Improving Child-Serving Systems to Protect Children in Allegheny County:

A Report of the Child Fatality / Near Fatality Review Team 2009–2010

2011

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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, early intervention, crises 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 offices including: Aging; Behavioral Health; Children, Youth and Families; Community Services; and, Intellectual Disability.

DHS research products are available for viewing and download at the DHS Research and Evaluation web page at **www.alleghenycounty.us/Human-Services/Resources/Research-and-Reports.aspx**.

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ABBREVIATIONS

ALTE	Apparent Life Threatening Event
CFNF	Child Fatality/Near Fatality
CPS	Child Protective Services
CPSL	Child Protective Services Law
COA	Council on Accreditation
CYF	[DHS] Office of Children, Youth and Families
DARE	[DHS] Office of Data Analysis, Research and Evaluation
DHS	[Allegheny County] Department of Human Services
DPW	[Pennsylvania] Department of Public Welfare
ERM	Emergency Response Meetings
PQI	Performance and Quality Improvement
QI	Quality Improvement

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 the 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 the 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 where they know 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 made by the child/parents)
- An admission of the acts of abuse by the perpetrator

Law Enforcement Official — the Attorney General, County District Attorney, State Police Officer, County Sheriff, County Police Officer, County Detective, or 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 Contendre — 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

Glossary

(continued)

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 the Child's Welfare — a 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 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 the child's 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 the child's life or development or impairs the 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

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 definition that includes two types of child abuse investigation status determinations, indicated and founded. An "indicated report" is a child abuse report in which 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 service investigation; or (iii) an admission of the acts of abuse by the perpetrator. A "founded report" is a child abuse report in which 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 is unfounded if the report is not true, cannot be proven, or does not meet the legal definition of child abuse or student abuse

EXECUTIVE SUMMARY

On July 3, 2008, Pennsylvania Governor Edward G. Rendell signed Act 33 of 2008 into law. Act 33 requires that circumstances surrounding cases of suspected child abuse resulting in child fatalities and near fatalities be reviewed at both the 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, 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.

The CFNF review team examined 19 cases of suspected child abuse that resulted in child death or near death from January 1, 2009 through December 30, 2010. This report describes the findings from these reviews in order to inform the public of the 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 fatalities or near fatalities.

KEY FINDINGS

Among the 19 child fatalities (five) or near fatalities (14) reviewed by the CFNF team:

- The majority of children (68%) were one or younger. Teenagers comprised only 11 percent of incidents.
- Almost half of the children were white. Twenty-one percent were African American. Race data was not available for 11 percent of CFNF subject children.
- Head trauma caused more death or injury than all other causes of death or injury combined.

- Perpetrators of abuse were parents, caregivers or intimate partners, and 15 of the 19 incidents took place in the homes of parents, caregivers or partners.
- Over half of the perpetrators had a criminal history and 50 percent had previous involvement with the mental health system. Thirty-three percent had a documented history of domestic violence.
- More than half of families (58%) were unknown to CYF, either by referral or history of involvement, at the time of the fatal or near fatal incidents.

The CFNF review team made 18 recommendations during 2009 and 2010 to mitigate systemic gaps identified during the CFNF review process. A complete list of these recommendations can be found in **Appendix A**.

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 to include specific requirements related to county CFNF review teams. Act 33 mandates implementation of county CFNF 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 thirty-first day of receipt of an oral report about a child fatality or near fatality if the status of the abuse investigation is substantiated[2] or if the status determination has not yet been made.

To improve transparency and accountability related to CFNF incidents, Act 33 also requires that the county release a written report on the child fatality or near fatality. Pennsylvania's Department of Public Welfare (DPW) must receive the report within 90 days of the county convening a CFNF review. The written report may 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
- Recommendation 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 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 Allegheny County Health Department's Child Death Review and the case practice focus of the Emergency Response Meetings (ERM) performed by the Allegheny County DHS 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 identify concrete actions that serve to protect children from future abuse and neglect.

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 nationally acclaimed 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. The QI team works outside of the operational chain of command for child welfare and reports 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
- The Medical Examiner's Office
- The District Attorney's office
- Children's Court
- The CYF Advisory Board
- The Director's Action Line (DAL)
- The legal community
- Community providers

METHODOLOGY

Case Review Process

Case record review is frequently used in circumstances where the family had previous involvement with CYF and in cases where CYF has undertaken a child protective services investigation based on current allegations of abuse or neglect 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; understand causes of incidents and methods of prevention; identify system-wide issues and barriers that prevent

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 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 reviewed by 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 child protective services investigation related to the fatality or near fatality under review.

