Improving Systems to Protect Children in Allegheny County

A Report of the Child Fatality/Near-Fatality Review Team 2012

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ABBREVIATIONS / ACRONYMS

ALTE	Apparent Life Threatening Event
BIP	Batterers Intervention Programs
CAC	Child Advocacy Center
CFNF	Child Fatality/Near-Fatality
CPS	Child Protective Services
CPSL	Child Protective Services Law
COA	Council on Accreditation
CYF	Office of Children, Youth and Families
DARE	Office of Data Analysis, Research and Evaluation
DHS	[Allegheny County] Department of Human Services
DPW	[Pennsylvania] Department of Public Welfare
ERM	Emergency Response Meetings
GPS	General Protective Services
PBP	Pittsburgh Bureau of Police
PQI	Performance and Quality Improvement
QI	Quality Improvement

GLOSSARY

- **Behavioral Health Services —** coordinated, community-focused system of mental health and substance abuse services, including prevention, crisis intervention, treatment, case management and community services
- **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 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 Advocacy Center —** a local public agency or nonprofit entity providing a child-focused, facility-based program dedicated to coordinating a formalized multidisciplinary response[1] to suspected child abuse that, at a minimum, either onsite or through a partnership with another entity or entities, assists county agencies, investigative teams and law enforcement by providing services, including forensic interviews, medical evaluations, therapeutic interventions, victim support and advocacy, team case reviews, and a system for case tracking
- **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
- **Child Protective Services (CPS) Report —** a report of suspected child abuse received and numbered by ChildLine and referred to a child welfare agency for investigation and, when indicated, provision of related services
- **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

[1] http://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/23/00.063..HTML

Glossary
(continued)

- **Field Screen —** a field visit conducted by a child welfare agency to evaluate immediate safety of each child in a family, through observation of environmental factors of each child's residence, and to consider the need for further assessment; when further assessment is warranted, the case is assigned to a caseworker who conducts a full CPS investigation or GPS assessment
- **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
- **General Protective Services (GPS) Report —** a report received by a child welfare agency that triggers an assessment of current safety and potential risk of harm to children (including children living in the home and the mother's children living outside the home, but within Allegheny County) and, when indicated, the provision of related services to prevent the potential for harm to a child
- **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 of the child, parents)
  - An admission of the acts of abuse by the perpetrator
- **Law Enforcement Official —** the Attorney General, a County District Attorney, a State Police Officer, a County Sheriff, a County Police Officer, a County Detective, or a 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
- **Near-Fatality —** an act that, as certified by a physician, places a child in serious or critical condition
- **Nolo Contendere —** 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 Court (for juvenile alleged perpetrators) or Criminal Court charges
- **Perpetrator —** a perpetrator, as defined by the Pennsylvania Child Protective Services Law (CPSL)[2], has committed abuse and is the parent of the child, responsible for the welfare of the child residing in the same house, or is the paramour of the parent or caretaker of the child. The person responsible for a child's welfare provides permanent or temporary care, supervision, mental health treatment or diagnosis, training, or control of the child in lieu of parental care, supervision or control

[2] http://pacode.com/secure/data/055/055toc.html

- **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 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
- **Resource Family —** previously termed foster family; a family that provides temporary foster or kinship care for children who need out-of-home placement; might eventually provide permanency for the child, including adoption
- **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 where 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 whereby 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, the governor of Pennsylvania signed Act 33 of 2008 into law. An amendment to the Child Protective Services Law (CPSL), Act 33 requires that circumstances surrounding cases of suspected child abuse resulting in child fatalities and near-fatalities[3] 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. The CFNF review process, a component of the continuous quality improvement process of the Allegheny County Department of Human Services (DHS), is a comprehensive and multi-disciplinary review of child deaths and near-deaths for cases where there is a suspicion of child abuse to better understand how and why these children die and to use these findings to make systematic changes that will prevent future deaths. Members of the CFNF Review Team share best practices and lessons learned with the aim of improving the health and safety of all children in Allegheny County. In addition, these reviews add greater transparency and accountability to DHS's practices by granting the public access to information related to each child fatality or near-fatality when abuse is suspected and/or substantiated.

[3] Defined as acts that, as certified by a physician, put a child in serious or critical condition at the time of injury.

The CFNF Review Team examined eight child deaths and near-deaths involving suspicion of child abuse during 2012. This report describes the findings from these reviews in order to determine the strengths and challenges of our system, identify solutions to address service needs of the children and families served, and identify areas that require systemic change to ultimately enhance our ability to better protect children. Presenting the results of the review process also serves to inform the public of the county's efforts to protect child victims of suspected abuse and neglect by implementing case practice and system reforms to reduce the likelihood of future child fatalities or near-fatalities.

Key Findings

The Allegheny County CFNF Review Team reviewed three child fatalities and five near-fatalities.

- The eight child fatalities and near-fatalities reviewed in 2012 represented a decrease over the previous two years (10 in 2010 and 15 in 2011).
- Among the eight cases reviewed by the CFNF Review Team:
    - Eighty-eight percent of the children were two years of age or younger; half were one year of age or younger.
    - Fifty percent of the children identified as white and 38 percent as African American, with one child who was internationally born and adopted by a local couple.
- Act 33 requires a review of the regulatory and statutory compliance of the county child welfare agency any time a child is involved in an incident and when the child and family resided in the county within the 16 months preceding the incident. According to this regulation, about 75 percent (six cases) were not known to Allegheny County CYF within the 16 months prior to the fatality or near-fatality. In 2012:
    - About 62 percent (five of the eight) were never known to Allegheny County's child welfare office.
    - However, two of these children (25 percent) were known to the child welfare office of another county.
    - Twenty-five percent (two children) were known to Allegheny County within the 16 months prior to the fatality or near-fatality incident; the prior investigation had been closed at intake.
- All of the children who died had previous involvement with a child welfare system during some point of their lives.
- Major trauma due to inflicted injuries was the leading cause of death or near-death in 63 percent (five of eight) of cases.
- About 87 percent (seven of eight cases) of events took place in the homes of parents.

