



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Dior Jenkins

Date of Birth: 03/04/2015

Date of Death: 07/11/2015

Date of Report to ChildLine: 07/09/2015

CWIS Referral ID: [REDACTED]

**FAMILY 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:

05/05/2016

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 08/07/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Dior Jenkins	Victim Child	03/04/2015
[REDACTED]	Mother	[REDACTED] 1995
[REDACTED]	Father	[REDACTED] 1996
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2012

Summary of OCYF Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, siblings and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the investigative social worker as well as the social worker from the community umbrella agency. SERO attended the Act 33 Review Team meeting held on 08/07/2015.

Children and Youth Involvement Prior to Incident:

The family had no prior history.

Circumstances of Child Fatality and Related Case Activity:

On 07/09/2015 the county received a [REDACTED] report alleging that the four month old child arrived at St. Christopher's Hospital via ambulance and was cool to the touch. Upon further examination it was noted the child had [REDACTED]

[REDACTED] The child was in serious condition and was not expected to survive. The child and three year old sibling were in the care of [REDACTED] at the

time. [REDACTED] reported that all three had been napping. The child was in her car seat in the bed along with the sibling and himself. At one point the child woke up crying so he changed her diaper and they all went back to sleep. When he awoke again, the child was unresponsive, slouched over in the car seat. [REDACTED] went to a neighbor's home and called the mother. She instructed him to call 911. She called 911 as well and then met them at the hospital. [REDACTED] stated the sibling may have stepped on the child when he got out of the bed. The doctor reports [REDACTED] explanation is not consistent with the injuries sustained. The mother was not present in the home at the time of the incident and a five year old sibling was temporarily staying in the home of the maternal great-grandmother.

The safety of the child and her siblings were immediately assessed. Safety threats were identified. The mother did not believe [REDACTED] harmed the child. Initially the maternal grandmother was identified as a placement resource for the siblings. The maternal great-grandmother was ruled out due to a recent fire and the home being in disrepair, [REDACTED]

[REDACTED] On 07/11/2015, the child died as a result of her [REDACTED] was arrested on 07/13/2015 and remains incarcerated at this time. The mother continues to deny any form of [REDACTED] and does not believe [REDACTED] would harm the child. The family was accepted for service on this date. Services include case management, [REDACTED] services. The children also receive [REDACTED]

The maternal grandmother informed the county she could no longer care for the siblings on 07/15/2015, citing differences with the mother. A family friend was identified as a resource. The children were moved to this home on 07/16/2015.

[REDACTED] agreed to be interviewed by the county from prison, without an attorney present on 07/22/2015. He reiterated his version of events. He added that at the direction of the 911 operator he attempted CPR. He did not accompany the child in the ambulance to the hospital stating he had to stay with the three year old even though family had come to the home. That sibling never woke up until after the ambulance left with the victim child. He denies injuring or hitting the child.

On 07/24/2015 the family friend informed the county she could no longer care for the children due to issues with the family as well. [REDACTED] the children were moved to a provider foster home on that date.

[REDACTED] The children were placed with the maternal cousin on that date. The county [REDACTED] the report [REDACTED] on 08/18/2015. He remains incarcerated and is awaiting trial for murder, involuntary manslaughter, and endangering the welfare of children. The siblings continue to reside in the same foster home together through a provider agency [REDACTED]

pertains to the Commissioner's concerns [REDACTED] with their recommendations to amend the CPSL. Upon further conversation with the team, it was clarified that this was more of a discussion for the future and the team is aware of the process of changing current law and the likelihood of that not occurring at this time.

Department of Human Services Findings:

- County Strengths:
There was clear documentation in the case notes and investigation report. All parties were interviewed including [REDACTED] Diligence was evident in locating potential kinship resources. Assessments resulted in relevant services for the family.

- County Weaknesses:
None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
None noted.

Department of Human Services Recommendations:

The county should continue to enhance all social workers skill levels in working with potential victims of domestic violence to provide support needed to ensure safety for victims and children.