pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Nina Gomes

Date of Birth: 07/22/2014
Date of Death: 09/28/2015
Date of Report to Child Line: 09/29/2015
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

03/07/2016

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Philadelphia County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/16/2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Nina Gomes	Victim Child	07/22/2014
[redacted]	Biological Mother	[redacted]1985
	Biological Father	[redacted]1978
	Sibling	[redacted]2010
	Sibling	[redacted]2012

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the [redacted] family. SERO staff participated in the ACT 33 meeting that occurred on 10/16/2015 in which Philadelphia DHS staff, medical professionals and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement Prior to Incident:

There were no prior reports for this family in Philadelphia County

Circumstances of Child (Near) Fatality and Related Case Activity:

On 09/24/2015, the victim child was found face down and unresponsive in a bathtub by her mother. The victim child was transported to Elkins Park Hospital by Police and Fire Rescue and later that day transferred via medivac to Children's Hospital of Philadelphia (CHOP) [redacted] The victim child was admitted [redacted]

Philadelphia Department of Human Services (DHS) initially received a [redacted] report on 09/24/2015. On 09/29/2015, the report was submitted to ChildLine for re-evaluation [redacted]

The case was assigned on 09/25/2015. DHS visited the victim child in the hospital on this date. Her biological mother, [redacted] was interviewed by DHS and informed DHS that she had placed the victim child and her two siblings in the bathtub to play with their toys while she did laundry and changed the children's bed linen. The mother reported that the laundry machine was located in the bathroom and she went in and out of the bathroom periodically as she completed the chores. The mother further reported that she could hear the children playing and that the victim child had been out of her line of sight for less than five minutes, but suddenly they were quiet. The mother admitted to DHS that this was not the first time she had left the victim child in the bathtub unsupervised and only did so once the victim child was able to walk.

The mother reported that she noticed that the victim child's two siblings were out of the bath tub and once she went back into the bathroom she also saw that the water level was higher than the 1 to 2 inches of water that she previously filled the bath tub with. The mother denied having heard any water running. Also on 09/25/2015, DHS interviewed the biological father. The biological father reported that he was at work during the time of the incident. DHS also interviewed the victim child's 5 year old sibling. The child reported that while he, the victim child and his 3 year old brother were in the bathtub, he turned on the water and the victim child got water into her eyes and fell into the water. The child further reported that he became scared and did not know what to do, so he left the bathroom without informing his mother of what was occurring and went and sat on the sofa.

Due to the Papal visit and subsequent road closures, the family remained within CHOP at the bedside of the victim child. DHS deemed the other children safe under the supervision of their father.

On 09/28/2015, the victim child passed away from her injuries. The victim child had suffered brain death as a result of drowning.

On 09/29/2015, DHS visited the home of the victim child. The victim child's 5 year old sibling demonstrated for DHS how he turned on the bathtub water. The child reportedly experienced no difficulties repeating the task. DHS completed a home assessment and safety assessment and determined the home to be safe with no safety threats. The victim child's siblings were deemed safe under the care of the biological mother with the father's supervision.

The final status was submitted on 10/23/2015. [redacted] Law enforcement was involved with the case but they closed it with no criminal charges pending.

On 10/20/2015, DHS determined that there were no safety threats and that the family was not in need of formal services within the home. The victim child's 5 year old sibling was referred [redacted] The family was referred [redacted] DHS closed the case on this date.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

- Strengths in compliance with statutes, regulations and services to children and families;

  The team believed that the intake Social Work Service Manager did a great job completing this investigation. This was the intake Social Work Service Manager's first time conducting an investigation; her documentation of family, medical personnel and law enforcement contacts was thorough and comprehensive.

  The intake Social Work Supervisor provided the worker with excellent guidance throughout the investigation and ACT 33 process.

  Deficiencies in compliance with statutes, regulations and services to children and families;

  None

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

  None

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  None

Department Review of County Internal Report:

SERO received the Philadelphia Department of Human Services Child Fatality Team Draft. SERO concurred with all of the information in the report and the final draft was received on 01/11/2016.

Department of Human Services Findings:

- County Strengths:

  Philadelphia DHS responded to this referral in a timely manner and conducted a thorough assessment.

  Philadelphia DHS worked cooperatively with CHOP and appropriately notified law enforcement of the incident.

- County Weaknesses:

  There were no county weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  Philadelphia DHS CYS was found to have operated within statutory and regulatory compliance with regards to this incident.

Department of Human Services Recommendations:

Philadelphia DHS should continue to conduct thorough investigations and collaborate with law enforcement.

Philadelphia DHS should continue to thoroughly document pertinent information to all their cases in a timely manner.

More educational materials need to be provided to parents stressing the importance of adult supervision of children near water.