DATA ANALYSIS[3]

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 the underlying issues were identified and if services were provided to address these issues
- a determination of whether a safety assessment was completed in accordance with established safety assessment and management process time frames, whether the facts of the safety analysis support the safety decision, and whether the actions taken and the services provided were appropriate to mitigate all identified safety threats and enhance protective capacities
- a determination of whether the risk assessment was completed in accordance with regulatory time frames, whether the facts support the level of risk identified, and whether 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
- 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

[3] Members of the 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.

- 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 the people involved in the current child protective services investigation as well as those involved with the family in cases where 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 relating 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

The persons 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

The following is an analysis of the child fatality and near fatality incidents that took place in Allegheny County in 2009–2010, five of which were fatal and 14 of which were near fatal. Vignettes contained in Appendix B provide details about some of these incidents.

CHILD FATALITY OR NEAR FATALITY SUBJECT CHILDREN

Demographic Information

Almost 70 percent of children involved in CFNF review cases were male. Sixty-eight percent of the children were age one year or younger. Twenty-one percent of the children were between ages two and five. The remaining 11 percent were 15 to 17 years old. These figures are similar to national statistics. In 2009, 64 percent of the children that died from maltreatment were age one or younger. During that same year, only 0.1 percent of youth in the United States who died due to abuse were ages 16 and 17, and four percent of youth across the county who died from abuse were ages 12 through 15.[4]

[4] Children's Bureau, U.S. Department of Health and Human Services (2010) In Child Maltreatment 2009 http://www.childwelfare.gov/can/fatalities.cfm.

Forty-seven percent of the children were white, 21 percent were African American, and 21 percent were biracial or multi-racial. For 11 percent of the children, race was not identified in the case record.

TABLE A: **Age and Race of Children in Act 33 Cases (2009–2010)**

	0–1	2–5	6–14	15–17	TOTAL
African American	4	0	0	0	4
White	6	2	0	1	9
Biracial or Multi-racial	1	2	0	1	4
Unknown	2	0	0	0	2
TOTAL	**13**	**4**	**0**	**2**	**19**

Prior Child Welfare Involvement of Children in Act 33 Cases

There were 11 incidents involving children with whom CYF had never previously received a report of suspected abuse and had never opened a case. Seven of the CFNF cases reviewed involved children who were previously active[5], but not active at the time of the CFNF incidents. Only one Act 33 case involved a child with whom CYF was active at the time of death.

[5] Previously active includes (1) referrals that were screened out at the Intake level due to the report not warranting CYF intervention; (2) referrals that were screened out at Intake once a field screen by a caseworker ensured the safety of a child; and (3) closed family services cases.

TABLE B: Involvement with Allegheny County CYF (2009–2010)

CYF-ACTIVE	PERCENTAGE
Not known	58%
Active prior to incident	37%
Active at the time of incident	5%

CHILD FATALITY OR NEAR FATALITY INCIDENTS

Cause of Injury or Death

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

TABLE C: Cause of Injury or Death in CFNF Incidents (2009–2010)

	FATALITY	NEAR FATALITY
Abusive head trauma	0	11
Blunt force trauma	3	1
Gunshot	2	0
Ingestion (cocaine)	0	1
Strangulation	0	1

Location of Incident

In 13 cases, the injuries occurred in the home of the parent. Two of the CFNF incidents occurred in the home of an intimate partner of a parent or relative. In two cases, the location of the fatal or near fatal event could not be determined due to the number of locations in which the child was present during the timeline for injuries. One child sustained injuries while in the care of a public agency, and another CFNF incident occurred in a motel.

Perpetrators

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.

TABLE D: **Relationship of Perpetrator to Child in CFNF Incidents Resulting from Suspected Child Abuse and Neglect (2009–2010)**

RELATIONSHIP OF PERPETRATOR TO CHILD	PERCENTAGE
Father	50%
Mother	29%
Intimate male partner of parent	7%
Intimate female partner of parent	7%
Intimate male partner of relative	7%

Demographic Information

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

According to case record review, 43 percent of perpetrators were white, 36 percent were African American, and 14 percent were bi- or multi-racial. Race information for the remaining seven percent of perpetrators was unknown to CYF caseworkers.