- Abuse was substantiated in one fatality incident and two near-fatality incidents. The remaining two fatalities and three near-fatalities are pending court proceedings.
- All four perpetrators and seven alleged perpetrators of abuse were known to the victims; they were the parents or intimate partners of the parents.
- Seventy-five percent of perpetrators were known to a child welfare office as children.
- Seventy-five percent of perpetrators had a reported criminal history.
- Seventy-five percent of perpetrators had a reported history of domestic violence.

The CFNF Review Team made a number of recommendations to mitigate systemic gaps identified during the 2012 review process.

This year, the overwhelming majority of cases reviewed by the Allegheny County CFNF Review Team involved families, perpetrators and alleged perpetrators with multi-systems involvement. As such, recommendations to reduce the likelihood of future child fatalities and near-fatalities directly related to child abuse and neglect included a host of recommendations related to changes at the state and local levels, including, but not limited to, legislative reforms to ensure the safety of children attending cyber charter schools, and improved information sharing among Family Court, Juvenile Court and child welfare agencies. The flexible funding opportunities offered through the Allegheny County Human Service Block Grant[4] and the Pennsylvania Child Welfare Demonstration Project[5] will provide opportunities for Allegheny County to address some of the recommendations related to child welfare policy and practice.

[4] http://www.alleghenycounty.us/dhs/DPW-BlockGrant.aspx

[5] http://www.alleghenycounty.us/dhs/IV-E_Waiver_Demonstration_Project.aspx

BACKGROUND

Pennsylvania Act 33 of 2008

In 2008, Pennsylvania amended the state CPSL, Section 6365 (relating to services for prevention, investigation and treatment of child abuse) through the passage of Act 33. The amendments were designed to include specific requirements related to county Act 33 review teams. Act 33 mandates implementation of county child fatality/near-fatality reviews to understand the circumstances surrounding cases of suspected child abuse and neglect that result in child deaths or near-deaths. Act 33 requires the CFNF review team to convene by the 31st day of receipt of an oral report related to a child fatality or near-fatality if the status of the abuse investigation is substantiated[6] or if the status determination has not been made yet.

To improve transparency and accountability related to child fatality/near-fatality incidents when there is suspicion and/or substantiation of child abuse, Act 33 requires that the county release a written report on the child fatality or near-fatality. Pennsylvania's Department of Public Welfare (DPW) receives the report within 90 days of the county's convening a CFNF

[6] 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 that 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.

review. The written report may also be released to the public, with some exceptions, 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
- recommendations 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.

Allegheny County's CFNF Reviews

Allegheny County's CFNF review process builds upon the systemic approach of the Allegheny County Health Department's Child Death Review[7] and the case practice focus of the internal Emergency Response Meetings (ERM) conducted by Allegheny County DHS, Office of Children, Youth and Families (CYF). By conducting detailed reviews of child fatalities and near-fatalities and analyzing related trends, the review team is able to identify the strengths and challenges of child- and family-serving systems and to identify concrete actions that serve to protect children from future abuse and neglect.

[7] Please visit http://www.alleghenycounty.us/dhs/accfnf.aspx for more information.

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 team that works outside of the operational chain of command for child welfare and that reports directly to the DARE Deputy Director and to the DHS Director.

CFNF Review Team

The CFNF review team comprises members who represent a cross-section of experts in the areas of child abuse and neglect.

The standing team, chaired by a pediatrician with international expertise in child abuse and neglect and facilitated by a professor emeritus from a nationally recognized university, includes representatives from:

- Allegheny County Department of Human Services (DHS)
- Allegheny County DHS CYF Advisory Board
- Allegheny County Health Department
- Allegheny County Medical Examiner's Office

- Allegheny County District Attorney's Office
- Allegheny County Children's Court
- Pennsylvania Department of Public Welfare, Office of Children, Youth and Families
- Pittsburgh Bureau of Police and the Allegheny County Police Department
- Community providers with expertise in family violence and child abuse and neglect
- Community Care Behavioral Health

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 systemwide 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 by 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 for 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.

Document Review[8]

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 so, whether services were provided to address these issues

[8] 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 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 the indicators of risk identified
- regulatory and statutory compliance
- an appraisal of the health and safety of all children in the family
- 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 those people involved in the current child protective services investigation as well as those people 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 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 people 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

DATA ANALYSIS

The following is an analysis of the eight child fatality and near-fatality incidents that took place in Allegheny County in 2012 in which there was suspicion and/or substantiation of child abuse. Three of these incidents were fatalities and five were near-fatalities.[9] Vignettes contained in Appendix C provide an overview of some of these incidents.

[9] As of the end of 2012, substantiation of abuse/neglect had occurred in three of the eight cases; five cases were pending the outcome of criminal proceedings.

CFNF Subject Children

Demographic Information

Table 1 provides demographic information on the subject children. Six of the eight children (75 percent) were male. Fifty percent of the children were white, and 38 percent of the children were African American. About 87 percent of cases involved children under the age of three years. One of the children was 11 years old.

TABLE 1: **Age, Race and Gender of Children in CFNF Cases (2012)**

2012	0–1		2–5		6–14		15–17		TOTAL[10]	
African American	**2**	**25%**	**0**	**0**	**1**	**13%**	**0**	**0**	**3**	**38%**
• Females	1	13%	0	0	0	0	0	0	1	13%
• Males	1	13%	0	0	1	13%	0	0	2	25%
White	**2**	**25%**	**2**	**25%**	**0**	**0**	**0**	**0**	**4**	**50%**
• Females	0	0	0	0	0	0	0	0	0	0
• Males	2	25%	2	25%	0	0	0	0	4	50%
Other	**0**	**0**	**1**	**13%**	**0**	**0**	**0**	**0**	**1**	**13%**
• Females	0	0	1	13%	0	0	0	0	1	13%
• Males	0	0	0	0	0	0	0	0	0	0
Totals	**4**	**50%**	**3**	**38%**	**1**	**13%**	**0**	**0**	**8**	**100%**

[10] Percentages throughout this report may not sum to 100 percent due to rounding.

