



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:
John Hurley

Date of Birth: 09/03/2014
Date of Death: 10/10/2014
Date of Report: 10/10/2014

**FAMILY HAS NO PRIOR HISTORY WITH THE
PHILADELPHIA DEPARTMENT OF HUMAN SERVICES**

REPORT FINALIZED ON:
September 30, 2015

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 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report on 11/21/2014.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>	<u>Date of Death:</u>
Hurley, John	Victim Child	09/03/2014	10/10/2014
[REDACTED]	Mother	[REDACTED] 1992	
[REDACTED]	Father	[REDACTED] 1991	
[REDACTED]	Sibling	[REDACTED] 2013	

Other Household Members:

[REDACTED]	Paternal Grandfather	[REDACTED] 1971
[REDACTED]	Paternal (Step) Grandmother	[REDACTED] 1987
[REDACTED]	Paternal Cousin	[REDACTED] 2009

Notification of Child Fatality:

Philadelphia Department of Human Services (DHS) received a [REDACTED] report on October 10, 2014 after [REDACTED] had been called to the home due to the victim child being in cardiac arrest. [REDACTED] observed that the child had blood in his nose and mouth, also, the child's forehead was very pale with markings on the child's face matching a nearby sofa cushion. There was blood on the child's clothing and sofa. It was unknown what caused the bleeding. It was felt that the paleness on the child's face could have been caused by pressure such as a support beam in the sofa. [REDACTED] noticed that the home was unkempt and very crowded. The victim child's mother stated she had laid the child down on his back this morning after eating. However it appears that the child had been lying face down due to the matching marking on his face which corresponds with the sofa cushion. The victim child's mother also reported that she put the victim child to sleep at 5:00am and checked on him at 6:00am; but, the family did not contact 911 until 9:00am. [REDACTED] did not see a crib or other sleeping arrangements for the child. [REDACTED] the situation in the home did not match her accounts of what happened to the child. Therefore a report [REDACTED] ensued. The victim child was pronounced dead at 9:40am.

Summary of Pennsylvania Department of Human Services (PA-DHS) Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current investigation case notes conducted by the Philadelphia DHS investigator. Follow-up interviews were also conducted with the Philadelphia Department of Human Services Investigator and her Supervisor. Also, additional information was received from Philadelphia County Administrator of the Child Fatality Unit as well as from a caseworker from [REDACTED] agency. Moreover, SERO gathered additional information from the Medical Examiner's Office personnel and the Philadelphia Police Special Victim Unit Detective.

Summary of Services to Family:

Children and Youth Involvement prior to Incident

Philadelphia Department of Human Services did not have any prior history with this family.

Circumstances of Child Fatality and Related Case Activity:

Philadelphia DHS received a [REDACTED] Report alleging that a one month old child had died in his home.

[REDACTED] It was reported that the victim child was found unresponsive by his parent. A household composition was then determined and it was learned that the homeowners, who were licensed foster parents and their kinship foster child, were not at the home at the time of the incident as they were on vacation. It was also reported that the family that was there (with the deceased child) was unknown to the county and stated that they were housesitting for the foster parents. However after continued questions with the investigator it was learned that this family lived in the home with the foster family. Moreover, that there was another child in this family household whose safety needed assessed and it was determined that due to [REDACTED] the victim child's death their surviving child would be placed into foster care to ensure his safety [REDACTED] He was placed in kinship foster care on 10/10/2014 with his paternal grandfather and his wife. As the investigation continued the parents slowly began to become trustworthy and the mother admitted that she was co-sleeping with her child and never intended on hurting him yet alone kill him. The parents also admitted to leaving the home each time a child welfare professional [REDACTED] was at the home as to not get the licensed foster parents into trouble. However on 10/16/2014, a preliminary report from the Medical Examiner's Office indicated no evidence of trauma to the victim child's body and the lividity pattern suggested that the child was lying face down which lends to the possibility of co-sleeping which was a factor in the child's death. It appears that this information validated the mother's story [REDACTED] on 10/21/2014. However the Child Protective Services (CPS) investigation was conducted by the regional office. During the regional office investigation the parents were grief stricken and they moved from one relative or friend to another as permanent housing was a real concern for this family. The regional office investigator, [REDACTED] was able to locate the family to be interviewed. The mother was still distraught when she was interviewed and was extremely emotional during her interview as she gave account of how the child died. The Medical Examiner's Office investigation of the victim child's body revealed that there was no evidence to support child

abuse and the Toxicology Report results was reported as negative. The [REDACTED] was completed for this case on 12/03/2014 as [REDACTED] for there was no evidence to support and/or establish intent to injure or kill the infant. The police concurred and there were no charges pressed by law enforcement.

Current Case Status:

[REDACTED] However due to the parents' unstable housing situation they have separated and each of them have been somewhat noncompliance at this time. [REDACTED]

The father is currently working and looking for a home for him and his son. The mother has not complied with the objectives [REDACTED]

[REDACTED] The mother has not been compliant with keeping scheduled appointments. However she is very compliant as it relates to her visitations with her son. [REDACTED]

[REDACTED] The child is safe in the kinship home and has met all goals as it relates to his well-being. The current goal is still reunification but that goal is with the father due to mother's non-compliance with meeting family service plan objectives. There are no providers currently working with the family other than casework services [REDACTED] [REDACTED] agency is still engaging the family towards the [REDACTED] to assist the family with reunification efforts. There is no criminal investigation pending at this time.

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

There was an Act 33 Review Team convened and they held their meeting on 11/21/2014

Strengths: DHS felt that their team conducted a thorough investigation that was completely documented. They also felt their collaboration with law enforcement was good.

Deficiencies: None identified

- Recommendations for Change at the Local Level: No recommendations
- Recommendations for Change at the State Level: No recommendations

Department Review of County Internal Report:

There was an Act 33 Review Team convened on 11/21/2014 as warranted by the Child Protective Services Law.

Department of Human Services Findings:

- County Strengths: Philadelphia-DHS did move quickly to secure the safety of the family's remaining child within this investigation.
- County Weaknesses: None noted.
- Statutory and Regulatory Areas of Non-Compliance: None noted.

Department of Human Services Recommendations: None at this time