impact and/or violent shaking. The oldest child, a victim of a fatal event caused by inflicted bodily injuries, was eight years old.

TABLE 1: **Age of Children Who Were Victims in Fatality and Near-Fatality Incidents, 2016**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Birth to 6 Months	10	53%	1	33%
6 Months to 1 Year	2	11%	0	0%
1 Year to 2 Years	3	16%	1	33%
2 Years to 5 Years	4	21%	0	0%
6 Years and Older	0	0%	1	33%
Total Child Victims	**19**	**100%**	**3**	**100%**

As shown in **Table 2**, white children were more often the victim of a near-fatal event (58%), while black children and children of two or more races were the victims of all three fatality incidents. While the overall number of fatalities and near-fatalities is small, disproportionality[3] does exist when compared to the Allegheny County population. As of the 2010 U.S. Census, approximately 72 percent of all Allegheny County children under 18 were white, 19 percent were black, five percent were multiracial, and three percent were Asian.

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

- Multiracial children were victims in a quarter of the fatalities and near-fatalities (two of the three fatalities and four of the 19 near-fatalities) in 2016, but made up only five percent of the County's under-18 population.
- Of the three fatalities, one (33%) was a black child, while the County's under-18 black population was 19 percent of the County.
- White children were involved in 11 of the 19 (58%) near-fatalities and zero of the fatalities, compared to an under-18 population of 72 percent.

3 For the purpose 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.

TABLE 2: **Race of Children Who Were Victims in Fatality or Near-Fatality Incidents, 2016**

	NEAR-FATALITY		FATALITY		RATE PER 100,000	PERCENT OF COUNTY POPULATION UNDER 18
	#	%	#	%		
White	11	58%	0	0%	6	72%
Black	3	16%	1	33%	9	19%
Multiracial	4	21%	2	67%	50	5%
Asian	1	5%	0	0%	14	3%
Total	**19**	**100%**	**3**	**100%**	**79**	**100%**

Of the 22 child fatality and near-fatality incidents, 59 percent (13) were male, and 41 percent (9) were female (**Table 3**).

TABLE 3: **Gender of Children Who Were Victims in Fatality or Near-Fatality Incidents, 2016**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Male	10	53%	3	100%
Female	9	47%	0	0%
Total Child Victims	**19**	**100%**	**3**	**100%**

Causes of Fatalities and Near-Fatalities

Table 4 shows the causes of all fatalities and near-fatalities, as determined by the Allegheny County Medical Examiner's Office and/or medical reports. Violent acts were the cause of 74 percent of near-fatalities and were the cause of five percent of fatalities. Abusive head trauma[4] (53%) was the leading violent act that resulted in near-fatal injuries, followed by inflicted bodily injuries (11%).

Of note are the five near-fatalities that were a result of substance ingestion. Two children ingested Subutex (medication prescribed to adult caregivers for the treatment of opioid dependence). One infant was intentionally given methadone placed in his baby bottle, one child ingested cocaine, and one child ingested a prescribed psychotropic medication belonging to an unrelated household member.

4 "Abusive head trauma is the most common reason for hospital admissions in abused children and primarily affects children aged 2 years and under. ...[H]ead trauma is the leading manner of death in abused children; fatal head injury is particularly common in children under age 1 year." James Lukefahr MD. Essentials of Pediatrics. © 2008

TABLE 4: **Cause of Fatal and Near-Fatal Incidents, 2016**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Violent Acts	12	64%	0	0%
Abusive Head Trauma	*10*	*53%*	*0*	*0%*
Inflicted Bodily Injuries	*2*	*11%*	*1*	*33%*
Drug ingestion	5	26%	0	0%
Delay/Failure to Provide Medical Care	1	5%	0	0%
Poisoning	1	5%	0	0%
Suffocation	0	0%	1	33%
Unsafe Sleep	0	0%	1	33%
Total Acts	**19**	**100%**	**3**	**100%**

Location of Incidents

Fifteen of the 22 near-fatal and fatal incidents (68%) occurred in family homes. Four incidents occurred at a babysitter's home (18%), two in the community (9%) and one in an out-of-home placement with a family member (5%).