TABLE E: **Age and Race of Perpetrators in CFNF Cases in Allegheny County (2009–2010)**

	18–25	26–33	34–41	42–49	50 AND OLDER
African American	1	2	1	1	0
White	2	3	1	0	0
Biracial or multi-racial	1	1	0	0	0
Unknown	0	0	0	0	1

Social Histories

Social history information was obtained through examination of county databases, medical records, medical examiner's 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 F: Social History of Alleged Perpetrators in CFNF Cases in Allegheny County (2009–2010), n = 14

SOCIAL HISTORY	PERCENTAGE OF PERPETRATORS
Criminal History	
Criminal history	64%
No Criminal History	36%
Child Welfare Involvemen[6]	
History of involvement as child or parent	71%
No or unknown history of involvement[7]	29%
Known to CYF as a child	50%
Known to CYF as a parent	29%
Known to CYF as a parent and child	21%
Not known to CYF prior to incident	21%
Domestic Violence[8]	
History of domestic violence	57%
Social History	
No known history of domestic violence	43%
Protection from Abuse Order filed against them	35%
Substance Abuse[9]	
History of substance abuse	71%
No known history of substance abuse	29%
Sought substance abuse treatment	21%
Education	
High school diploma or equivalent	36%
No high school diploma or equivalent	21%
Technical or other training certification	7%
Educational attainment unknown	36%
Employment	
Employed at time of incident	29%
Not employed at time of incident	57%
Employment status unknown	14%
Mental Health[10]	
History of involvement with mental health system	50%
No history of involvement with mental health system	50%
Confirmed mental health diagnosis	14%
Received mental health services	7%

6 "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.

7 The one perpetrator with an unknown history of child welfare involvement refers to a perpetrator that recently relocated to Pennsylvania. This perpetrator has resided in several states and did not disclose any history of involvement with any child welfare systems to CYF.

8 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.

9 We understand involvement with substance abuse treatment to include: (i) a diagnosis of substance dependency; (ii) participation in clinical treatment; or, (iii) self-report.

10 We understand a history of mental health involvement as any 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.

CYF Response

Abuse or neglect was substantiated in less than half (48%) of all cases reviewed. There was no substantiated abuse or neglect in 21 percent of the cases reviewed. In 21 percent of cases reviewed, an abuse determination was still pending substantiation by criminal court findings as of December 31, 2010. CYF develops safety plans for the children and surviving siblings based upon the nature and circumstances of the injuries incurred in the fatality or near fatality incident.

TABLE G: Percentage of Substantiated Abuse Determinations in Act 33 Cases (2009–2010)

	NEAR FATALITY	FATALITY	ALL CFNF INCIDENTS
Act 33 reviews with substantiated abuse or neglect	54%	38%	48%

CYF opened family services cases on 68 percent of all of the fatalities or near fatalities reviewed. In the remaining 26 percent of fatalities or near fatalities reviewed, CYF involvement ceased upon conclusion of the CPS investigation at the intake level. Of the six fatalities or near fatalities where CYF involvement ended upon the conclusion of the CPS investigation, neither parent was the perpetrator of the abuse in four of the cases, and the children remained in the care of their mother or father. In one case, the child inflicted the injuries upon himself while in placement at a licensed juvenile detention facility, requiring the investigation by the Department of Public Welfare, Office of Children, Youth and Families, rather than our CYF office. CYF did not open a case with this youth, as behavioral health and juvenile probation were active at the time of the near fatality event. The last incident involved a child who accidentally self-inflicted a fatal injury while in the care of a parent, and CYF did not open a case at the conclusion of the child protective services' investigation once a safety plan for the surviving siblings was identified.

For incidents in which abuse was substantiated, CYF opened family services cases on 47 percent of the fatality or near fatality incidents. In incidences in which the child died, CYF opened family services cases on 40 percent of fatality or near fatality incidents reviewed.