Prior Child Welfare Involvement of Children in CFNF Cases

Act 33 requires a review of the regulatory and statutory compliance of the county child welfare agency any time a child is involved in an incident and has been known to the agency within the past 16 months.[11] Using this framework, six of the eight children were not known to Allegheny County prior to the fatal or near-fatal event.[12] About two-thirds (five of the eight) were never known to the agency, including two families that resided in other jurisdictions prior to the deaths of those children. Only one of the eight (representing 13 percent) was known to Allegheny County more than 16 months prior to the fatal incident. In this case, the child, who was later the subject of a fatality report, was residing with kin through a voluntary arrangement with the family. The mother and her intimate partner declined voluntary behavioral health services, and the family services case was closed when the later-deceased child was assessed to be safe in the care of maternal relatives. The child's younger sibling was assessed to be safe in the care of the mother and the younger sibling's father, who was later identified as the perpetrator of the child death.

[11] For the purposes of both the CFNF review process and this report, examination of CFNF cases begins with the initial referral to CYF, in order to understand and improve decision-making along all possible points of intervention.

[12] Pa. C.S. §6343 relating to investigating performance of county agency mandates review of statutory and regulatory compliance by the county agency where the fatality occurred and the child resided within the 16 months preceding the fatality or near-fatality.

Of the two children who were known to Allegheny County CYF within the past 16 months of the fatality and/or near-fatality, both cases were inactive with Allegheny County at the time of the incidents. In the case of the first child, Allegheny County received a report related to inadequate housing and alleged neglect of the children. The investigation was closed at intake due to safety being assured for the child and his two older siblings. (The father of one sibling was granted full

custody of his child through Family Court and the other child resided with a maternal relative through informal arrangement by the mother, while the mother and her intimate partner were in the process of obtaining a larger home.) In the second case, CYF screened out the referral because the alleged victim was an adult and not a household member.

The families of the two deceased children who were not known to Allegheny County had been known to their home child welfare jurisdictions within the 16 months preceding the fatal events: one case from Somerset County and one case from Berkeley County, West Virginia. In the Somerset County case, involvement by the other county agency concluded at the intake level when the General Protective Services (GPS) assessment identified no safety concerns for the deceased child's siblings. The family services case in the out-of-state jurisdiction closed with the child being assessed as safe in the care of his parents and with his mother voluntarily participating in community-based behavioral health services.

TABLE 2: **Involvement with Allegheny County Child Welfare (2012)**

ALLEGHENY COUNTY CHILD WELFARE INVOLVEMENT	FATALITY		NEAR-FATALITY		TOTALS	
Not known within 16 months preceding the CFNF event	**3**	**38%**	**3**	**38%**	**6**	**75%**
• No involvement with agency	2	25%	3	38%	5	63%
• Closed case more than 16 months prior	1	13%	0	0	1	13%
Known within 16 months preceding the CFNF event	**0**	**0**	**2**	**0**	**2**	**25%**
• Active at time of incident	0	0	0	0	0	0
• Closed GPS assessment, case not accepted for service; inactive at time of CFNF incident	0	0	1	13%	1	13%
• Referral screened out (no jurisdiction)[13]	0	0	1	13%	1	13%
Totals	**3**	**38%**	**5**	**63%**	**8**	**100%**

[13] Report information did not meet the legal definition of child maltreatment or risk. However, as per agency policy, CYF performed a Field Screen assessment to ensure the safety of all minor children residing in the home as one of the children was under the age of six.

Child Fatality or Near-Fatality Incidents

Cause of Injury or Death

In near-fatality incidents, the cause of injury is cited from the child's medical record. Cause of death in fatal incidents is cited from the Medical Examiner's report. In approximately 60 percent of near-fatality cases reviewed, the cause of injury was Abusive Head Trauma, according to the child's medical records. In two-thirds of fatality cases reviewed, the cause of death was Blunt Force Trauma, according to the Medical Examiner.

TABLE 3: **Cause of Injury or Death in CFNF Incidents (2012)**

2012	FATALITY	NEAR-FATALITY
Abusive Head Trauma	0	3
Blunt Force Trauma	2	0
Drowning	1	0
Fire (burns and inhalation injury)	0	1
Scalding	0	1
Totals	**3**	**5**

Location of Incident

Seven of the eight incidents occurred in the family home; one of the eight occurred in a public location. Half of the incidents in which a child died or nearly died occurred within the City of Pittsburgh.

TABLE 4: **Location of Children in CFNF Incidents (2012)**

LOCATION OF CFNF INCIDENTS	2012
Home of Parent	7
Motel	1
Totals	**8**

ChildLine Status Determinations

In 2012, ChildLine certified eight child fatalities and/or near-fatalities in Allegheny County as Act 33 cases, requiring review by the CFNF Review Team. As of 12/31/12, Allegheny County CYF had substantiated abuse or neglect in three (38 percent) of the cases reviewed (one fatality and two near-fatalities). The remaining cases are pending the outcome of court proceedings (see **Table 5**, below).

TABLE 5: **Percentage of Substantiated Abuse Determinations in CFNF Cases (2012)**

	2012	TOTAL PERCENTAGE
Fatality		
• Substantiated	1	13%
• Unsubstantiated	0	0%
• Pending criminal court proceedings	2	25%
Near-Fatality		
• Substantiated	2	25%
• Unsubstantiated	0	0%
• Pending criminal/juvenile court proceedings	3	38%
Totals	**8**	**100%**

Perpetrators

Among the eight total cases reviewed during 2012, there was substantiated abuse in three cases, comprising four actors who were determined to be perpetrators. The other five cases are pending the outcome of court proceedings. All four of these perpetrators were known to the child victims. They were either a birth parent or an intimate partner of a parent. In the remaining five cases, seven alleged perpetrators of abuse have pending charges and are, therefore, not included in this section.

TABLE 6: **Relationship of Perpetrator to Child in CFNF Incidents Resulting from Child Abuse and Neglect (2012)**

	NUMBER	PERCENT
Mother	1	25%
Father	0	0
Male intimate partner of parent	3	75%
Totals	**4**	**100%**

Demographic Information

The majority (75 percent) of perpetrators were male. Half were 17 and 18 years of age, and half were ages 28 and 29. According to case record reviews, three of the four perpetrators (75 percent) identified as African American.

Social Histories of Perpetrators in CFNF Cases

Social history information was obtained through examination of county databases, medical records, medical examiner reports, law enforcement records and CYF records. A perpetrator may not have volunteered information on one or more of the domains examined below. The following represents the social history for the four perpetrators substantiated in 2012.