Demographics and Social Histories of Perpetrators

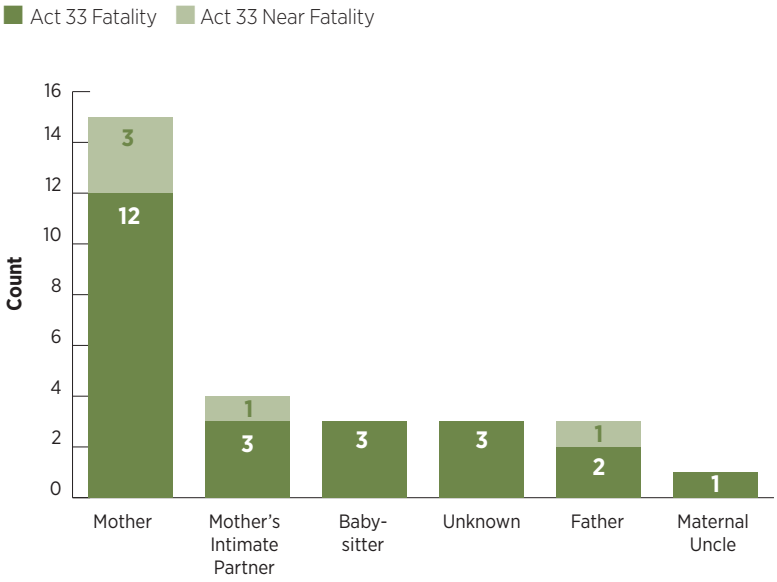
There were 26 named perpetrators involved in the 22 fatal and near-fatal incidents that were examined. Three perpetrators could not be identified. **Table 5** shows the age, race and gender of the perpetrators. As shown, most perpetrators in fatality and near-fatality incidents were under age 30. Perpetrators of the near-fatal incidents were more often white (67%); conversely, four of the five perpetrators of fatal incidents were black (80%). When looking at the gender of the perpetrators, over half were female in both near-fatality and fatality incidents.

TABLE 5: **Demographics of Perpetrators**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Age				
Under Age 20	3	13%	0	0%
Age 20–29	8	33%	3	60%
Age 30–39	9	38%	2	40%
Age 40–49	1	4%	0	0%
Race				
White	16	67%	0	0
Black	5	21%	4	80%
Multiracial	0	0%	1	20%
Gender				
Female	13	54%	3	60%
Male	8	33%	2	40%

Eighty percent of the perpetrators of fatalities and 58 percent of perpetrators of near-fatalities were parents of the children (**Figure 2**).

FIGURE 2: **Relationship of Perpetrators to Victims of Fatality and Near-Fatality Events, 2016**



Almost all named perpetrators (92%) had histories of involvement with social/human services systems, as identified through case record review, interviews, medical records, medical examiner reports, law enforcement records and review of client data in the DHS Data Warehouse (**Table 6**). Named perpetrators for all three child fatalities had involvement in the criminal justice and child welfare systems and had engaged in intimate partner violence, either as perpetrators or as victims.

TABLE 6: **Social History and Human Services Involvement of Perpetrators**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Educational Status				
Some High School	5	21%	1	20%
Graduated High School/ Obtained GED	5	21%	3	60%
Unknown	14	58%	1	20%
Employment Status				
Unemployed	4	17%	1	20%
Employed	5	21%	3	60%
Unknown	15	63%	1	20%
Adult Criminal Justice System	13	54%	5	100%
Juvenile Justice System	5	21%	1	20%
History of Intimate Partner Violence, Either as Victim or Perpetrator	11	46%	5	100%
Mental Health Services	14	58%	3	60%
Substance Use Services	10	42%	3	60%
Child Welfare Services, Either as Children or Parents	14	58%	5	100%

Demographics and Social Histories of Non-Offending Parents

Information about non-offending parents was examined for 26 individuals (displayed in **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 and near-fatality incidents were under age 30. The racial breakdown of non-offending parents mirrors that of the perpetrators (63% white in near-fatality incidents; 50% black in fatal incidents). Most non-offending parents were fathers in both near-fatality (67%) and fatality incidents (100%).

TABLE 7: **Demographics of Non-Offending Parents**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Age				
Under Age 20	2	8%	0	0%
Age 20–29	11	46%	1	50%
Age 30–39	9	38%	1	50%
Age 40–49	1	4%	0	0%
Age 50–59	1	4%	0	0%
Race				
White	15	63%	0	0%
Black	4	17%	1	50%
Multiracial	3	8%	1	50%
Asian	2	8%	0	0%
Unable to Determine	1	4%	0	0%
Gender				
Male	16	67%	2	100%
Female	8	33%	0	0%
Relationship to Victim				
Father	16	67%	2	100%
Mother	8	33%	0	0%

Sixty-nine percent (18) of non-offending parents had a history of involvement with other social/human services systems, as identified through case record review, interviews, medical records, medical examiner reports, law enforcement records and review of client data in the DHS Data Warehouse (**Table 8**).