TABLE H: CYF Response to Act 33 Referrals by Substantiated Abuse Determination (2009–2010)

	ACCEPTED FOR FAMILY SERVICES	CLOSED AT INTAKE	NEVER REFERRED TO CYF[11]
Substantiated	9	3	0
Unsubstantiated	3	0	1
Pending Criminal Court determination	1	2	0

[11] This Act 33 review was performed in accordance with 23 Pa. C.S. §3490.56 regarding Pennsylvania Department of Public Welfare, Office of Children, Youth and Families, Western Regional Office's responsibility to investigate suspected child abuse perpetrated by persons employed or supervised by child care services and residential facilities.

TABLE I: **CYF Response to Act 33 Referrals by Fatality or Near Fatality (2009–2010)**

	FATALITY	NEAR FATALITY
Accepted for Family Services	2	11
Closed at Intake level	3	2
Never referred to CYF	0	1

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

- Grief counseling
- Anger management services
- Housing assistance
- Family Group Decision-Making (FGDM)
- Substance abuse treatment
- Developmental screenings
- Behavioral Health Rehabilitation Services (BHRS)
- Parenting classes
- Child care and medical day care
- In-home services
- Supports coordination for people with intellectual disabilities
- DHS Justice-Related Services (JRS)
- Medical Assistance Transportation Program (MATP)
- Psychological evaluations
- Victim and witness assistance services

CONCLUSION

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 chaired by an independent expert in the area of child abuse. 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 team has had an opportunity to learn what has happened within each family's life that led to such a traumatic experience. This has resulted in a better understanding of Allegheny County's child-serving systems' strengths and challenges and concrete actions that serve to protect children from future abuse and neglect.

APPENDIX A: RECOMMENDATIONS

The CFNF review team's recommendations for reducing the likelihood of fatality and near fatality incidents caused by abuse focus heavily on the need for improved education and training, communication and collaboration, and service delivery among public and private organizations. The review team also supported the development of a DHS Action Alert communiqué, intended to equip those who work directly with consumers of human services with specific directives and practical information they can use to support their efforts. The CFNF review team plans to build upon the efforts of this mandated process to robustly protect the children of Allegheny County from abuse.

Opportunities for Improvement Identified Through CFNF Review Process

Education and Training

- Discussion regarding domestic violence with law enforcement agencies (Women's Center & Shelter)
- CYF and courts to address training needs of court and CYF personnel on use of psychological and/or psychiatric evaluations as predictor of a tendency toward violent behavior
- CYF to provide mandated reporting training to area hospitals to assure compliance with suspected child abuse reporting procedures
- Discussion with medical personnel, Medical Examiner's Office staff, court personnel, and child welfare personnel on Abusive Head Trauma research
- Enhanced training in risk assessments and notification of personnel to ensure safety and supervision commensurate with risk within detention settings

Communication and Collaboration

- Review of ChildLine communication to county of "near fatality" status at time of ChildLine notification to counties
- Review of reporting requirements mandated by the Pennsylvania Crimes Code §5106, Failure to Report Injuries by Firearm or Criminal Act
- Review of referral process between municipality police and Allegheny County police departments to ensure immediate referral and response for abuse investigations
- Review and reissue of Inter-County Case Transfer Policy as it related to CPSL, 3490.401 and internal review of inter-county transfer cases by administration
- Review of communication protocol between CHP Emergency Department and law enforcement and CHP Emergency Department and CYF
- Review of consultation request protocol between CHP Emergency Department and Child Advocacy Clinic when a child presents with suspected abuse or neglect

Appendix A
(continued)

- Review of the timing of forensic interviews of child witnesses to fatal and near fatal incidents to ensure that factors such as acute trauma or physical condition of children do not influence results
- DHS and detention administration to address means to access DHS databases for identification of service provision required to ensure the health and safety of residents; comprehensive review of policies and procedures related to communication of health-related information with Juvenile Probation and among detention departments while assuring compliance with statutes and regulations
- Immediate and comprehensive review of juvenile detention policies and procedures related to communication of health-related information while assuring compliance with statutes and regulations; review should take into account the provisions of HIPAA that serve to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect children's health and well-being