TABLE 7: **Social History of Perpetrators in CFNF Cases in Allegheny County (2012)**

SOCIAL HISTORY	NUMBER OF PERPETRATORS	PERCENTAGE OF PERPETRATORS
Prior criminal history	2	50%
Prior delinquency history	1	25%
No criminal history	1	25%
Child Welfare Involvement[14]		
No or unknown history of involvement	1	25%
History of involvement as a child or a parent	3	75%
• Known to Allegheny County CYF as a child	2	50%
• Known to Allegheny County CYF as a parent	1	25%
• Known to Allegheny County CYF as a child and a parent	1	25%
Domestic Violence[15]		
History of domestic violence	3	75%
No known history of domestic violence	1	25%
Behavioral Health – Mental Health[16]		
History of involvement with mental health system	4	100%
• Received mental health services	3	75%
No known history of involvement with mental health system	0	0%
Behavioral Health - Substance Abuse[17]		
History of substance abuse	3	75%
No known history of substance abuse	1	0%
Education		
No high school diploma or equivalent	0	0%
High school diploma or equivalent	3	75%
Technical or other training certification	0	0%
College, University or Professional School	0	0%
Educational attainment unknown	1	25%
Employment		
Employed at time of event	2	50%
Not employed at time of event	0	0%
Employment status unknown	2	50%

N=4

[14] "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.

[15] 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.

[16] We understand a history of behavioral health involvement in the mental health system 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.

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

Supplemental Abuse Determinations

DHS's practice is to report CFNF data for the period of January 1st through December 31st of a given year. However, a determination of abuse or neglect may not be made until after the year-end date. Moreover, original reports[18] reflect the number of cases in which maltreatment or neglect was substantiated through the CPS investigation. Investigation determinations may have a disposition of pending criminal court action or pending juvenile court action, meaning the court adjudications will establish whether or not an abuse determination is substantiated. As court proceedings often take time to conclude, the reported total of substantiated reports from a previous year may increase in a subsequent year. For the purposes of this report, modified totals reflect substantiations as determined through both the CYF investigation and criminal court findings of abuse.

[18] Descriptions of original report and modified totals taken from Pennsylvania Department of Public Welfare Annual Child Abuse Report (2011) http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_012532.pdf.

Table 8 shows the number of fatalities and near-fatalities due to substantiated abuse, first as originally reported in each calendar year and second as of the current calendar year, for the years 2009 through 2012. For 2009, the modified total represents six cases involving six perpetrators. Criminal court proceedings are currently ongoing for one case in which the CPS investigation determination was not substantiated due to an unknown perpetrator. Law enforcement made an arrest in May 2012, charging the alleged perpetrator with Simple Assault, Aggravated Assault, Endangering the Welfare of a Child and Recklessly Endangering Another Person.

For 2010, the modified total represents nine cases involving 11 perpetrators. An acquittal in criminal court resulted in an abuse determination not being substantiated and thus posing challenges to multi-year comparisons of this data. Twelve cases comprised the combined original report data for 2009–2010. Fifteen cases comprise the modified total at the end of the year for 2009–2010.

For 2011, the modified total represents six cases involving eight perpetrators. For two of these cases, the criminal court proceedings remain ongoing. The law enforcement investigation remains ongoing in two cases, in which abuse determinations were not substantiated.

For 2012, the original report includes three cases involving four perpetrators. Criminal court proceedings remain ongoing in all eight fatality and near-fatality cases.

TABLE 8: **Substantiation after Determination of the CPS Investigation by Case (through December 31, 2012)**

	2009	2010	2011	2012
Original report for each year	4	7	5	3
Modified total at the end of current year	6	9	6	NA
Not substantiated	2	1	6	0
Cases still pending	1	0	3	5
Total Cases Reviewed	**9**	**10**	**15**	**8**

SYSTEMS' RESPONSES TO CFNF INCIDENTS

County child welfare offices, child advocacy centers (CAC), county children and youth agencies, child and family advocates, medical and human services providers, law enforcement, and local courts collaboratively serve as the foundation of the child protection system. All of the children involved in fatal or near-fatal incidents received services including, but not limited to, emergency medical care and forensic medical assessment through a CAC. For each referral to CYF, timely and comprehensive assessment and safety planning occurred. Allegheny County responded immediately to the abuse reports, conducted thorough investigations, and ensured the safety of the children and their siblings, placing the children with kin or a resource family when continued residence in the home of their parents was not in their best interest. Fifty percent of the children and their siblings were removed from the care of their parents. At the time of the report, two children are placed with kin and two children are in resource[19] homes. The CFNF Review in three of eight cases (38 percent) necessitated collaboration with other county children and youth agencies as those families were previously known to child welfare in those jurisdictions; each case also had an active custody order through Family Court. Investigative interviews by local police and CYF were all conducted in accordance with the joint protocol developed by the district attorney, and the criminal investigations have concluded. Court proceedings are ongoing for all eight cases. **Table 10** organizes the post-fatality or near-fatality response conducted by these public systems by status of CYF involvement. Appendix A shows services that the families, perpetrators and alleged perpetrators received in 2012 from a wider representation of the child welfare system, including community-based services.

[19] Previously termed foster family (see glossary).

Open Child Welfare Case

Of the fatality and near-fatality cases reviewed, none was open for ongoing services at the time of the events.

Cases Opened by Child Welfare

CYF opened family services cases on seven (88 percent) of the cases reviewed.

In one of the two deaths, the abuse determination was substantiated. The child died from blunt force trauma as a result of inflicted physical abuse. CYF immediately took custody of the surviving sibling and ensured the child's safety by placing him with kinship caregivers.

The second fatality involved a child who suffered traumatic brain injury resulting from an attack by the family dog. CYF initially received a GPS referral for the fatality caused by the dog attack and responded by assuring the safety of the deceased child's two siblings who were residing with one of the children's father in another county. That county's child welfare agency conducted a home assessment. Allegheny County CYF later received a supplemental Child Protective Services (CPS) referral related to the child's death from the dog attack, requiring the CFNF review. The abuse determination is pending criminal proceedings.