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

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Educational Status				
Some High School	7	29%	0	0%
Graduated High School/ Obtained GED	7	29%	1	50%
Unknown	10	42%	1	50%
Employment Status				
Unemployed	6	25%	0	0%
Employed	12	50%	2	100%
Unknown	6	25%	0	0%
Adult Criminal Justice System	13	54%	2	100%
Juvenile Justice System	6	25%	0	0%
History of Intimate Partner Violence, either as victim or perpetrator	14	58%	1	50%
Mental Health Services	14	58%	1	50%
Substance Use Services	12	50%	2	100%
Child Welfare Services, either as children or parents	16	67%	2	100%

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 Act 33 incident. A prior report to child welfare is an independent risk factor for injury mortality before the age of five years (Putnam-Hornstein, 2011). 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**). The majority of families involved in fatality and near-fatality incidents had previous involvement with the child welfare system (63% of near-fatalities and 100% of fatalities). Four families had no prior or current involvement with child welfare, and three had open cases involving the child or his/her family members.

TABLE 9: **Family Involvement in Child Welfare**

	NEAR-FATALITY		FATALITY	
	#	%	#	%
Never known to child welfare	4	21%	0	0%
Previous involvement with child welfare	12	63%	3	100%
Open case on child and/or family members	3	16%	0	0%

For those with previous involvement with child welfare services, the amount of time since the prior referral ranged from 19 days to three years for child near-fatality and fatality incidents.

CHILD WELFARE SERVICE DECISIONS[5]

Allegheny County Child Welfare pursued the following course of action regarding the 19 incidents that were not active at the time of the incident:

- The agency accepted 15 families for service (12 near-fatality cases, 3 fatality cases) and did not accept the remaining four families for service, for the following reasons:
  - One family was active with another child welfare jurisdiction in a contiguous county.
  - One family did not reside in Allegheny County during the time of the near-fatal incident, and later moved to another county during the investigation. It is unknown if they were accepted for ongoing services in that county.
  - One family relocated to another state during the investigation.
  - One family was assessed as able to care for the child without child welfare involvement. The family was referred to a community support resource to assist with locating new housing and connecting to other community supports.

5 Child welfare agencies are required to make a determination as to the outcome of a child protective services investigation. Over three quarters (17) of all Act 33 reports for 2016 were indicated, i.e., CYF found substantial evidence that abuse has occurred based on medical evidence, the child protective service investigation, or an admission by the perpetrator. Among the 17 reports that were indicated, one case was indicated against an unknown perpetrator. Three reports were unfounded, i.e., there was a lack of evidence that the child was abused.

KEY AREAS OF RECOMMENDATIONS

A key component to the Act 33 review process is the identification of recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse. The Allegheny County Act 33 Review Team makes recommendations designed to address child welfare practice and systems' performance challenges that are identified through the specific case under review and that are often applicable to other cases served by child welfare and other family-serving systems.

The Act 33 Review Team identified three overarching themes that crossed many of the 2016 case reviews and that significantly impact child safety and well-being. The first theme, prior child welfare involvement, was identified as a risk factor for child maltreatment. The Act 33 Review Team identified a pattern of investigative practice challenges that helped inform the development of the *DHS Office of Children, Youth and Families Investigative Practice Standards*, a guide for investigative practitioners. The second theme noted across reviews was the prevalence of intimate partner violence (IPV) for both alleged perpetrators and non-offending parents. In response, CYF has contracted with a nationally recognized organization and a local domestic violence agency to develop and implement an IPV training curriculum and to increase capacity-building for ongoing skill-building, consultation, and support to CYF staff, systems partners, and families experiencing IPV. Last, parental substance use, associated with impaired parenting skills and a contributor to child deaths and near-deaths, was evident in the majority of Act 33 cases. DHS has implemented a number of strategies to enhance system response to families involved with both substance use and child welfare systems, including addition of a substance abuse consultation specialist within CYF; implementation of a substance use screening tool as a component to the assessment process; and funding of new housing resources for families with parents in need of substance use supports and treatment.