Service Delivery

- CYF to review and enhance domestic violence services, including:
- Assessment of providers' capacities to provide comprehensive domestic violence services for adolescents in residential and independent living placements, with focus on teen parents, including fathers
- Consideration of requirement for CYF providers to detail domestic violence services within their service descriptions, including procedures for assessment, interventions and treatment referrals, and monitor of service provisions by CYF's Contract Monitor Unit
- CYF to review protocol for filing dependency petitions on children of dependent mothers, including consultation with solicitors
- CYF to review and reissue protocol related to requirement for plan of intervention (including forensic interview, medical examination) to be completed when a child makes a disclosure of sexual maltreatment. The protocol includes consultation with the County Law Department in the event that parents do not agree with any part of plan of intervention to determine the need for court intervention
- CYF to reassess safety, risk and aftercare planning associated with closure of CYF case prior to decision for case closure
- Internal review of CYF cases not accepted for services that have multiple reports of maltreatment to ensure comprehensive assessment of safety factors prior to case acceptance / case closure decisions

APPENDIX B: SAMPLE OF CASE INCIDENT VIGNETTES

A 21-month-old male child suffered serious physical injuries.

His injuries included extensive bilateral retinal hemorrhages and multiple bruises of varying ages over the body. The injuries sustained required surgery. The child was in the sole care of the mother, who had past CYF involvement as a teen mother in care, at the time of the incident. The abuse determination was founded by the court. The child and sibling were placed with the paternal grandmother, and the mother has been criminally charged and incarcerated. Case review noted significant domestic violence between the mother's former boyfriend and the father of the child and mother.

Recommendations

- CYF to review protocol for filing dependency petitions on children of dependent mothers, including consultation with solicitors
- CYF to review and enhance domestic violence services, including:
    - Assessment of providers' capacities to provide comprehensive domestic violence services for adolescents in residential and independent living placements, with focus on teen parents, including fathers
- Consideration of requirement for CYF providers to detail domestic violence services within their service descriptions, including procedures for assessment, interventions and treatment referrals, and monitor of service provisions by CYF's Contract Monitor Unit

A two-year-old male child suffered serious physical injuries due to abusive head trauma.

The child and a sibling were left in the sole care of mother's male intimate partner while mother was out with another child. Mother's intimate partner admitted to law enforcement officials that he caused the injuries to the child by throwing him against a wall when the child would not stop crying. The injured child and another sibling were placed with the birth father, with services provided by CYF to support the transition. The perpetrator has been criminally charged and incarcerated. The siblings and mother had previous involvement with CYF.

Recommendations

- CYF to review and reissue protocol related to requirement for plan of intervention (including forensic interview, medical examination) to be completed when a child makes a disclosure of sexual maltreatment; the protocol includes consultation with the County Law Department in the event that parents do not agree with any part of the plan of intervention to determine the need for court intervention
- CYF to provide mandated reporting training to area hospitals to assure compliance with suspected child abuse reporting procedures

Appendix B
(continued)

A 15-year-old girl died as a result of a gunshot wound at her home.

The perpetrator, the mother's former male intimate partner, was reportedly angry because he believed that the child's mother was involved romantically with other men and shot the mother. He then repeatedly shot the child because she had witnessed the murder. CYF substantiated the abuse report. CYF developed a safety plan for the surviving sibling, who is now residing with her father and is receiving counseling from a local victims' support service. The perpetrator pled guilty to the murders and is serving a life sentence. This family was not known to CYF prior to the incident.

Recommendation

- Discussion regarding domestic violence with law enforcement agencies (Women's Center & Shelter)

A two-year-old female child died as a result of blunt force trauma.

The child and her two siblings suffered multiple injuries while in the sole care of the mother's male intimate partner. The child's injuries were the most severe, including bruising, subdural hemorrhage and retinal hemorrhages. The intimate partner alleged that the children fell down the stairs when startled by his shouting at them after they followed him up the stairs. The mother's intimate male partner pled guilty to endangering the welfare of children and received a sentence of probation. The abuse determination was founded. The surviving siblings remain in the care of the mother, with in-home services provided by CYF. The family was not known to CYF prior to the incident.

Recommendations

- Review of reporting requirements mandated by the Pennsylvania Crimes Code §5106, Failure to Report Injuries by Firearm or Criminal Act
- Review of the timing of forensic interviews of child witnesses to fatal and near fatal incidents to ensure that factors, such as acute trauma, and physical condition of children, do not influence results

An eight-week-old male child suffered serious physical injuries.