Five of the seven cases accepted for ongoing family services were in response to near-fatal incidents. Regarding one of the two near-deaths in which abuse was substantiated, the child suffered serious injuries. He was discharged from the hospital to an agency resource family and, a month later, was placed in a kinship home.

In the second near-fatality in which abuse was substantiated, the child sustained critical injuries in the home of the mother and was later placed in the custody of his father. CYF opened the family services case to assist the father with services to strengthen his caregiving skills, because prior to the event he cared for the child for only short intervals, according to the terms of the informal custody agreement of the parents. The father successfully completed services, and, three months after the child returned to the care of his father, CYF withdrew the dependency petition and Juvenile Court granted primary custody to the father and closed the case.

Of the three unsubstantiated near-fatality cases, one case involved a child who sustained serious scalding injuries. The child was initially admitted to the regional pediatric hospital and then transferred to another medical facility that specialized in burns. The father filed a Protection From Abuse (PFA) Order against the mother and requested full custody through Family Court. Full custody was granted to the father, and CYF instituted crisis in-home services to assist the father with an employment search and transferring the child's benefits to the father. CYF closed this investigation at the intake level two months after receiving the initial referral. The final PFA had not been heard at the time of this publication. The abuse determination is pending Juvenile Court proceedings.

Another child sustained critical burn injuries from a fire in the home where she resided with both parents. She was initially treated in the burn unit of a local hospital before being transferred to an out-of-state hospital that specializes in burn injuries. The child was deemed safe in the care of her father, the non-offending parent, and released to his care upon her discharge from the hospital. The parents and child moved in with relatives for support.

For the third case, CYF responded to the initial GPS referral. The child and her brother, both adopted internationally, were admitted to the regional pediatric hospital within hours of each other. CYF immediately took custody of all of the children, placing the two biological children with kin. The kinship caregivers were unable to provide the level of care, supervision and attention necessary to address the behavioral health needs of the adopted son. He was placed in a resource home where his sister was placed upon her discharge from aftercare services at a rehabilitative center. Crisis in-home services were instituted to supervise visitation between the parents and their biological children. CYF received a supplemental CPS referral approximately one month after the initial report from ChildLine, citing that the child's serious medical condition met the criteria for a CFNF review. The CPS investigation was unable to determine the alleged perpetrators responsible for the physical injuries to the child; therefore, the abuse determination is pending criminal court proceedings. The biological children remain together in a resource home. CYF continues to have an open case with the family.

Cases Not Opened by Allegheny County Child Welfare

One of the eight cases reviewed involved a child who drowned in a bathtub and whose family resided in another state. Allegheny County CYF involvement ended upon conclusion of the CPS investigation at the intake level, as there were no surviving children in the household. Emergency medical services transported the child to the regional pediatric hospital where, after prolonged attempts at resuscitation, he was placed on life support with no spontaneous activity. Substantiation of maltreatment is pending criminal court findings.

TABLE 9: **Allegheny County CYF Response to CFNF Referrals by Fatality or Near-Fatality (2012)**

	FATALITY	NEAR-FATALITY	TOTALS
Already Open in Family Services	0	0	0
Accepted for Family Services	2	5	7
Closed at Intake	1	0	1
Totals	**3**	**5**	**8**

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

- Grief counseling
- Anger management
- Housing assistance
- Family Group Decision Making
- Substance abuse treatment
- Developmental screenings
- Behavioral health rehabilitation
- Parenting classes
- Child care and medical day care
- In-home services
- DHS Justice-Related Services
- Medical Assistance Transportation
- Psychological evaluations
- Victim and witness assistance

Appendix A shows services provided to families, perpetrators and alleged perpetrators from a number of systems. Services provided prior to the CFNF event describe those services received within 12 months prior to the fatal or near-fatal incident. Post-event services describe those services provided after the event and were tracked through December 31, 2012. Services were

provided to a family member or perpetrator within 12 months of the CFNF incident in seven cases; however, it was noted through case review that in six cases (75 percent), individuals within the household constellation had previous systems' involvement (e.g., jail, behavioral health, intellectual disability, early intervention, etc.).

All of the families received services after the death or near-death of the child. While family and household compositions varied across cases, in seven of the eight (88 percent) cases, both parents received services. In 88 percent of cases, the perpetrator or alleged perpetrator received some level of services. Child welfare services denote cases in which the perpetrator or alleged perpetrator is the parent of the deceased or injured child.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

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. 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 Review Team has been able to delve into the specific circumstances and events that led to the devastating outcome, resulting in a better understanding of Allegheny County's child-serving systems' strengths and challenges and identifying concrete actions that serve to protect children from future abuse and neglect.

Recommendations

The CFNF Review Team's recommendations for reducing the likelihood of fatality and near-fatality incidents caused by abuse and neglect focus on the need for improved education and training, communication and collaboration, and service delivery by and among public and private organizations. Although the work of the CFNF Review Team spurred critical systems reforms, the Review Team plans to build upon the efforts of this mandated process to robustly protect the children of Allegheny County from abuse. Appendix B contains a complete listing of recommendations.

CFNF Recommendations: Key Reforms

Assessment and Service Planning Processes

- DHS adopted DHS Conferencing and Teaming as its common, universal case management practice. Conferencing and Teaming is a key strategy in the systemwide adoption of a DHS Practice Model,[20] integrating DHS services according to a shared vision and values, in order to promote the health, well-being and self-reliance of those served. This common case practice of assessing, planning and integrating services fosters and supports the weaving of services around the particular needs of client/consumer participants. Implementation of Conferencing and Teaming has begun in the regional offices (2013).
- DHS adopted initial assessment tools that integrate services from throughout the system to help ensure that each person receives the proper assistance that he or she needs. Child and Adolescent Needs and Strengths (CANS) was developed to assist in the decision support and service planning, quality improvement and outcomes monitoring of services to children and adolescents and their families with the primary objectives of permanency, safety and improved quality of life. The CANS assessment process works to empower people at every level of the system to collaboratively identify and address the most important needs facing children and families, and to capitalize on their strengths. The implementation of the CANS occurred in phases across the DHS program offices (2009–2013).
- DHS formed a workgroup to review and revise the Field Screen and Call Screening Policies and develop an implementation plan to implement the revised policies (Spring 2013).
- DHS workgroups have been established to deploy a Family Finding unit to bolster diligent search and family engagement efforts by casework staff (May 2013).
- The PA DPW Office of Children, Youth and Families is in the early stages of developing a statewide child welfare information management system that will, at minimum, allow counties to research current involvement and prior history of families with any Pennsylvania county child welfare agency; it will also have the capability of providing statistical data, including trends, through interface with county case management systems and databases.
- CYF is in the planning stages of a redesign of the Family Service Plan (FSP) to include consolidation between the FSP and Child Permanency Plan as well as highlighting the interface with Juvenile Probation. The implementation plan includes training for casework staff, development of new policies and forms, and a pilot of the new FSP (June 2013).

