pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Unknown Baby Boy

Date of Birth: Unknown
Date of Death: Unknown

Date of Report to ChildLine: 04/13/2016
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:
12/07/2016

Unreacted 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 Department of Human Services (DHS) has not convened a review team in accordance with the Child Protective Services Law related to this report. [redacted] and the status determination was made within 30 days of the report being filed with ChildLine.

Family Constellation:

First and Last Name	Relationship	Date of Birth
[redacted]	mother	[redacted] 1979
Baby boy	victim child	unknown
[redacted]	sibling	[redacted] 2000
[redacted]	sibling	[redacted] 2002

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth, and Families was in continual communication with Philadelphia DHS during the investigation. It was established that there is no record of the mother having a baby that died so there were no files to review. The regional office confirmed that all of the other children were full term and delivered in the hospital.

Children and Youth Involvement prior to Incident:

The family was not known to Philadelphia DHS prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

On 04/12/2016, [redacted] told her permanency caseworker that her brother, [redacted], told her that in 2002 or 2003, their sibling, an 8 month old baby boy, died due to an asthma attack because [redacted] did not get him medical treatment. It was determined during the county's investigation that [redacted] indicated he had been told this story by [redacted] resided with their mother at the time and would have been ages three and one. The permanency caseworker asked the children what had happened to the baby and they reported that [redacted] threw baby boy in the trash and it was never reported to authorities.

Philadelphia DHS determinate that there is no record of [redacted] having a baby that died. A hospital patient search for [redacted] was conducted and it was discovered that [redacted] sometimes used a different last name. An additional search was conducted using the other name [redacted] used. The search produced a list all of [redacted] current children. The search also listed other names but they did not fit the timeframe of the allegation. The county established that there was no police report or police involvement. [redacted] denied the allegations.

Philadelphia DHS filed their completed [redacted] investigation with ChildLine 05/02/2016 with an [redacted] status determination.

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

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

  Not completed as an Act 33 meeting was not conducted because the investigation was completed within 30 days of the date of report.

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

  Not completed as an Act 33 meeting was not conducted because the investigation was completed within 30 days of the date of report.

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

  Not completed as an Act 33 meeting was not conducted because the investigation was completed within 30 days of the date of report.

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

  Not completed as an Act 33 meeting was not conducted because the investigation was completed within 30 days of the date of report.

Department Review of County Internal Report:
The Department has received the County's report dated 04/26/2016 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

- A competent [redacted] investigation was completed by Philadelphia DHS.
- The caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the [redacted] investigation.

County Weaknesses:
No weaknesses identified.

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:
There are no recommendations.