The child sustained injuries, including subconjuctival bilateral hemorrhages, numerous fractures in lower extremities, clavicle and rib fractures, and blood in stool. There was evidence of both fresh and older fractures. ChildLine did not immediately communicate the near fatality status to the county at the time of the report. Allegheny County CYF was unable to substantiate the abuse report due to inability to identify the perpetrator(s). The family had previous involvement with CYF.

Recommendations

- Review of ChildLine communication to county of "near fatality" status at time of ChildLine notification to counties

Appendix B
(continued)

- Review of reporting requirements mandated by the Pennsylvania Crimes Code §5106, Failure to Report Injuries by Firearm or Criminal Act
- Internal review of CYF cases not accepted for services that have multiple reports of maltreatment to ensure comprehensive assessment of safety factors prior to case acceptance / case closure decisions

A 10-week-old male child suffered serious physical injuries.

The child was taken to the hospital with an Apparent Life Threatening Event (ALTE) and diagnosed with acute right–side subdural and retinal hemorrhages. CYF substantiated the abuse report and named the father as the perpetrator of the abuse. The child and two siblings remain in the care of the mother with extended family supports. The family was not known to the county agency prior to the incident.

Recommendations

- CYF and Courts to address training needs of court and CYF personnel on use of psychological and/or psychiatric evaluations as predictor of a tendency toward violent behavior
- Discussion with medical personnel, Medical Examiner's Office staff, court personnel and child welfare personnel on Abusive Head Trauma research
- Review of referral process between municipality police and Allegheny County police departments to ensure immediate referral and response for abuse investigations
- CYF to reassess safety, risk and aftercare planning associated with closure of CYF case prior to decision for case closure

A 17-year-old male child suffered serious physical injuries as a result of a suicide attempt at a licensed public facility.

The child was taken to the hospital after attempting suicide by strangulation. The PA Department of Public Welfare, Office of Children, Youth and Families did not substantiate the abuse report; however, DPW OCYF identified a regulatory compliance issue related to supervision, and the facility immediately implemented a corrective action plan. The youth was not known to the County CYF but was known to the Allegheny County juvenile probation system.

Recommendations

- Enhanced training in risk assessments and notification of personnel to ensure safety and supervision commensurate with risk within detention settings
- DHS and detention administration to address means to access DHS databases for identification of service provision required to ensure the health and safety of residents; comprehensive review of policies and procedures related to communication of health-related information with Juvenile Probation and among detention departments while assuring compliance with statutes and regulations

Appendix B
(continued)

- Immediate and comprehensive review of juvenile detention policies and procedures related to communication of health-related information while assuring compliance with statutes and regulations; review should take into account the provisions of HIPAA that serve to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being

A 13-month-old male child suffered serious physical injuries due to ingestion of an illegal substance while in the care of his parents.

The child was initially placed with paternal grandparents and now resides with maternal aunt and uncle with a goal of reunification with parents. The family has been known to Allegheny and Armstrong Counties within 16 months prior to the near fatality.

Recommendations

- Review and reissue of Inter-county Case Transfer Policy as it related to CPSL, 3490.401 and internal review of inter-county transfer cases by administration
- Review of consultation request protocol between CHP Emergency Department and Child Advocacy Clinic when a child presents with suspected abuse or neglect

A 10-week-old male child suffered serious physical injuries.

The child was taken to the hospital with an Apparent Life Threatening Event (ALTE) and diagnosed with acute right-side subdural and retinal hemorrhages. Allegheny County CYF substantiated the abuse report and named the father as the perpetrator of the abuse. The two siblings remained in the care of the mother with 24-hour supervision by family members. The family was not known to CYF prior to the incident.

A 22-month-old female child suffered serious physical injuries while in the care of her father and his intimate female partner.

The child was taken to the hospital with an Apparent Life Threatening Event (ALTE) and diagnosed with an acute subdural hematoma and retinal hemorrhages. The father pled guilty to endangering the welfare of children, reckless endangerment of another person, and aggravated assault, and received a sentence of four to 10 years of incarceration. His intimate partner pled guilty to endangering the welfare of children and received a sentence of probation. The abuse determination was founded. The child remains in the care of her mother, with services provided by CYF. CYF also took custody of the intimate partner's newborn infant and placed the infant 6in foster care with a relative. The infant was later adjudicated dependent. The family was not known to CYF prior to the incident.