[20] http://www.alleghenycounty.us/dhs/ai/practice_model.aspx

Domestic Violence

- At the request of the Allegheny County Court of Common Pleas, the District Attorney and the Allegheny County Jail, DHS conducted a service inventory review of local batterer intervention programs (BIP), including interviews with program staff, systems partners and national experts; literature review; program observation; and survey and data collection (Spring, Summer 2012).
    - A report detailing issues identified and recommended next steps was presented to the Courts, District Attorney, Probation and Jail (August 2012).
    - Development of a request for proposal (RFP) and certification process (Fall, Winter 2013).
    - RFP issued for a contracted jail-based provider and in-community BIP providers (January 2013).
    - BIP certification, contracting and implementation process began (April 2013).

Communication and Collaboration across Public and Private Agencies

- DHS Office of Data Analysis, Research and Evaluation conducted an internal review utilizing information from the data-sharing agreement with Pittsburgh Public Schools to determine the extent to which DHS serves students enrolled in virtual education and home school programs.[21]
- CYF and Juvenile Probation has established a workgroup to improve the interfaces contained within the Shared Case Responsibility (SCR) policy regarding joint case management; notification of case closure; confidentiality and information sharing; and combined court proceedings (2013).
- Allegheny County was one of 11 jurisdictions nationwide chosen to participate in the Crossover Youth Practice Model. The practice model was developed by Georgetown University Public Policy Institute's Center for Juvenile Justice Reform (CJJR) and supported by Casey Family Programs to enhance practices for youth served by both the juvenile justice and child welfare systems. Allegheny County Children's Court, Court of Common Pleas Family Division, Department of Human Services and Juvenile Probation established an implementation team to launch the Crossover Youth Practice Model Initiative that will integrate and align their missions, visions and core practice principles to influence practice development and training curricula and serve as focal points for supervision, quality improvement processes and assessments of outcome data (May 2013).

[21] The results of the analysis indicated that three percent of Pittsburgh Public School students are enrolled in a cyber charter school and less than one percent are home-schooled. Students attending cyber charter schools have human services involvement but at a rate lower than that of the district as a whole; there is minimal human services involvement among home-schooled children.

APPENDIX A: SERVICES PROVIDED BY CFNF CASE

	SERVICES PROVIDED PRIOR TO CFNF EVENT		SERVICES PROVIDED AFTER CFNF EVENT	
	Family	**Perpetrator(s)/ Alleged Perpetrator(s)**	**Family**	**Perpetrator(s)/ Alleged Perpetrator(s)**
CASE 1	• Community Services	• Community Services	• Child Advocacy Center • Housing Assistance • Family Group Decision Making	• Child Welfare
CASE 2	• Juvenile Probation	• Juvenile Probation • Child Welfare • After-School Programs • Tutoring • Mentoring • Behavioral Health	• Early Intervention • Child Advocacy Center • Foster Care • Behavioral Health • Father Support Group • Family Group Decision Making • Behavioral Health	• Juvenile Probation • Behavioral Health • Child Welfare
CASE 3	• Child Welfare	• Behavioral Health	• Child Advocacy Center • Foster Care • Kinship Care • Legal Services • Early Intervention • Parenting Classes • Housing Assistance • Transportation Services • Family Support Center • In-Home Services • Family Group Decision Making	• Child Welfare
CASE 4	• None	• None	• Domestic Violence Counseling • Behavioral Health • Victim Services • Child Advocacy Center • Transportation Services • Legal Services • Kinship Care • Family Group Decision Making	• Behavioral Health • Child Welfare

TABLE CONTINUED ON FOLLOWING PAGE

Appendix A: Services Provided by CFNF Case
(continued)

	SERVICES PROVIDED PRIOR TO CFNF EVENT		SERVICES PROVIDED AFTER CFNF EVENT	
	Family	**Perpetrator(s)/ Alleged Perpetrator(s)**	**Family**	**Perpetrator(s)/ Alleged Perpetrator(s)**
CASE 5	• Child Welfare	• None	• Child Advocacy Center • Legal Services • Transportation Services	• None
CASE 6	• Behavioral Health	• Behavioral Health	• Child Advocacy Center • Behavioral Health	• Behavioral Health
CASE 7	• Early Intervention • Behavioral Health • Post Adoption Services	• Spiritual Counseling	• Child Advocacy Center • Foster Care • Kinship Care • Early Intervention • Crisis In-Home Services • Behavioral Health • Parenting Classes	• Behavioral Health • Child Welfare
CASE 8	• Early Intervention • Behavioral Health	• Behavioral Health	• Child Advocacy Center • Crisis In-Home Services • Behavioral Health • Family Support Center • Parenting Classes	• Juvenile Probation • Behavioral Health [a] Child Welfare

APPENDIX B: CFNF RECOMMENDATIONS

Professional Development 2012

- Enhanced training and supervision of issues related to the assessment and understanding of alcohol and other drugs with all family members.
- Reinforcement of training and supervision to ensure compliance with shared case management processes between CYF and Juvenile Probation.
- Re-issuance of agency policy and state regulations related to completion of the Ages and Stages evaluation for children in out-of-home care.
- Reinforcement in training and supervision regarding agency policy to obtain a complete physical exam and conduct separate interviews with children and parents/caregivers when there is suspicion or allegations of family violence.

