COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

EMILIE ELIZABETH ERFAN

BORN: 8/08/2009
DIED: 9/25/2009

FAMILY KNOWN TO:
No social services agency in Pennsylvania

10/20/2009

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

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

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation

Name	Relationship	Date of Birth
Emilie Erfan	Victim child	8/8/2009
[redacted]	Mother	[redacted]1989
[redacted]	Father	[redacted]/1987

Notification of Fatality:

One month old Emilie was brought to Hahnemann University Hospital on 9/14/2009, and transferred to St. Christopher's Hospital for Children. Child had [redacted] (old and new bleeds) and rib fractures. The rib fractures were about two weeks old. Child was on life support and brain dead. Emilie was not expected to survive, and was taken off life support and passed away on 9/25/2009.

Emilie was born at AtlantiCare Regional Medical Center in Pomona, N.J. Delivery was normal, with no complications. Emilie's primary care provider had been Rainbow Pediatrics; her last well visit was 8/15/2009. The family moved to Philadelphia 9/5/2009. There is a possibility that some of the injuries occurred in N.J. The parents acknowledged the injuries but reported being ignorant about how they occurred.

Documents Reviewed and Individuals Interviewed:

For this review the SERO reviewed the Special Victim's Unit interviews.
SERO interviewed [redacted], the assigned [redacted] investigator from DHS. SERO attended the County's Internal Fatality Review Meeting regarding this case on 10/2/2009. SERO contacted New Jersey Department of Youth and Family Services to determine the status of their investigation.

Circumstances of Child's Fatality:

The parents brought Emilie to Hahnemann Hospital on 9/14/2009 after Emilie had stopped eating, urinating and defecating. At the hospital, Emilie was cold and had stopped breathing. The mother reported to Special Victims Unit that Emilie had not drunk formula or defecated for two days. The mother reported that she was not urinating as much as she used to. The mother reported that they had left Emilie with a babysitter on September 11th for a couple of hours, and that these changes were observed after being

picked up from the babysitter. Child was placed on life support and determined to be brain dead. Child was taken off life support on 9/11/2009.

The doctors explained to the mother that the brain damage was caused by being dropped or shaken. The mother said that five or six days prior to going to the hospital, she had had difficulty carrying Emilie up the subway stairs and noticed that Emilie bounced a lot in the car seat. Both parents denied being aware of Emilie being dropped or hitting her head. The father was never left alone with Emilie. The father reported that two weeks prior to hospitalization that she was "throwing up" her formula. He stated that they had changed formulas and she no longer was vomiting.

The doctor reported that the baby's injuries were more likely caused by being shaken, rather than blunt force trauma. However, the child was negative for retinal hemorrhage. Dr. [redacted] was able to determine that the new brain bleeds occurred within the week that they lived in Philadelphia.

Two [redacted] investigations were conducted. On 9/24/2009, [redacted] This investigation was [redacted] 10/28/2009. Medical evidence "determined that the injuries were two weeks old, which would indicate that the injuries happened in NJ." This case was referred to New Jersey Department of Youth and Family Services. [redacted] reported that it could not be determined if the new bleeding was the result of a new injury in Philadelphia or continuous bleeding from the old injury.

The second [redacted] investigation was reported on 10/16/2009 for medical neglect. The CY48 stated that "due to the delay in victim child receiving medical care, her condition worsened, leading to victim child's death." This was [redacted] for both parents on 12/2/009.

Statutory and Regulatory Compliance issues:

- Case was not known to county agency prior to report; family was living in another state.

Current / most recent status of case:

- [redacted] investigation was [redacted] for Lack of Medical Care. Case was closed at completion of investigation since there were no other children in home.
- SVU has investigated. Due to the difficulty of determining when and where the injuries occurred, the Philadelphia police were not pursuing criminal actions.

County Strengths and Deficiencies as Identified by Act 33 Review:

Strengths-

- The Act 33 Review team felt that the DHS Social Worker did a thorough job investigating this case. She was able to establish good collateral contacts. The case documentation was excellent, providing a clear and concise sequence of events. The Social Worker documented St. Christopher Hospital staff's

unwillingness to sign the safety plan, an issue raised at previous Act 33 reviews and which is the subject of a recommendation below.

- Since the family had moved from New Jersey to Philadelphia a week prior to the hospitalization, it was difficult to determine where the injuries occurred and which agency had jurisdiction to make a [redacted] report. The social worker worked intensively with DHS's hotline and DYFS's hotline until a report was generated. She pursued the case as if it were already [redacted] report which prevented any untimely delays in the investigation.
- As recommended in a prior Act 33 review, the DHS Social Worker consulted with a DHS nurse early in the investigation to gain clarity on the medical issues regarding Emilia.
- Both the DHS worker and the SVU investigator conducted interviews with the identified babysitter. Emilie was actually left in a dorm with a number of college students. Every student who was involved with the babysitting was interviewed.

Deficiencies-

- None identified.

Recommendations for changes at the Local (County) Levels as Identified in Act 33 Review:

- The team recommended that DHS work with DPW and area hospitals to explore the requirement of the hospital's signature on safety plans.

SERO Strengths and Deficiencies:

County Strengths-

- DHS contacted NJ DYFS to determine if family was known to their agency.
- DHS initially received this report as a GPS. They vigorously pursued this investigation to determine if it should be upgraded to a [redacted], and referred it to DYFS as [redacted] when it was determined that the injuries occurred in NJ.
- DHS obtained birth records and well baby records for this child.

County Deficiencies-

- None identified.

SERO Findings:

- SERO followed up with DYFS to determine the outcome of their investigation. DYFS did not actually conduct an investigation. They spoke with their county prosecutor who chose not to pursue the case. As a result of this phone call to DYFS, the Intake Supervisor was going to review the case with a Case Practice Specialist as to why it was not investigated in N.J. since the injuries occurred there.