



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Angell Flagg

Date of Birth: 10/15/2015
Date of Death: 11/14/2015
Date of Report to ChildLine: 11/12/2015
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Yes, the family was known by the Philadelphia DHS.

REPORT FINALIZED ON:
05/04/2016

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 DHS was not required to convene a review team in accordance with the Child Protective Services Law related to this report. [REDACTED] the status determination has been made regarding the report within 30 days of the report to ChildLine.

Family Constellation:

Angell Flagg	Victim Child	10/15/2015
[REDACTED]	Biological Mother	[REDACTED] 1987
[REDACTED]	Biological Sister	[REDACTED] 2014
[REDACTED]	Mother's Pastor	

Summary of OCYF Child (Near) Fatality Review Activities:

Philadelphia DHS was not required to convene a review team in accordance with the Child Protective Services Law related to this report. The fatality [REDACTED] the status determination has been made regarding the report within 30 days of the report to ChildLine

Children and Youth Involvement prior to Incident:

A [REDACTED] report (allegations – unsafe shelter, lack of food, and inadequate medical care) was received on 3/21/13 and determined to be valid. On 4/3/13, the case was opened for services for older siblings [REDACTED] Services provided to the family included Kinship Care [REDACTED] and CUA In-home non-safety services (through CUA 10/Wordsworth). [REDACTED]

Circumstances of Child Near Fatality and Related Case Activity:

The hotline generated a [REDACTED] report, on 11/12/15, for the above case/child (Angell Flagg, 4wks old). The hotline received the information, from the RS, at

approximately 4:00 p.m. on 11/12/15. Upon receipt of this [REDACTED] report, the case was already active with SWSM [REDACTED]. The hotline spoke with Dr. [REDACTED] at St. Christopher Hospital. Dr. [REDACTED] gave the verbal certification for the child's condition as a near fatality. According to the reporter, the mother alleged to have fed the child in the morning and placed the child in her crib. The mother went to check on the child two hours later and found the child unresponsive. The mother contacted the police. EMS transported the child to Einstein Hospital. Child was transferred to St. Christopher's Hospital and was currently [REDACTED] and her condition was seriously critical. Previous to this report, on 11/6/15, it was reported that the victim child had high levels of [REDACTED] and that the mother was not following up with recommended [REDACTED] for the child. The mother missed two doctor appointments [REDACTED] for the child in October 2015. A [REDACTED] report was generated regarding the missed medical appointments. At approximately 6:00 p.m. Dr. [REDACTED] contacted the hotline. Dr. McColgan stated that the child's condition is being certified as a "near-fatality." According to Dr. [REDACTED], the child was dying and on life-support. The child has [REDACTED]

The child's condition was seriously critical. The infant died on 11/14/2015 after being taken off life support. The autopsy was completed. Philadelphia DHS internally reviewed the case on 11/20/2015. The Intake team [REDACTED] on 12/01/2015; the injuries that were noted in the 11/12/15 [REDACTED] narrative were not present when the Medical Examiner's Office (MEO) completed the autopsy. There was no evidence of [REDACTED] are non-specific [REDACTED]. At this point, the MEO is not able to point to anything which would say that Angell's death is suspicious for abuse. The Act 33 meeting that was currently scheduled for 12/4/16 was cancelled.

There are no other children in the mother's care. [REDACTED] The Mother's other children had not been in her care for some time. [REDACTED] remains in kinship care with her paternal great-grandparents. The great-grandparents are also caring for two of the mother's other children. [REDACTED]

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

- The county acted diligently with the investigation
- The county took, in timely matter, the necessary measures to protect the other child
- 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:

Philadelphia DHS was not required to convene a review team in accordance with the Child Protective Services Law related to this report; however, all the information and documentation was reviewed by the SERO and we agreed with Philadelphia DHS determinations.

Department of Human Services Findings:

The Medical Examiner strongly suggested that Dr. [REDACTED], at St Christopher Hospital be re-contacted to clarify some of her statements regarding this [REDACTED] death. The Medical Examiner reviewed the medical chart itself and some of the statements that are being attributed to Dr. [REDACTED] were not accurate.

[REDACTED]

However, according to The Medical Examiner these statements are not medically accurate:

1. There is no evidence of brain trauma. – The CAT scan of the brain only indicates damage to the brain from lack of oxygen, which is what you would expect to see after a cardiac arrest. There is no mention of trauma in the CAT scan report.
2. The retinal hemorrhages are non-specific. – The information about the retinal hemorrhages that Dr. [REDACTED] relied on appears to have come from the fellow's exam.

[REDACTED]

The autopsy, meanwhile, is negative for trauma. At this time, neither The Medical Examiner nor the case pathologist has anything that can point to this case that would make this a suspicious death.

As of today, the [REDACTED] Police have no intention to take action [REDACTED] Mother is receiving no services from DHS.

- County Strengths:

The Team felt that a competent [REDACTED] investigation was completed by Philadelphia DHS which included contacts with the family, medical information from St. Christopher's Hospital.

The Team felt that case documentation was thorough and that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the [REDACTED] investigation.

- County Weaknesses:

NONE

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

A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:

NONE