Policies and Practices 2012

- CFNF Review Team supports the requirement that all physicians licensed to practice in Pennsylvania participate in EPIC-Suspected Child Abuse and Neglect (SCAN), a statewide continuing medical education program focusing on child abuse recognition and reporting.
- CFNF Review Team supports legislative reform and enhanced guidance from the Department of Education regarding oversight of cyber charter schools:
    - Commonwealth legislature to strengthen legislation to mandate action steps, timelines for school districts, systems to respond to truancy.
    - Support for statewide educational policy changes, including more stringent oversight for cyber charter schools and home-schooled students particularly related to physical health and academic requirements.
    - Oversight by authorizing body to ensure that schools communicate information regarding school policy infractions and state-mandated educational requirements (e.g., truancy prevention plan, physical health screenings) to the child's legal parent(s) and/or guardian(s).
    - Web camera verification to ensure that the enrolled cyber charter school student is indeed the individual participating in the activities of each scheduled school calendar day.
    - Consideration of regional on-grounds facilities for cyber charter schools to conduct activities, lessons that permit teachers/staff to perform face-to-face assessments with the child to ensure safety and assess need for additional academic or community supportive resources.
    - Pennsylvania Department of Education to audit cyber charter school records to verify that required documentation is included in student records.

Appendix B: CFNF Recommendations
(continued)

- Review of behavioral health provider's policy regarding non-compliance by consumer with treatment as well as provider policy related to provision of psychotropic medications to consumers based upon a number of treatment visits prior to scheduling a psychiatric evaluation for medication management.
- Review of prenatal services policy to determine whether screening is offered to identify behavioral health needs and referrals to appropriate services, including parenting skills.
- Consideration of enhanced education and supports to youth transitioning from the child to the adult behavioral health systems.
- Improved coordination between physical health and behavioral health providers.
- Support for Commonwealth legislature to review and revise 55 Pa. Code §3350 Adoption Services to mandating that the placement agency provide the local adoption agency with background information regarding the process for matching children to families.
- CFNF Review Team recommends enhanced guidance from DPW regarding training for prospective adoptive parents regarding:
    - Need for requirement for parents to complete an evidence-based parenting curriculum, as part of the pre-placement home study, which emphasizes parenting children who have experienced trauma and adversity. Topics should include, but not be limited to, the effects and potential long-range impacts of prenatal alcohol and other substance exposures; pre- and post-natal malnutrition; physical, sexual and emotional abuse; neglect, including food insecurity; experiencing or witnessing violence; and institutional care.
    - Training to be delivered in a face-to-face method, with sufficient time for questions and answers as well as supported discussion and ongoing assessment of capacity to care for children with special needs.
    - Consideration for cross-system training provided to medical, behavioral health, adoption services, human services and early childhood development practitioners regarding issues related to children with histories of trauma and domestic and international adoption.
- CYF engagement in advanced planning for alternative caregivers in the event that parents/caregivers are facing criminal charges and possible incarceration, if convicted.
- CYF clarification and policy reissue related to contact with child welfare agencies in counties where families had previously resided.
- Review of CYF policy regarding a family's non-compliance with recommended services; i.e., policy requires consultation with the solicitors for consideration of judicial review in cases where families do not agree with CYF service recommendations.

Appendix B: CFNF Recommendations
(continued)

- Review and reissue of agency policy regarding obtaining criminal clearances.
- Review Team discussion of the imperative for obtaining information from collateral contacts as a practice standard, as well as the limitations in accessing information from protected health records in the absence of legally executed releases of information or court orders.

Intersystem Issues

- Development of a monitoring system across criminal courts and between magisterial district courts, family courts and juvenile courts to ensure consistency of language and communication of any conditions, including visitation restrictions, imposed by respective courts.
- Development of a mechanism for adoption agencies to check with DPW and/or adoption agencies to determine whether prospective parents are already known to adoptive agencies.
- Support for development of communication mechanisms, including but not limited to shared electronic records, as well as ongoing case conferencing with multiple community-based and physical health providers.

Resource Capacity

- CYF and adoption agencies engage with local members and descendants of the international community to build informal supports to adoptive parents, to recruit potential placement resources, and to enhance education and awareness of issues impacting children adopted internationally.
- Support for trauma-informed training to pediatric mental health professionals in efforts to improve training and grow the workforce of trauma-knowledgeable pediatric mental health professionals to benefit not only adoptive children, but many others as well.
- DHS Office of Data Analysis, Research and Evaluation study utilizing information from the data-sharing agreement with Pittsburgh Public Schools to determine extent to which DHS serves students enrolled in virtual education and home-school programs.

Public Awareness

- Public education regarding the appropriate temperatures for water heaters and bathing.
- Support for Pennsylvania's Statewide Adoption & Permanency Network (SWAN) to provide evidence-based, trauma-informed pre-placement education and post-placement supports to all families that adopt children with histories of trauma or adversity.

APPENDIX C: SAMPLE OF CFNF CASE INCIDENT VIGNETTES

Case Vignette One

An 18-month-old boy suffered significant physical injuries. The child was in the care of his mother's intimate male partner while the mother was reportedly out of the home. Interviews with law enforcement, medical personnel and CYF caseworkers noted variations in the mother's account of her whereabouts and the length of time out of the home. The child was medically assessed as having significant chronic and acute physical injuries. CYF established an immediate safety plan by assuming custody of the child at the time of discharge from the hospital and placing him with a resource family, then later with his father in the home of the paternal kin. The CPS abuse report was indicated against the mother and her intimate partner as perpetrators, as each admitted to being in a caregiving role at the time injuries occurred. The mother's partner was arrested, charged with Aggravated Assault and Endangering the Welfare of a Child, and placed on electronic home monitoring pending court proceedings. The mother was arrested, charged with Aggravated Assault, Reckless Endangerment of Another Person and Endangering the Welfare of a Child. Court proceedings are ongoing.

Recommendations

- Case record review by CFNF Review Team noted that the mother's intimate male partner had recently been under the supervision of Juvenile Probation. Interviews conducted through the CPS investigation noted reports of intimate partner violence between the mother and her partner.
    - Review of supervisory and staff development supports needed to enhance assessment and understanding of domestic violence by caseworkers and providers with direct case management responsibilities.
- Review the effectiveness of existing process for jurisdictional transfer of cases between criminal courts, magisterial district courts and juvenile courts to ensure communication of terms of court orders related to parent–child contact, including visitation restrictions that are imposed by respective courts.
- The Review Team noted that the mother had an extensive history of involvement with the child welfare and behavioral health systems. The mother was a teenage parent who recently reached the age of majority, and her participation in behavioral health treatment had lapsed.
    - Review of behavioral health provider's policy that requires compliance with service appointments prior to scheduling of a psychiatric evaluation for treatment recommendations.
    - Consideration of enhanced education and supports to youth transitioning from the child to the adult behavioral health systems.
    - Discussion with prenatal service providers to determine whether screening is offered to identify behavioral health needs and referrals to appropriate services, including parenting skills.

Appendix C: Sample of CFNF Case Incident Vignettes
(continued)

Outcomes

- DHS Office of Behavioral Health conducted an assessment of policy and procedures of an outpatient treatment provider. This administrative review indicated capacity challenges of treatment provider that were addressed between the provider and the DHS Office of Behavioral Health (October 2012).

Case Vignette Two

A two-year-old boy suffered significant injuries while in the sole care of his mother's intimate male partner. The mother was at work at the time the near-fatality incident allegedly occurred. The mother's partner reported that the child had fallen at the home. The medical assessment noted that the child sustained multiple bruises and intracranial bleeding, and indicated that the accounts of the fall and the timing of the injuries were inconsistent with medical evidence. CYF established a safety plan by assuming custody of the child and placing him in the care of his maternal grandfather. CYF indicated the abuse report against the mother's partner who was arrested. He pled nolo contendere on charges of Aggravated Assault and Endangering the Welfare of a Child, and received a sentence of three to five years of confinement.

Recommendations

- The Review Team noted that the child had not received an early intervention assessment, as required by state regulation and agency policy. CYF and the provider agency stated that they were unclear as to whether the mother was required to give consent. The Review Team recommended re-issuance of agency policy and state regulations related to completion of the Ages and Stages evaluation for children in out-of-home care.
- The Review Team noted that during the previous GPS referral, the perpetrator was residing in the family home and had refused to give consent for CYF to obtain criminal clearances. CYF did not search public websites for available criminal background information within the county. The Team discussed access to public databases and the need for a statewide database to access information related to criminal convictions in other counties across the Commonwealth.
- The Review Team recommended that CYF clarify and reissue policy related to contact with child welfare agencies in other counties where families previously resided to determine if parents are party to cases in other jurisdictions. In this case, the alleged perpetrator was father to other children who resided in another county and were believed to have been involved with a child welfare agency in that other county. Contact with the child welfare agency in that county did not occur.

Outcomes

- DHS formed a workgroup to review and revise the Field Screen and Call Screening Policies and develop an implementation plan (Spring 2013).

Appendix C: Sample of CFNF Case Incident Vignettes
(continued)

- CYF reviewed and revised the Developmental Screening, Referrals and Information Policy (2012).
- The provider agency was made aware of the issues related to the early intervention assessment and addressed regulatory and agency requirements immediately with their staff (2012).
- DPW Office of Children, Youth and Families is in the early stages of developing a statewide child welfare information management system that will, at minimum, allow counties to research current involvement and prior history of families with any Pennsylvania county child welfare agency and also have the capability of providing statistical data, including trends, through interface with county case management systems and databases.

Case Vignette Three

An 11-year-old boy died from blunt force trauma as a result of inflicted physical abuse. The child and his five-year-old brother were in the sole care of his mother's intimate male partner while the mother was at work. The mother reported returning home from work and finding the child severely injured; she delayed notification of emergency medical services. At the scene, her partner admitted to law enforcement to inflicting injuries to the child with various implements and his fists over the course of nine hours. CYF immediately took custody of the surviving sibling and placed him with kinship caregivers. CYF indicated the abuse report against the mother's partner as perpetrator. Criminal court proceedings are ongoing against the mother and her partner.

Recommendations

- Case record review of previous CYF involvement indicated that the parents declined services as recommended by CYF.
    - Review of CYF policy regarding a family's non-compliance with recommended services; i.e., policy requires consultation with the solicitors for consideration of judicial review in cases where families do not agree with CYF service recommendations.
- Case record review of previous CYF involvement indicated that CYF conducted joint family interviews (i.e., child was interviewed in the presence of parents).
    - Reinforcement of best practice to conduct separate interviews with children, parents or caregivers when there is suspicion or allegations of family violence.
- Both children were enrolled in separate cyber charter schools, which are public schools and which must meet mandatory educational requirements, with some administrative exceptions. Case record review indicated that the deceased child and his family did not participate in a Truancy Elimination Plan meeting, as described in the state Basic Educational Circular (BEC). In addition, there is no documentation available to the Review Team that the child received a mandated sixth-grade physical examination/comprehensive exam performed by a physician, nor is there documentation that the school requested that the parents have the child medically evaluated.

Appendix C: Sample of CFNF Case Incident Vignettes
(continued)

- Support for statewide educational policy changes, including more stringent oversight for cyber charter schools and home-schooled students related to state-mandated physical health and academic requirements; Pennsylvania Department of Education to audit cyber charter school records to verify that required documentation is included in student records.
- Web camera verification to ensure that the enrolled cyber charter school student is indeed the individual participating in the activities of each scheduled school calendar day.
- Commonwealth legislature to strengthen legislation to mandate action steps, timelines for school districts and systems' response to truancy.
- Consideration for issuance of quarterly progress reports on cyber charter students to ensure that academic and attendance targets are met and tracked.
- Development of a mechanism for local education authorities to identify students who have never been enrolled in an educational setting as well as to determine attendance.
- DHS Office of Data Analysis, Research and Evaluation conducted a study utilizing information from the data-sharing agreement with Pittsburgh Public Schools to determine extent to which DHS serves students enrolled in virtual education programs.

Outcomes

- CYF reviewed policies related to Child Protective Services investigations and General Protective Services assessments and found that current policies require the practice of separate interviewing of alleged victims, a central part of state-mandated training. CYF will reinforce training through coaching and supervision (2012).
- DHS Office of Data Analysis, Research and Evaluation conducted a study utilizing information from the data-sharing agreement with Pittsburgh Public Schools to determine the extent to which DHS serves students enrolled in virtual education and home-school programs. The results of this analysis indicated that sufficient evidence does not exist at this time to warrant interventions by DHS (2012).